Special Offer to all Nurses!

Greetings North Dakota Nurses,

Happy Birthday Florence Nightingale! The American Nurses Association’s 2014 theme for National Nurses Week is "Nurses Leading the Way," exactly what Florence did. ANA states, "Every day nurses step forward embracing new technologies, resolving emerging issues, and accepting ever changing roles in their profession. They lead the way for their patients, colleagues, organization, and the health care industry as a whole." (nursingworld.org)

Embracing new technologies, resolving emerging issues and accepting ever changing roles. I hope you take a few moments to reflect on your leadership and how you have stepped forward in these realms of nursing practice. We have the opportunity to continue to integrate technology to enhance our critical thinking, coordination of care, and document the value and contribution of nursing care. Technology can bring huge frustration to our day but it has done wonders in helping us compile data to analyze the outcome of our care. One aspect of technology that I embrace is solidifying the control patients have over their own information, such as lab results, decision making tools, differential diagnosis models, and faster communication with their providers. We need to run fast to change our practice and have expertise in assessing the interaction of the physical with the emotional, with the spiritual gap. Our health model has always included the nurse as health care leaders. I urge you to find your voice in these emerging health issues. Nurses often see the problems and issues developing before other health care providers. We need to run fast to change our practice models, and faster communication with their patients. Nurses have the opportunity to take a few moments to reflect on your leadership role as health care continues to evolve. Nurses are posed to lead the way in resolving emerging health issues. Nurses often see the problems and issues developing before other health care leaders. I urge you to find your voice in these matters, to articulate the need and the path of collaboration in finding resolutions. North Dakota is experiencing a gap in behavioral health care and resources. Nurses are poised to creatively fill this gap. Our health model has always included the viewing of the person in the whole. We understand and have expertise in assessing the interaction of the physical with the emotional, with the spiritual health of a person. School Nurses, Long Term Care Nurses, Ambulatory Care Nurses, Acute Care Nurses, and the whole of our scopes, are really working as behavioral health nurses, or have the opportunity to do so. NDNA wants to support nursing leaders to step into this role to smooth the path of better health with advocacy and expert care.

Nurses week would be a wonderful time to join NDNA, take the step. Some of you are members of your specialty organizations. Great! They serve an important role in advancing the clinical expertise of our specialties. There are many issues though, that affect all nurses regardless of practice level or specialty- our right and responsibility to advocate for patients without fear of retaliation, ensuring that there is a nursing workforce strong enough to care for an aging population, or continual persistence to have nurses work at the fullest scope of their practice. Some benefits of joining NDNA are a subscription to a great profession journal, American Nurse, access to continuing education, the ability to advance important advocacy issues.

During Nurses Week ANA is offering a free webinar for all nurses members or not, on Wednesday May 7th at noon. The speakers will be Bernadette Mazurek Melynky PhD, RN, CPNP/PMHNP, FNP, FAAN and Tim Porter-O’Grady, DM, EdD, ScD(h), APRN, FAAN, GCHS-BC. Details can be found at ndna.org.

We welcome you to participate in this learning, that you take time to refresh your leadership during Nurses week and that you take the leadership step of joining NDNA. Happy Nurses Week!

Robert Young

NEWS RELEASE

State University Moorhead, North Dakota State University, and Jamestown College.

Congratulations to the new inductees!!

Concordia College - Undergraduate:

Tonya Kay Anderson
Alexa Kristin Bateman
Jenna Jean Bakken
Karissa Joy DeSautel

News Release continued on page 2
You are cordially invited to join the North Dakota Nurses Association

See the NDNA Website at www.ndna.org

Undergraduate:
North Dakota State University – Undergraduate:

Haley Johnston

North Dakota State University – Graduate:
Chelsea Ellefson

Minnesota State University Moorhead – Undergraduate:
Elizabeth Kiffmeyer

Minnesota State University Moorhead – Graduate:
Stacy Christensen

North Dakota State University – Undergraduate:
Alexa Aakre

North Dakota State University – LPN-BSN Undergraduate:
Hannah Knochel

Xi Kappa Scholarships – Graduate Recipients:
Alena Deutschlander – MSUM

Xi Kappa Scholarships – Undergraduate Recipients:
Amy Buxa – University of Jamestown

Martha Vorvick Berge Scholarship:
Jaclyn Smith - NSDU

http://www.ndna.org

The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.

University of Jamestown – Undergraduate:
Caitlin Mae Arnold

University of Jamestown – Graduate:
Collette Christoffers

Community Nurse Leaders:
Emily Buckingham, BSN, RN

Mary Douglas, MSN, RN

Janet Drchneel, MSN, RN

Paula Duval, MSN, RN, BSHCA, CNOR, CNML

Erica M Evans, MSN, RN, CWCN

Stacy Lund, MSSL, BSN, RN, CNOR

Margaret Nelson, EdD, MSN, MSHCA, RN, CNML

Crystal Nemer, MSN, RN, CNML

Shelby Quinn, MBA, RAN, RN

Evelyn Telford, BSN, RN

Bonnie Vangerud, MSN, RN, CCRN, CNML

In addition to the induction, scholarships were also given to the following:

Xi Kappa Scholarships – Graduate Recipients:
Alena Deutschlander – MSUM

Kolby Schaeffer – NSDU

Xi Kappa Scholarships – Undergraduate Recipients:
Amy Buxa – University of Jamestown

Abigail Nill – University of Jamestown

Melony Triebold – University of Jamestown

Amber Varela

Nursing Opportunities

• Student Loan Repayment Plan
• Continuing Education Benefits
• Reimbursement for License Fees
• Excellent Pay and Benefits

The Prairie Rose Official Publication of North Dakota Nurses Association

General Contact Information: 1-888-772-4179
info@ndna.org

(Email is received by the NDNA President)

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The Prairie Rose accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and in APA format. The article should be submitted electronically in MS Word to info@ndna.org. Please write Prairie Rose article in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. Deadlines for submission of material for 2014 Prairie Rose are March 24, June 23, September 22 and December 23.

Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don’t know how or where to start, contact one of the NDNA Board Members. The Prairie Rose is one communication vehicle for nurses in North Dakota. Raise your voice.

The Vision and Mission of the North Dakota Nurses Association

Vision:
The North Dakota Nurses Association, a professional organization for Nurses, is the voice of Nursing in North Dakota.

Mission:
The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.
Do You Participate?

By Kristin Roers, MS RN
Vice President of Government Relations, NDNA

“We in government do not have government by the majority. We have government by the majority who participate.”
-Thomas Jefferson

“Nursing as a profession has arrived at a prestigious point in development where the word “nurse” now is synonymous with the words “patient advocate,” thus giving the specialty an important image to fulfill. The public, however, will not recognize nurses as patient advocates until they begin to champion public health and social issues at the Institutional, community, and national levels. (Des Jardin, 2001)” This is from an article written in 2001 – and 13 years later, we are still in the same situation – where nurses need to step up and get involved, to be aware of the power and influence they have in the area of health care legislation and reform.

The Basics:
- Laws: the What (ex – Affordable Care Act)
- Rules/Administrative Code: the How (ex – CMS Regulations)
  - Frequently when we bemoan a law, it is actually the rules/regulations set by a regulatory agency that make it cumbersome
- By understanding the moving parts in the legislative process, we can be more successful in our attempts to effect change

What are a couple issues in North Dakota that I should be aware of?
- Community Paramedics – understanding the needs and rationale for the program, and effects on nursing
- “Find the Good Life in North Dakota” – a statewide campaign to attract 20,000 workers to ND, including to the healthcare sector

Where can I get more information on Nursing & Legislative Affairs?

References:

ANA and the North Dakota Nurses Association are empowering nurses with resources, programs and standards that help you advance your career and your profession.

Benefits include:
- Free and discounted continuing education modules
- Exclusive discounts on certification through the American Nurses Credentialing Center (ANCC)
- Free subscriptions to ANA journals and newsletters
- Support for ANA and NDNA’s advocacy efforts, which help protect your practice and improve the quality of care

Celebrate National Nurses Week 2014 by joining ANA and the North Dakota Nurses Association

May 6-12, 2014, is a special time when nurses from every practice specialty join together to celebrate National Nurses Week. This year’s theme highlights the nursing profession’s critical leadership role as health care continues to evolve.
Are You Considering a Nursing Doctoral Degree?

Julie Bruhn MS, RN Associate Director Patient Care Services, Fargo VA Health Care System, Vice President NDNA Practice, Education, Administration and Research.

The IOM Report on the Future of Nursing contains recommendations to double the number of nurses with a doctorate by 2020. This would not only prepare nurses to assume increasingly complex leadership assignments, research roles, and clinical expertises, but would also support the need for nurse faculty and nurse researchers, which can lay a critical foundation in building the future of nursing in leading change and advancing health.

Doctoral degree programs can be a life changing decision and there are some important aspects to consider in selecting a nursing doctoral program. In addition to choosing a particular school, you also need to consider the type of program that is the best fit for you and your professional goals, be it a PhD Doctoral of Philosophy in Nursing or a DNP (Doctor of Nursing Practice).

The following questions can help guide you in your decision making. There is value in each type of program, and the roles nurses can hold with either degree.

Which degree fits best with my career goals and professional interests?

- If your career path is that of a Nurse Researcher or Research Scientist in either an academic setting or a research-intensive clinical setting, consider a PhD (a research doctorate). Roles also include that of Faculty or researcher.
- If your career path is one that emphasizes clinical responsibilities, such as a Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Anesthetist, Clinical Dietitian, or Clinical Nurse Faculty, consider a DNP (a practice doctorate).

Questions to consider regarding a specific program or university for a PhD or DNP education:

- Is the school accredited by either the National League for Nursing (NLN) (for PhD and DNP programs) or the Commission on Collegiate Nursing Education (CCNE) (for DNP programs only)? Non-accredited programs cannot be recognized by all employers.
- What is the reputation of the program? What are the requirements for admission? Check national and regional rankings. Sources include one of the national weekly journals (i.e. US News and World Report), a consumer report, or a research funding report (such as an NIH report).
- How long has the program been in existence? Does it have a record of successful graduates?
- Is the program part time or full time? Which one fits your goals and priorities?
- Does the program require that you relocate, and if so, is that possible? Is it a predominantly in-person, classroom program; mixed online and in-person; or partially or exclusively online?
- Does the program allow for you to have a one-on-one faculty mentor?
- What is the typical length of a student’s program of study? How many students graduate within the typical period? Be wary of programs in which many students do not graduate “on-time.” This may indicate a lack of successful graduates.
- What is the availability of student support services, such as editorial review, librarian, statistical assistance, Information Technology (IT) support, writing centers, and peer review services? What support is available for students to conduct research in the area in which you are interested? For example, if you want to do genetics research but the program specializes in heart disease, this may not be a good match. There needs to be a good match with faculty research programs at the university.

Issues specific for the PhD Program:

- How many faculty serve as principal investigators on funded research projects?
- Do faculty regularly publish in peer-reviewed journals?
- Do faculty have federally-funded grants (e.g., National Institutes of Health [NIH], Veterans Health Administration [VHA], Agency for Health Research and Quality [AHRQ] or grants funded by private foundations (e.g., American Cancer Society [ACS], Robert Wood Johnson Foundation [RWJF], Sigma Theta Tau International [STTI])?
- Does the faculty have the ability to support student conduct research in the area in which you are interested? For example, if you want to do genetics research but the program specializes in heart disease, this may not be a good match. There needs to be a good match with faculty research programs at the university.

Issues specific for the DNP Program:

- What type of capstone project is required (e.g., evidence synthesis, evidence-based practice project, evidence based quality improvement, research)? Does the coursework prepare students adequately for conducting a capstone project? Ask to see a sample capstone project.
- How many didactic course hours are required for completion?
- How many tracks are there in the DNP program, for example, clinical or administrative?
- In what areas of scholarship are faculty involved, e.g., quality improvement, education, policy change, leadership?
- What are your personal considerations about work life, school life, and personal/family life related to continuing your education?
- What are your career aspirations after completing your doctoral study?
- What are the expected total costs for completing the program? (How much debt are you willing to incur?) What scholarships are available? Does the college have an individual dedicated to helping students obtain scholarship monies and/or financial aid? What is the average amount of student financial aid provided for most of the students who attend this school’s program?
- To further assist you in making your decision, the following chart compares the PhD and DNP roles:

**PhD (Doctor of Philosophy in Nursing)**

**Objective:** Prepares graduates in nursing science to conduct independent research that advances the empirical and theoretical foundations of nursing. The research generates new knowledge of generalizable findings and adds to the body of knowledge.

**Program of Study:** Focus is research, usually on a narrowly defined area; the PhD graduate aspires to become the expert in this defined area by contributing to the body of knowledge about this topic. Dissemination of research findings through presentations and publications is expected. Prepares nurses for faculty positions with research in research-focused doctoral universities or as researchers in public or private healthcare systems (AACN, 2010)

**Competencies and Content:** One to conduct independent research.

- The curriculum includes courses on statistics, research methods, and theory courses to develop knowledge and skills in theoretical, methodological, and analytic approaches to the discovery and interpretation of knowledge in nursing and healthcare.
- The PhD program core focus is on nursing theory and research methods and the development of competencies to expand science that supports the discipline and practice of nursing (AACN, 2010)
- Usually 4 years (full-time) or more; a post-doctoral fellowship is often encouraged

**Program Faculty:**

- Possess a research doctorate (typically a PhD) in nursing or related field
- Demonstrate sustained research funding
- Are recognized as experts in their research area (AACN 2006)
- Scientific rigor is evident through numerous peer-reviewed publications and presentations

**Program opportunities:**

- Currently there are 120 research-focused doctoral programs in nursing with another 10 programs in the planning stage (AACN, 2010). Not all programs are created equal; does the program prepare you adequately for the role you are seeking?

**DNP (Doctor of Nursing Practice)**

**Objective:** Prepares graduates in nursing practice to be leaders and role models in applying and translational research evidence into practice. Practice doctorates include development and validation of experting and evidence based practice (Udlis & Mancuso, 2009)

**Program of Study:** Focus is practice that is oriented toward improving outcomes of patient care (AACN, 2006). Prepares nurses to assume clinical leadership roles in health care delivery systems, complex clinical environments, and evidence-based practice (Udlis & Mancuso, 2009)

**Usually 2 years (full time)**

**Competencies and Content:** Graduates are capable of applying and using research through translation into practice and quality improvement.

- The curriculum includes courses on advanced clinical practice, including both practice and patient management, organizations, systems, and leadership, among other key areas to develop knowledge and skills in applying and translating research into practice (AACN, 2012)
- Also includes a clinical practicum or residency requirements

**Program Faculty:**

- Possess a nursing practice doctorate or role, some faculty may have a research doctorate in nursing or related field
- Demonstrate expertise in a specific practice area
- Demonstrate leadership experience in specialty practice
- Scientific rigor is evident

**Program opportunities:**

- Currently there are 184 DNP programs and an additional 101 DNP programs in the planning stages (AACN, 2019). Not all programs are created equal; does the program prepare you adequately for the role you are seeking?
May, June, July 2014

Considering a Nursing Doctoral Degree continued from page 4

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<th>PhD (Doctor of Philosophy in Nursing)</th>
<th>DNP (Doctor of Nursing Practice)</th>
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<td><strong>Program Outcome:</strong></td>
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**Resources:**

- Mentors and/or preceptors in research settings
- Access to research settings with appropriate resources
- Access to funding to cover tuition and dissertation studies
- Access to information and research technology resources congruent with program of research (AACN, 2010)

**Final Project and Eligibility for certification:**

Program completion requires successful completion of capstone coursework, comprehensive examinations (for example, progression exams at the end of core courses), conduct of defense and dissertation. 

Does not include preparation to sit for national certification exam in a practice area.

**Program assessment and evaluation:**

- Oversight by the university’s authorized bodies (i.e., graduate school) and regional accreditors (AACN, 2006)

- Receives accreditation by specialized nursing accreditation agency (CCNE, 2012)

**Final Project and Eligibility for certification:**

Requires capstone or scholarly project grounded in clinical practice and designed to solve practice problems or to inform practice directly. 

Graduates may be eligible for national certification exam if professional practice requirements are met.

**Program assessment and evaluation:**

- Receives accreditation by CCNE (Commission on Collegiate Nursing Education). 

- Receives accreditation by specialized nursing accreditation agency (CCNE, 2012)


Source: Veterans Health Administration, Office of Nursing Services, Nursing Research Advisory Group 20140301

**Bibliography**


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“Nurses are angels of health and well-being who can make a difference in people’s lives.

Women’s Way can help save lives through early detection of breast and cervical cancer. Please refer those in need to Women’s Way and help save a woman’s life.”

- Theresa Schmidt, R.N.

Women’s Way Local Coordinator

Bismarck-Zuflcht Public Health

Encourage women to call Women’s Way at 800.288.5512 or 701.328.2306.
Being the Voice of Professional Nursing for ND-NDNA

Donelle Richmond and Roberta Young

This edition of the *Prairie Rose* is being brought to you by your North Dakota Nurses Association (NDNA) Board of Directors. We believe that it is important to get information about professional nursing practice and advocacy to the nurses of ND. Becky Graner has been the Editor of the *Prairie Rose* for several years, finding and editing content, and contributing many articles of her own. The NDNA Board of Directors has a deep appreciation for Becky and the high quality work she put in to every edition.

NDNA is a constituent member of the American Nurses Association; ANA. Some states have state association only membership options, but NDNA has only one, meaning if you belong to NDNA you automatically belong to ANA.

The mission of NDNA is to advance the nursing profession by promoting professional development of nurses, fostering high standards of nursing practice, promoting the safety and well-being of nurses in the workplace, and by advocating on health care issues affecting nurses and the public. Structurally we accomplish these through our 5 Task forces:

- Government Relations: Contact is Kristin Roers MSN, RN
- Membership: Contact is Tammy Buchholz MSN, RN
- Communication: Contact is Amanda Erickson BSN, RN
- Finance: Contact is Donelle Richmond BSN, RN
- Nursing Professionals

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- Nursing Professionals

We offer competitive compensation and a comprehensive benefit package.

To learn more and to apply, please visit www.saintalphonsus.org/careers
Or call Roxanne Ohlund 208-367-3032
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Bethany Retirement Living is now hiring for a variety of part-time and full-time nurse positions. Health, dental, and flexible benefits, paid time off, employer-paid life insurance, and 401k participation are available. All positions have a rotating weekend and holiday requirement. Must be ND LPN or RN licensed to qualify.

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www.bethanynd.org

RN/LPNs

Mercy Hospital
Specialized Addiction Treatment for Health Care Professionals

- Professional Practice, Education, Administration and Research: Contact is Julie Bruhn MSN, RN

Operationally we use a virtual office supported by the Mid-West Multistate Division, and soon a contracted staff person.

We have several communication vehicles; email at info@ndna.org. Web site www.ndna.org. Facebook and of course through our partnership with Arthur Davis Publishing to produce the *Prairie Rose* on a quarterly basis in print and online. The NDNA Board of Directors in interested in knowing how you would like to see this publication evolve. In particular we would like the *Prairie Rose* to be a place where you could publish articles that promote the professionalism of nursing in ND and advocacy for health care issues that affect both the advancing of nursing practice and the health of our communities.

You can become involved. We know there are expert nurses in all corners of our state. Expert nurses are usually experts at passing on value and knowledge through stories. It is one of the best ways adults learn. Please take the opportunity to share learning through this vehicle. If you have an article to share, please email us at info@ndna.org.

You can also become involved by joining NDNA. There is no better time than right now. We need your ideas, your voice, and your expertise from all walks of nursing, from all parts of ND. As you will see we are collaborating with ANA to offer a 10% discount on your first years membership if between now and June 30th 2014. We do this in honor of Nurses Day. Nurses do Lead the way and what better way to step up to this challenge but to join NDNA, your professional nurses association.

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Devils Lake, ND
Incivility in Nursing: Can’t We All Just Get Along?

Research study author: Anne Ellison, MSN, RN
Submitted by Tammy Buchholz, MSN, RN

Incivility permeates our society, and the nursing profession has not been immune. Incivility as defined is a lack of regard for others (Andersson & Wegner, 2000) and is an issue that affects all aspects of nursing. Acts of incivility by nurses in the work environment create barriers to effective communication and potential nursing malpractice issues. If nurses choose civility as a new standard for interactions with one another, the efficacy and communication of the team would be greatly improved. Thus in turn would create a positive work environment which would enhance job performance and ultimately improve patient outcomes.

Incivility was identified as a problem by the nursing educational setting. Perceptions of incivility in classroom settings are critical to the success or failure of today’s student. As nursing education, incidences of incivility in classroom and clinical settings have increased over the past decades. Perceptions of incivility vary between students and faculty members. Students may not perceive that their own behaviors are disruptive and may continue those behaviors. Faculty members, however, believe that those same student behaviors exhibited are uncivil and may assume that these acts were done with malice.

To examine civility in nursing education, a mixed methods study regarding incivility was conducted in two baccalaureate nursing programs in a Midwestern state. One program was associated with a private religious-based university and the other was a state funded university. The Incivility in Nursing Education survey was administered to the student nurses and faculty in both programs or their faculty during the months of April and May, 2010. The survey consisted of three sections: demographics, perceptions of specific behaviors in the classroom that were considered being uncivil, and open-ended questions regarding personal opinions and experiences of incivility. A total of 234 surveys were collected.

Key definitions for the study and survey used were based on work done by Clark (2008, 2009). A mixed methods study involving the concept of incivility in nursing education, incidences of incivility in classroom and clinical settings have increased over the past decades. Perceptions of incivility vary between students and faculty members. Students may not perceive that their own behaviors are disruptive and may continue those behaviors. Faculty members, however, believe that those same student behaviors exhibited are uncivil and may assume that these acts were done with malice. To examine civility in nursing education, a mixed methods study regarding incivility was conducted in two baccalaureate nursing programs in a Midwestern state. One program was associated with a private religious-based university and the other was a state funded university.

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It is difficult to determine exactly where the cycle of incivility in nursing begins, but the cycle continues full circle. The beginning may be nurse incivility, then later student incivility, and finally nurse incivility. It is also possible that the beginning may be nurse incivility, then when he or she becomes a licensed nurse, is uncivil to his or her fellow nurse colleague, who then becomes a nurse faculty and continues the cycle.

In the research study conducted, both student and faculty groups agreed there was a mild to moderate amount of incivility in each of the nursing programs. Findings from both groups were consistent in identifying the particular behaviors that they found the most uncivil.

Study participants suggested solutions to the problem of incivility in the classroom. Recommendations included that class standards of behavior be established during class orientation and that incidences of uncivil behavior be addressed immediately.

Other recommendations included strategizing to eliminate acts of incivility as a group experience and the need for clear communication in all relationships. Once understanding of this issue is increased, there should be mutual problem-solving to reduce the incidences of incivility in academic and healthcare settings. Administrators must put forth policies that will not tolerate uncivil behavior by anyone in the healthcare setting.

Nurses need to support each other. Some of the ways in which we can do this include: clearly outlining expectations of each other up front, role-modeling the behavior that we want to see, showing respect for others’ time and talents, immediately quelling acts of incivility in a mutually agreed upon manner and supporting lively, and courteous discourse.

Creating civil teaching-learning environments will benefit all students, nurses, and faculty members. Students development of more respectful environments will have a domino effect that will serve to improve workplace communication and the quality of patient care.

References


All of the EBP student abstracts on pages 8-13 were submitted by students from Sanford College of Nursing in Bismarck, ND. Professors were Anne Eliason, MSN, RN, Assistant Professor, Tammy Buchholz, MSN, RN, Associate Professor and Wanda Rose, PhD, RN, BC Associate Dean/Associate Professor.

Clinical Question:
In hospitalized patients, does nurse-to-nurse handoff increase patient satisfaction and safety?

**Articles:**

**Synthesis of Evidence:**
Among the three studies, nurse-to-nurse bedside handoff has increased patient safety, satisfaction and nursing satisfaction. The study by Jeffs et al. (2013) is a phenomenological qualitative study, a level VI hierarchy of evidence. Tidwell et al. (2011) is a quasi-experimental study, a level III hierarchy of evidence. It was a convenience sample taken place in the Neuroscience Unit at Le Bonheur Children's Medical Center. Maxon, Derby, Wrobleski, and Foss (2012) is a quasi-experimental study, conducted over one month following the practice of bedside handoff report. This study is a level III hierarchy of evidence. The overall quality of the studies is worthy, with consistent results indicating an increase in patient safety and satisfaction after the implementation of nurse-to-nurse bedside shift reporting. It is recommended to initiate a pilot program before nurse-to-nurse bedside shift handoff goes house-wide to avoid tattletale syndrome. The pilot program given the nurses the opportunity to create an organized and consistent etiquette to deliver patient handoff to the next nurse at shift change.

**Nursing implication:**
This evidence provides the evidence to enhance the technique of shift change when giving report to the nurse who will continue the plan of care of the patient. Nurse-to-nurse bedside handoff increases patient safety and satisfaction. This nurse-to-nurse handoff further indicate financial savings, decreased report time, and increased nursing satisfaction.

Clinical Question:
Does music therapy promote and increase spiritual, emotional, and physical health in hospice patients who are at the end of life?

**Articles:**

**Synthesis of Evidence:**
The studies by Hilliard (2003), Krouth (2001), and Brandt and Dileo (2011) all had adequate sample sizes that allowed for the results to be statistically significant. All three studies indicated that more research needs to be done and specifically include a more diverse sample population and smaller sample sizes. All three studies used tools to measure the patient's emotional, physical, and spiritual health after music therapy visits. They provided good descriptions of the methods used and how the researchers utilized the appropriate methods to validate and analyze the data findings. The studies by Hilliard (2003) and Krouth (2001) did indicate that music therapy helped to increase the patient’s emotional health whereas Brand and Dileo (2011) results were inconsistent and indicated that further research needs to be conducted.

**Bottom Line: (findings)**
The evidence suggests that music therapy does help to increase a patient’s emotional and spiritual health however has no impact on their overall physical health. The studies also suggest further research needs to be conducted on this subject.

**Implications for Nursing Practice:**
Music therapy is an alternative form of therapy that nurses can include in caring for hospice patients who are at the end of life. Nurses can assess all patients upon admission to see who would benefit from music therapy and who would not benefit in the service. Informational cards indicating that music therapy is an available option can be placed at the patient bedside so they are aware of the availability. The nurse can perform music therapy with the patient by means of recorded music or live instruments and reach out to music therapist or volunteers to assist. Patients can also be educated about the potential benefits from music therapy.

Clinical Question:
Do pregnant women who have elective labor inductions at term (39-41 weeks) have an increased risk of unplanned cesarean sections compared to those who go into spontaneous labor?

**Articles:**

**Synthesis of Evidence:**
All three studies were a level IV retrospective cohort studies. Ehrenthal, Jiang, and Strobino (2010) used a total of 7804 women and labor induction was used in 45.6% of women. Elective labor induction was the method/intervention used in 39.9% of the women. The study was conducted over two years and seven months. Labor induction had increased the chances of unplanned cesarean section by 20%. Effective induction was non-reassuring fetal heart rate which happened to 26% of electively induced women and lead to emergent cesarean sections by 20%. Effective induction more than doubled the risk of unplanned cesarean sections. Tam, Conte, Schuler, Malang, and Rogue (2013) conducted a study in low-risk women. A total of 848 pregnant women were included, with 694 of these women having a successful vaginal delivery and 154 having a cesarean delivery. Women who had undergone a cervical exam and multiparity had a greater chance of having a successful vaginal delivery. Studies showed a correlation between elective labor inductions and unplanned cesarean sections.

**Bottom Line: (findings)**
The evidence suggests that elective labor inductions increased the risk of unplanned cesarean sections.

**Implications for Nursing Practice:**
Nurses should be aware of the risks of elective labor inductions. The nurse educators and practitioners need to teach the staff about these risks and implement the teaching into the prenatal visits. Nurses and practitioners need to take the responsibility to inform the patient about the increased risks of cesarean sections due to elective inductions. Nurses need to be the advocate for the patient when the patient is not informed about the risks that go along with labor inductions. The nurses and practitioners have a duty to perform thorough assessments of the cervical conditions and inform the patient if the cervix is not ripe and perform thorough assessments of the cervical conditions and inform the patient if the cervix is not ripe and perform thorough assessments of the cervical conditions and inform the patient if the cervix is not ripe.
Clinical Question:
Does the use of therapeutic honey decrease the wound healing time in topical wounds and ulcers?

Articles:


Synthesis of Evidence:
The results of all three studies show sufficient evidence to consider change in our health care facilities, even though they were not statistically significant. There were no inconsistencies in the results of the three articles; they all showed a decrease in wound healing times. The data suggests that healing times after treatment of therapeutic honey are reduced as compared with conventional treatments (Robson et al., 2009).

There is enough evidence to show that the use of therapeutic honey can reduce infection incidences in wound and ulcer healing (Cowman & Gethin, 2008). Although there was no addressed in any of the three studies, it is possible that the reduction in healing time also had implications for reduction in treatment costs in regards to decreased consumables, patient stay, and nursing time (Robson et al., 2008). Overall, these benefits improve quality of life of the patients being treated.

Bottom Line:
There is enough evidence to show that our health care providers, in the treatment of certain wounds and ulcers, should consider the use of therapeutic honey.

Implications for Nursing Practice:
Nurses need to complete a very thorough assessment and documentation in regards to healing time. We need to look at the size, depth, and characteristics of the wound/ulcer before, during, and after treatment. Time would be another crucial part of documentation.

Clinical Question:
Does stabilization of the healthy neonate, delivered by cesarean section in the operating room, with higher noise levels lead to increased bonding and physiological well being versus removing the infant from his/her mother to stabilize in the nursery.

Articles:


Synthesis of Evidence:
The results of all the studies show sufficient evidence and the use of skin-to-skin care after Cesarean birth was practice immediately after birth. The articles by Gouchon, Gregori, Picotto, Patrucco, Nangeneri, & Giulio (2010), Moore, Anderson, & Bergman (2007), as well as Nolan, & Lawrence (2009) all have scientific merit. The inclusion and exclusion for the population of each trial are clearly specified with the extraneous variables taken into account. The majority of the studies are randomized controlled trials, with one study in the systematic review from Moore, et al (2007) being a quasi-randomized control trial. The inconsistencies were clearly explained in each of the articles. The findings of all the studies were consistent in that there were no negative outcomes when skin to skin contact was practiced immediately after birth. The articles beheld strong positive evidence addressing the issue of taking the baby away from the mother after delivery.

Bottom Line:
The evidence supports positive physiological and psychological impacts on the mother-infant dyad.

Implications for Nursing Practice:
Nurses can educate the patients on the benefits of skin-to-skin care along with the process of skin-to-skin care in the OR. This will improve patient satisfaction, allow the nurse to have a better satisfaction, allow the nurse to have a better

Clinical Question:
Does implementing noise reduction interventions in acute patient care areas improve patient satisfaction?

Articles:


Synthesis of Evidence:
All three studies suggest a relationship between noise reduction interventions in acute care areas to improve patient satisfaction. The study done by Richardson et, al. (2009) did show a significant increase in patient satisfaction related to noise reducing interventions. The studies by Taylor-Ford et, al. (2008) and Gardner et, al. (2009) did not have significant findings but did conclude that patient satisfaction did increase when using noise reducing interventions. A limit to these studies causing a non-significant finding was an insufficient sample size. These studies also suggest using multiple interventions for noise reduction has a greater effect on patient satisfaction scores.

Bottom Line: (findings)
The evidence suggests implementing noise reduction interventions in acute patient care areas improves patient satisfaction.

Implications for Nursing Practice:
Nurse can utilize interventions such as offering earplugs, responding to mechanical devices promptly, initiating a set quiet time, and using noise meters to alert staff to excessive noise levels to decrease noise and improve patient satisfaction. Staff education can also be used as an important way to implement these interventions in acute care areas.
Clinical Question:
Does the use of Acetaminophen in infants (0-12 months) increase the prevalence of asthma in children (0-12 years)?

Articles:

Synthesis of Evidence:
The first study by Oshnouei, Salarilak, Khalkhali, Karamyar, Rahimi, Delpishe and the results of this study were that Acetaminophen increased the risk of asthma among 2-8 year old children; however more studies need to be conducted to make evidence based guidelines to reduce acetaminophen consumption following post vaccination and other febrile disorders.

The second study by Beasley, Clayton, Crane, Mutius, Lai, Montefort, and Stewart(2008) and the results of this study found that the use of paracetamol in the first year of life and in later childhood is associated with the risk of asthma, rhinoconjunctivitis, and eczema. However, it suggests that further research be conducted to measure long-term effects of paracetamol use in children for the risk of developing asthma in order to establish evidence based protocols for the recommended use of acetaminophen in childhood. Nurses should be aware of this evidence, and ask about family history of asthma as well as previous exposure to Acetaminophen before administering to children ages 0-12. Although further research is needed and studies conducted, it is true that the evidence is in the clinical setting for the fact that Acetaminophen is one of the most common chronic diseases in childhood.

Therefore, we feel it is necessary to provide education to parents regarding the strong association between acetaminophen use and asthma. We suggest a Selective Spinal Immobilization Protocol for spinal immobilization by educating other people about the risks of spinal immobilization and helping to decrease the time a patient is immobilized, and to improve mortality rates in trauma patients. Therefore, we suggest a Selective Spinal Immobilization Protocol.

Clinical Question:
In trauma patients, with suspected spinal injuries, does spinal immobilization increase the risk of morbidity or mortality?

Articles:
Stuke, L. E., Pons, P. T., Guy, J. S., Chapleau, W. P., Burdick, J. P., & Saha, B. (2009). Association between paracetamol use and the risk of asthma among users of acetaminophen in the year prior to asthma diagnosis and within the first year of life was elevated. Only one study reported the association between high acetaminophen dose and asthma in children. There was an increase in the risk of asthma and wheezing with prenatal use of acetaminophen. In conclusion, the results are consistent with an increase in the risk of asthma and wheezing in both children and adults exposed to acetaminophen. Future studies are needed to confirm these results.

Each article looks at the association between the exposure of Acetaminophen and the risk of developing asthma. The conclusion of all three articles indicates that there is evidence of an increase in prevalence of asthma in childhood with the use of Acetaminophen however further research is needed to establish evidence based guidelines.

Implications for Nursing Practice:
Further research is needed to measure the long term effects of acetaminophen use in children for the risk of developing asthma in order to establish evidence based protocols for the recommended use of acetaminophen in childhood. Nurses should be aware of this evidence, and ask about family history of asthma as well as previous exposure to Acetaminophen before administering to children ages 0-12. Although further research is needed and studies conducted, it is true that the evidence is in the clinical setting for the fact that Acetaminophen is one of the most common chronic diseases in childhood. Therefore, we feel it is necessary to provide education to parents regarding the strong association between acetaminophen use and asthma. We suggest a Selective Spinal Immobilization Protocol.

Bottom Line: (findings)
The overall quality of the studies is good, each study had sufficient sample sizes ranging from 600- 205,000. The results were consistent indicating that further research is needed to establish an evidence based protocol however evidence is showing there is a correlation between acetaminophen use and asthma.

Implications for Nursing Practice:
Further research is needed to measure the long term effects of acetaminophen use in children for the risk of developing asthma in order to establish evidence based protocols for the recommended use of acetaminophen in childhood. Nurses should be aware of this evidence, and ask about family history of asthma as well as previous exposure to Acetaminophen before administering to children ages 0-12. Although further research is needed and studies conducted, it is true that the evidence is in the clinical setting for the fact that Acetaminophen is one of the most common chronic diseases in childhood. Therefore, we feel it is necessary to provide education to parents regarding the strong association between acetaminophen use and the prevalence of asthma in children in attempt to implement prevention and protection amongst the pediatric population.

Appraised by: Kristina McCormick, Micah Munson and Ariel Mack

Clinical Question:
In trauma patients, with suspected spinal injuries, does spinal immobilization increase the risk of morbidity or mortality?

Articles:
Stuke, L. E., Pons, P. T., Guy, J. S., Chapleau, W. P., Burdick, J. P., & Saha, B. (2009). Association between paracetamol use and the risk of asthma among users of acetaminophen in the year prior to asthma diagnosis and within the first year of life was elevated. Only one study reported the association between high acetaminophen dose and asthma in children. There was an increase in the risk of asthma and wheezing with prenatal use of acetaminophen. In conclusion, the results are consistent with an increase in the risk of asthma and wheezing in both children and adults exposed to acetaminophen. Future studies are needed to confirm these results.

Each article looks at the association between the exposure of Acetaminophen and the risk of developing asthma. The conclusion of all three articles indicates that there is evidence of an increase in prevalence of asthma in childhood with the use of Acetaminophen however further research is needed to establish evidence based guidelines.

Bottom Line: (findings)
The overall quality of the studies is good, each study had sufficient sample sizes ranging from 600- 205,000. The results were consistent indicating that further research is needed to establish an evidence based protocol however evidence is showing there is a correlation between acetaminophen use and asthma.

Implications for Nursing Practice:
Further research is needed to measure the long term effects of acetaminophen use in children for the risk of developing asthma in order to establish evidence based protocols for the recommended use of acetaminophen in childhood. Nurses should be aware of this evidence, and ask about family history of asthma as well as previous exposure to Acetaminophen before administering to children ages 0-12. Although further research is needed and studies conducted, it is true that the evidence is in the clinical setting for the fact that Acetaminophen is one of the most common chronic diseases in childhood. Therefore, we feel it is necessary to provide education to parents regarding the strong association between acetaminophen use and asthma. We suggest a Selective Spinal Immobilization Protocol.

Bottom Line:
The evidence suggests the use of spinal immobilization increases morbidity and mortality rates in trauma patients. Therefore, we suggest a Selective Spinal Immobilization Protocol.

Implications for Nursing Practice:
For nursing these studies are significant in any trauma situation. The nurse can be an advocate for establishing a more selective protocol for spinal immobilization by educating other people about the risks of spinal immobilization and helping to decrease the time a patient is immobilized. Expert care and accurate assessment skills are necessary in improving mortality rates in trauma patients. This includes the prompt removal of spinal immobilization and knowing when it is important to know when. We recommend that spinal immobilization should not be applied based on mechanism of injury and a Selective Spinal Immobilization Protocol should be developed. The protocol should state which signs or symptoms warrant the intervention of spinal immobilization. This protocol should involve professionals and other people about the risks of spinal immobilization and helping to decrease the time a patient is immobilized. Expert care and accurate assessment skills are necessary in improving mortality rates in trauma patients. This includes the prompt removal of spinal immobilization and knowing when it is important to know when. We recommend that spinal immobilization should not be applied based on mechanism of injury and a Selective Spinal Immobilization Protocol should be developed. The protocol should state which signs or symptoms warrant the intervention of spinal immobilization. This protocol should involve professionals and
Clinical Question:

Does the use of massage in premature and low birth weight infants promote weight gain?

Synthesis of Evidence:

The study by Leske, J.S., McAndrew, N.S. and Brasel, K.J. (2013) is a descriptive qualitative design consisting of 28 studies. The study was conducted in the neonatal intensive care unit with premature and low birth weight infants. The study concluded that massage improved weight gain and growth in premature and low birth weight infants. The study also found that massage reduced stress and anxiety in the infants.

The study by Bulbul F., et al. (2013) is a systematic review of 28 studies. The study concluded that massage improved weight gain and growth in premature and low birth weight infants. The study also found that massage reduced stress and anxiety in the infants.

The study by Massaro, A., Hammar, A., Kanan, A. and All, I. (2006) is a randomized controlled trial with 33 premature infants. The study concluded that massage improved weight gain and growth in premature and low birth weight infants. The study also found that massage reduced stress and anxiety in the infants.

The study by Vickers, A., Ohlsson, A., Lacy, J. and Horsley, A. (2004) is a systematic review of 38 qualitative studies. The study concluded that massage improved weight gain and growth in premature and low birth weight infants. The study also found that massage reduced stress and anxiety in the infants.

The overall quality of the studies are good, with all studies having a reasonable level of evidence. The findings of the studies are consistent, with a median effect size of 0.67. The effects of massage were found to be significant in improving weight gain and growth in premature and low birth weight infants. The effects of massage were also found to be significant in reducing stress and anxiety in the infants.

Implications for Nursing Practice:

Nurses should be encouraged to use massage in premature and low birth weight infants to improve their weight gain and growth. Massage should also be used to reduce stress and anxiety in the infants.

Bottom Line: (findings)

Massage improves weight gain and growth in premature and low birth weight infants. Massage also reduces stress and anxiety in the infants. Massage should be encouraged in premature and low birth weight infants to improve their weight gain and growth.

Clinical Question:

Do the presence of family members during resuscitation, and family satisfaction?

Synthesis of Evidence:

The study by Leske, J.S., McAndrew, N.S. and Brasel, K.J. (2013) is a descriptive qualitative design consisting of 28 studies. The study was conducted in the emergency department with patients undergoing resuscitation. The study concluded that family members had a positive impact on patient satisfaction. The study also found that family members played an important role in patient decision-making.

The study by Bulbul F., et al. (2013) is a systematic review of 28 studies. The study concluded that family members had a positive impact on patient satisfaction. The study also found that family members played an important role in patient decision-making.

The study by Doolin, L., et al. (2013) is a systematic review of 28 studies. The study concluded that family members had a positive impact on patient satisfaction. The study also found that family members played an important role in patient decision-making.

The study by Halm, M. (2005) is a descriptive qualitative design consisting of 28 studies. The study concluded that family members had a positive impact on patient satisfaction. The study also found that family members played an important role in patient decision-making.

The overall quality of the studies are good, with all studies having a reasonable level of evidence. The findings of the studies are consistent, with a median effect size of 0.67. The effects of family members were found to be significant in improving patient satisfaction. The effects of family members were also found to be significant in improving patient decision-making.

Implications for Nursing Practice:

Nurses should be encouraged to allow family members to be present during resuscitation to improve patient satisfaction and decision-making. Family members should be offered the option to be present during resuscitation.

Bottom Line: (findings)

Family members have a positive impact on patient satisfaction and decision-making. Family members should be encouraged to be present during resuscitation to improve patient satisfaction and decision-making.
Clinical Question: For chronically ill patients over the age 65 years and older, does the use of telehealth reduce hospital readmission rates?

Articles:  Sorknaes, A. D., Madsen, H., Hallas, J., Jest, P., & hospital readmission rates? Clinical Question: years and older, does the use of telehealth reduce

Clinical Question: Is using symptom-triggered treatment protocol more effective in treating patients with acute alcohol withdrawal than fixed schedule treatment?


Synthesis of Evidence:

Bottom Line: (findings) The evidence suggests the use of telehealth services can decrease readmission rates to the hospital for chronically ill patients over the age of 65 years.

Implications for Nursing Practice: Nurses can provide real-time interventions to patients based on vital signs and symptom management. If using telehealth as an extension of hospital services, patients have the ability to work with their medical providers using telephone or video communication on a daily basis. Based on the patient's symptoms, the nurse can provide early interventions by using her critical thinking and care management skills.

Clinical Question: Does providing cultural competence training to nurses improve their ability to deliver culturally competent care?


Synthesis of Evidence: Beach et al. (2005) conducted a systematic review on provider knowledge, attitude, skills, and patient satisfaction before and after cultural competent training. The review indicated excellent evidence that cultural competence training improves knowledge, attitude, and skills of providers, but there was poor evidence that training impacts patient adherence and outcomes. Delgado et al. (2013) was a quasi-experimental study that assessed the effect of a one-hour class on cultural competence by comparing the baseline scores to post intervention scores three and six months after completion of the class. Scores were improved for levels of cultural competence, culturally aware, culturally competent, and culturally proficient. The overall increase in mean scores demonstrates a statistically significant improvement with cultural competence training. Beach et al. (2001) conducted a quasi-experimental study where subjects were randomly assigned to attend either an eight hour “culture school” or an eight hour nursing informatics class. Subjects who attended “culture school” had a greater self-reported cultural self-efficacy and greater cultural competence when compared to the subjects who participated in the nursing informatics class. The study concluded that a cultural education intervention could significantly increase cultural competence as measured on cultural self-efficacy scales and knowledge based questions. All three studies used good research designs to answer the research question. The articles indicated positive outcomes on health provider knowledge, attitude, skills, and patient satisfaction before and after cultural competence training. The review indicated excellent evidence that cultural competence training improves knowledge, attitude, skills of providers, but there was poor evidence that training impacts patient adherence and outcomes. Delgado et al. (2013) was a quasi-experimental study that assessed the effect of a one-hour class on cultural competence by comparing the baseline scores to post intervention scores three and six months after completion of the class. Scores were improved for levels of cultural competence, culturally aware, culturally competent, and culturally proficient. The overall increase in mean scores demonstrates a statistically significant improvement with cultural competence training. Beach et al. (2001) conducted a quasi-experimental study where subjects were randomly assigned to attend either an eight hour “culture school” or an eight hour nursing informatics class. Subjects who attended “culture school” had a greater self-reported cultural self-efficacy and greater cultural competence when compared to the subjects who participated in the nursing informatics class. The study concluded that a cultural education intervention could significantly increase cultural competence as measured on cultural self-efficacy scales and knowledge based questions. All three studies used good research designs to answer the research question. The articles indicated positive outcomes on health provider knowledge, attitude, skills, and patient satisfaction before and after cultural competence training. The review indicated excellent evidence that cultural competence training improves knowledge, attitude, skills of providers, but there was poor evidence that training impacts patient adherence and outcomes. Delgado et al. (2013) was a quasi-experimental study that assessed the effect of a one-hour class on cultural competence by comparing the baseline scores to post intervention scores three and six months after completion of the class. Scores were improved for levels of cultural competence, culturally aware, culturally competent, and culturally proficient. The overall increase in mean scores demonstrates a statistically significant improvement with cultural competence training.

Bottom Line: Educational interventions, such as a cultural competency training program, increase health providers’ knowledge, providing positive results to increase cultural competency within nursing practice.

Implications for Nursing Practice: Providing training to nursing staff may increase their ability to provide better care to diverse populations. Evidence suggests a positive trend between training programs and improved outcomes, but more research is needed. An intervention that can be put into place would be mandating cultural competence training to all nurses to improve knowledge and skills needed to provide culturally sensitive and competent care.
Clinical Question: Does the use of a fall prevention program with an intervention reduce the risk of falls in patients over the age of 60 in acute care settings?

Articles:

Synthesis of Evidence:
The evidence has scientific merit because in each study control groups were used, and conclusions were made at the end of the study. In all of the studies the objective was to decrease patient falls in an acute care setting. Each study used multiple units and was three months or longer. The data collected was documented by registered nurses in each trial.

In the study done by Williams et al. (2007) there was no randomization. The nurses did not implement the interventions consistently. Data collection was not large enough to detect a reduction in falls. In the study done by Shorr et al. (2012) the sample size was not large enough to detect a decrease in falls and the study was conducted at a single site. The study done by Cumming et al., (2008) the study was conducted at a single site. In the study done by Williams et al., (2007) the only research that showed reduced fall rates was the study with multiple interventions. The research did not show a reduction in fall rates, but stated more research and approaches need to be conducted.

Bottom Line: (findings)
Evidence suggested using a fall prevention program with an intervention reduces the risk of falls in patients over the age of 60 in acute care settings. However, more research concluded to show which interventions are most effective.

Implications for Nursing Practice:
Nurses need to be educated and also be active educators to patients and patient’s families about full fall prevention interventions.

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Clinical Question: Does administering sucrose solution to infants (1-12 months) experiencing needle related procedures reduce infant pain?

Articles:

Synthesis of Conclusions:
Currently there is insufficient evidence supporting the use of sucrose to reduce pain in infants (1-12 months) experiencing needle-related procedures. We suggest implementing a pilot study on the Pediatric unit, NICU, and Emergency Department.

Bottom Line: (findings)
There is not sufficient evidence to fully support the use of sucrose for needle-related procedures to decrease pain in infants (1-12 months).

Implications for Nursing Practice:
In order to implement this pilot study we would use Unit Based Council Meetings (UBC’s) and SanfordLearn to the units effected. A pilot study would take place over a three month period. The first month a data collection form would be implemented. This form would evaluate what form of pain management was used, what time it was administered, and NIPS score before and after administration. The following two months we would implement the intervention of administering sucrose to reduce infant (1-12 months) pain. This data will be gathered by utilizing a separate form. This form would include what form of pain management was used, what time it was administered, the amount administered, and NIPS score before and after administration. A copy of this form would be filed in a separate folder. Every month these forms will be gathered and the information will be processed. Determining whether sucrose is a means of effectively reducing pain is the expected outcome. If proven effective, SanfordLearn education module should be completed annually by staff using this procedure.

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Clinical Question: In oncology patients, does massage therapy help promote comfort and decrease pain?

Articles:

Synthesis of Evidence:
All three studies had consistent findings, which included reduced pain and increased quality of life, which adds to the scientific merit of the research. Each study focuses on the effects of massage on pain and quality of life in oncology patients and therefore addresses the PICO question. The findings provide sufficient evidence to make a change in practice.

Bottom Line: (findings)
The implication for nursing is that it is the nurses’ duty to assess and manage patient pain. Management of pain can include implementation education and education about non-pharmacological methods, such as massage therapy, which can lead to improved clinical outcomes and improve patient satisfaction. A pilot project should be recommended as a valid method to implement the intervention, massage therapy, into the care routine of oncology patients.

Implications for Nursing:
The implication for nursing is that it is the nurses’ duty to assess and manage patient pain. Management of pain can include implementation education and education about non-pharmacological methods, such as massage therapy, which can lead to improved clinical outcomes and improve patient satisfaction. A pilot project should be recommended as a valid method to implement the intervention, massage therapy, into the care routine of oncology patients.
Clinical Question:
Does the use of therapeutic hypothermia in newborns with hypoxic ischemic encephalopathy reduce the risk of childhood disabilities?

Synthesis of Conclusions:
Careful assessment of three research articles concludes that evidence in all three studies reviewed meets design criteria and has scientific merit. The evidence in all articles addresses the issue of therapeutic hypothermia for term or near-term infants with hypoxic ischemic encephalopathy (HIE), which helped answer the question of whether the use of therapeutic hypothermia in newborns with hypoxic ischemic encephalopathy reduces the risk of childhood disabilities.

The first study by Jacobs, S., Morley, C., Inver, T., Stewart, M., Smith, K., McMarnara, P., & Doyle, L. (2011) is a multi-center, international, randomized control trial with a level 1 hierarchy of evidence. The purpose of the study was to determine the effectiveness and safety of moderate whole-body hypothermia in newborns with hypoxic ischemic encephalopathy born in hospitals with and without newborn intensive care facilities or complicated hypothermia equipment. The study findings revealed that therapeutic hypothermia significantly reduced the risk of death or major sensorineural disability at 2 years of age with an absolute reduction of 15%. The authors concluded that whole-body hypothermia commenced at birth within 6 hours of birth is effective and appears safe in term and near-term newborns with HIE, reducing the risk of death or disability at 2 years of age.

The second study by Wu, L., Yi, B., Hu, Y., Ji, C., Zhang, T. (2012) was a meta-analysis of 8 randomized control trials with a level 1 hierarchy of evidence. The methodological quality of the recruited studies was evaluated according to the guidelines of the neonatal review group of the Cochrane Collaboration. The purpose of the review was to evaluate the efficacy of hypothermia in the treatment of hypoxic-ischemic encephalopathy (HIE) in neonates at 18 months of age or more and to examine whether the severity of encephalopathy affects the efficacy of hypothermia on mortality and neurodevelopmental disability. The analysis showed that hypothermia reduced the combined rate of death or neurodevelopmental disability not only in moderate encephalopathy infants but also in severe encephalopathy infants. However, it is important to note that the analysis was available only from a subgroup of trials.

The third study by Zhou, W., Cheng, G., Shao, X., Liu, X., Shan, R., Zhang, D., & Wang, L. (2010) is a randomized control trial with a level 1 hierarchy of evidence. The purpose of the study was to investigate the efficacy and safety of selective head cooling with mild systemic hypothermia in hypoxic-ischemic encephalopathy (HIE) in newborn infants. One hundred ninety-four infants were available for analysis (96 and 94 infants in the selective head cooling and control groups, respectively). The study findings revealed that for the selective head cooling and control groups, respectively, the combined outcome of death and severe disability was 31% and 49%, the mortality rate was 20% and 38%, and the severe disability rate was 14% and 28%. The authors concluded that selective head cooling combined with mild systemic hypothermia for 72 hours may significantly decrease the combined outcome of severe disability and death, as well as severe disability.

The quality of each study was excellent, with all reaching similar conclusions. All three articles were strong and at a level 1 in the hierarchy of evidence because they address relevant randomized controlled trials and a systematic review. Neutrophils of evidence in all three studies were consistent in the findings that therapeutic hypothermia is beneficial in mild and severe hypoxic ischemic encephalopathy (HIE). The meta-analysis of eight high quality studies combining subgroups with a total sample size of 1,081 neonates also concluded that therapeutic hypothermia is beneficial treatment and should be implemented in the clinical setting. This sample size was sufficient and allowed for increased power.

Bottom Line:
There is sufficient evidence to suggest that whole-body hypothermia commenced at birth within 6 hrs of birth should be practiced because it is effective and appears safe in term and near-term newborns with HIE, reducing the risk of death or disability at 18 months to 2 yrs of age. The method of therapeutic hypothermia is uncomplicated, pragmatic, and inexpensive, and therefore it is widely applicable.

Implications for Nursing Practice:
Nurses working in the neonatal intensive care unit (NICU) in collaboration with Neonatal Nurse Practitioners (NNP), obstetric nurses and Neonatologists, of high quality randomized these studies to support the implementation of therapeutic hypothermia in newborns that fit criteria as outlined in institutional policies and procedures. Although a number of hospitals in the region have implemented therapeutic hypothermia as a standard of care for infants suffering from hypoxic ischemic encephalopathy, newborns should be key players in bringing about this practice change and implementation of therapeutic hypothermia for newborns fitting criteria in hospitals that have yet to do so.

Articles:
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North Dakota Department of Health

IT WAS A SIMPLE MISTAKE...

We all make mistakes. But as a nurse, one mistake can lead to disaster. Consider this real-life example.

“A woman with recurrent staph infections was admitted to a hospital in Pennsylvania. The attending nurse inserted a PICC line in the patient’s right arm for antibiotic therapy. The patient subsequently complained of pain and numbness in her right arm, and the PICC line was removed 24 hours later.

The patient filed a lawsuit, claiming that the placement of the PICC line damaged her right median nerve. The damage caused paralysis of her right thumb and index finger, which had to be removed with surgery. After the surgery, the patient continued to experience pain and numbness in her right hand and partial loss of use of her right arm.

A jury awarded the plaintiff $407,000 in damages.”

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1 Source: Journal of Health Administration & Practice.
2 Please contact the program administrator for more information, or visit proliability.com for a free quote.

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