

The PRAIRIE ROSE

NDNA
NORTH DAKOTA NURSES
ASSOCIATION
1912-2012

Inside

THE OFFICIAL PUBLICATION OF THE NORTH DAKOTA NURSES ASSOCIATION
Quarterly publication direct mailed to approximately 16,000 Registered Nurses and LPNs in North Dakota

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February, March, April 2015



Being a Super HERO
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“The Brain Connection”
April 17, 2015



SAVE THE DATE!



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PRESIDENT’S MESSAGE



Roberta Young

Greetings North Dakota Nurses,

I want to thank you for taking the time to read the publication of the North Dakota Nurses Association. This issue brings you a summary of the NDNA Annual meeting and the combined Board meetings of NDNA and the Nursing Students Association of North Dakota. It was an honor to get to know them and observe their leadership. We are also including an update on the HERO organization and how nurses have helped across the globe for years. There are 2 updates from the Mid-West Multi-State Division (MWMSD) for your perusal. We are fortunate to offer CE services for our state through the MWMSD. I hope you already have March 11th marked on your calendar for Nurses Day at the Legislature. You will be able to read a bit more about it in this edition. NDNA is proud to be a sponsor of the luncheon with our Legislators. We are also able to highlight several great Evidence Based Practice project abstracts from the NDSU Bismarck College of Nursing Research Day. Our future looks bright based on this work! WOW

I have recently experienced a major role change in my professional work. Working through the transition has heightened my realization of what parts of work are really of value and what is not. In a word, “relationships” provide the value. I have been so fortunate to work with great people who are also very fine health care leaders. They have taught me so much.

I have also had the privilege to work with a great group of nurses, nursing assistants, physicians, pharmacists, chaplains, who have a passion for expert palliative care. The root of the word palliative is to cloak, so the work is about cloaking or covering, managing symptoms so they are not annoying and getting in the way of life. Palliative care uses a multidisciplinary approach to manage not only physical symptoms of chronic and life limiting conditions but also mental, emotional, and spiritual wellbeing. This is a work that is the very foundation of nursing practice, because to be successful it has to be patient and family driven. That also makes it relationship driven.

Expert practitioners of palliative care live the value of honoring the patient clinician relationship, the true value of team relationships and relationship with self. Good palliative care is at its foundation, patient centered with intention. Meaning that it is not just cliché words of being “patient centered” but one where the question is asked out loud many times to help drill down to whose expectations is being met. The question is simple, “Is this the patient’s goal?” or “Is this what the patient has asked for.” The answer often

or may make others uncomfortable.

For instance if a patient chooses to tolerate a higher level of pain to be more alert, it may make nurses or a family member uncomfortable. In relationship with the patient, the nurse needs to respect and support their choice. In relationship with self, the nurse needs to be wise enough to examine his or her own motives for wanting the patient to have more pain meds. Does the nurse want to provide more pain medication because it will make the nurse feel more comfortable and successful?

This is where good team relationships become valuable. In a strong team, they can honestly call out behavior that is detrimental to the patient centered goal, in a caring manner. In a team that lacks trust, that kind of open dialogue may cause defensiveness and it can very difficult to untangle those conversations. We have all been there.

As you read this, I challenge you to examine your practice to improve and foster relationships that will result in improved patient/client care. Is it with a co-worker, or is it with yourself to acknowledge the need to be more willing to learn from patients and families. You can hone the skill of being present with patients and clients, so you are listening to the meaning of their words and questions not just the surface of the conversation.

Although I see the attention to relationship more visible in the work of palliative care, I know it is a good work for any practice including yours.

To read more check out: <http://www.nationalconsensusproject.org/>



NDNA and NSAND Boards of Directors, November 15, 2014

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Writing for Publication in the Prairie Rose

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 2015 Prairie Rose are 3/19/15, 6/19/15, 9/18/15 and 12/18/15.**

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: 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.

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NDNA 2014/2015 Advocacy Platform

- Promote access to safe, competent and affordable care.
 - Support new and evolving roles as long as there is role clarity, appropriate education and training, appropriate oversight and that nurses are recognized for their role as care coordinators, which may necessitate removal of the delegation rules in the Nurse Practice Act that limit nurses ability to exercise their judgment.¹
- Collaborating in the study of the Community paramedic pilot to ensure safe, gap free care.
 - Continue monitoring of pilot sites for measurable health outcomes.
 - Through legislation during the 2015 session, develop a scope of practice to better define the community paramedic role and skill set and to include a provision for Advanced Practice Registered Nurses to also supervise community paramedics.²
 - Require uniform education and training program including core components.²
 - Through legislation during the 2015 session, provide clear definition and reporting lines for accountability and mechanism for documentation of care including provider orders.²
- Advocating for increased access to behavioral health care
 - Will monitor bill development on funding for increased access of mental and behavioral health.
 - Monitor for increased funding for APRN education to provide Behavioral Health Care.
- Advocating for increased access to School Nursing
 - Students' health and health needs must be addressed in schools to achieve optimum learning.³
 - Supports the assignment and daily availability of a registered school nurse for the central management and implementation of school health services at the recommended ratio of one nurse for every 750 students, with an ultimate goal of at least one nurse in every school.³
 - On any given weekday, as much as 20% of the combined US population of children and adults can be found in schools (AHA, 2004). To best serve the health needs of students and staff in educational settings, ANA supports a collaborative school health model which requires the cooperation and participation of the school nurse, students, families, teachers, school administrators and staff, other health care professionals, and the community.³
- Collaborating with agencies such as American Cancer Society for decreased tobacco use.
 - Tobacco is a worldwide epidemic that requires the leadership and active involvement of nurses.⁴
 - All nurses and nursing organizations are actively involved in developing and supporting local, state, and national legislative and regulatory efforts that:
 - Restrict the direct and indirect marketing of tobacco products, including those products that might be launched in the future, and those making unproven health claims.⁴
 - Increase the price of tobacco products through taxation and allocate part of the revenue to tobacco-control programs and tobacco-related research.⁴
 - North Dakota has the 46th lowest cigarette tax of all 50 states and the District of Columbia.⁵

State	Tax per Pack	Ranking
New York	\$4.35	1st
Minnesota	\$2.83	7th
South Dakota	\$1.53	24th
Average	\$1.54	
Montana	\$1.70	19th
Wyoming	\$0.60	40th
North Dakota	\$0.44	46th
Missouri	\$0.17	51st

- Continue to advocate for increase access to professional nursing education and nurses working in the full authority of their practice.
 - Support higher education for nurses. We need fundamental wide-range planning for changes in the education and deployment of the nursing workforce.⁶
 - Reduce regulatory barriers, enabling Registered Nurses (RNs) to practice to the full extent of their education and training.⁶
 - Revise scope-of-practice laws that discourage full use of advanced practice nurses, pharmacists, and other allied health professionals (collaborative practice agreements, supervisory requirements, prescribing limitations).⁶

1 Janet Haebler, Associate Director, ANA State Government Affairs 10/30/14
 2 North Dakota Center for Nursing Policy Brief, Community Paramedic Pilot Study Recommendations, September 3, 2014
 3 Assuring Safe, High Quality Health Care in Pre-K Through 12 Educational Settings, American Nurses Association Position Statement, 03/2007
 4 Nursing Leadership in Global and Domestic Tobacco Control, Oncology Nursing Society Position, 01/2013
 5 Campaign for Tobacco-Free Kids, June 20, 2014
 6 Looking for Solutions to Improving Health Care in Your State?, IOM Recommendations, America Nurses Association, 07/2012

NURSES DAY

HOSTED BY THE ND CENTER FOR NURSING
MARCH 11, 2015, STATE CAPITOL

You Are Invited to Nurses Day at the Legislature!

ND Nurses' Day at the Legislature is a great opportunity for nurses and student nurses from across the state to become engaged in our state's legislative process. Nurses new to the policy arena will learn more about the process and see the legislature in action. Seasoned nursing advocates will have the chance to voice their passion for nursing issues and provide key visibility to organizational legislative priorities. North Dakota Nurses Association is a proud sponsor of the Nurses Day at the Legislature.

The goals of Nurses Day include:

1. Provide an opportunity for nurses to learn about the legislative process and interact with legislators on key issues during the legislative session.
2. Provide an opportunity for legislators to learn about key nursing issues and to interact with representatives from multiple nursing organizations across the state.

For more information about Nurses Day go to www.ndcenterfornursing.org and click on events tab on the top of the page.

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Report on the 2014 NDNA Annual Meeting of the Membership

by Donelle Richmond and Tammy Buchholz

Let me begin by giving a huge thank you to Tammy Buchholz for her excellent minutes of our recent meeting. I borrowed heavily from them to write this report. Thanks Tam!!

The annual meeting was held November 15th at the Radisson Hotel in Bismarck. Other than the low turn-out it was a very good meeting. The NDNA Board had begun the day by having a joint meeting with the Board of Directors of the Nursing Students Association of North Dakota (NSAND). It is sad to report but NSAND continues to have more members than NDNA! We are hoping our collaboration with them as students will show them the benefits of belonging to and supporting their professional organization after they enter the work force. NDNA board members will be joining the students at their annual convention in Minot the last weekend in January. We are also looking at partnering with them on local community activities and fund raisers in 2015.

After calling the meeting to order President Roberta Young announced some upcoming dates that everyone needs to add to their calendars. Nurses Day at the Legislature will be held March 11, 2015. The event is being coordinated by the North Dakota Center for Nursing with NDNA as one the sponsors. The second date is the 100 year celebration of the North Dakota Board of Nursing on May 21, 2015 at the Heritage Center in Bismarck. The Center for Nursing website has links to both events for more information.

Wanda Rose and Ev Quigley shared some history on the founding of the BON. It was at the urging of NDNA that the BON be created as a regulatory agency to oversee practice and policy. The first Executive Director of the BON was concurrently the President of NDNA. The creation of the BON in 1915 by the nurses of North Dakota, who are almost exclusively women, is even more impressive given that women did not get the right to vote until 1918. Be sure to read the next edition of the *Prairie Rose* for more history on the BON.

Jane Roggensack, NDNA delegate to ANA Membership Assembly, shared their experience at this year's meeting in June. Both Jane and Roberta participated in Lobby Day, when all

delegates visit Capitol Hill to meet with their respective Senators and Representatives to share concerns regarding health care policy. They were unable to meet personally with Senators Hoeven and Heitkamp or Representative Cramer, but they did share information with their aides. Other dialogue forums held at Membership Assembly centered on full practice authority for all RNs, the integration of palliative care into more health care systems, and the development of high-performance inter-professional teams.

President Young then reported on our (NDNAs) continued partnership with the Midwest Multi-State Division (MSD) through ANA. We have been able to use this partnership to gain efficiencies in accounting, reports, phone systems, website and emails. That is one of the three goals of the MSD. The other two are increasing membership and nurse advocacy. Those two goals will be the focus of the coming year for both NDNA and the MSD.

Next up was installation of new officers. Roberta Young, President and Donelle Richmond, VP of Finance, were both reinstated for their second terms. Jamie Hammer was installed as the VP of Practice, Education, Administration and Research. The board looks forward to getting to know and work with Jamie in the coming years.

Donelle Richmond reported on the financial status of NDNA. Thanks to the continued diligence of the board we are in a healthy situation. Our primary concern is that our main source of income is from membership dues, and even though our numbers have increased slightly this past year we feel a need to diversify and find additional sources. Our work with the MSD in developing a CE program is one option being developed. If anyone is interested in specific budget numbers please contact me directly.

Discussion then turned to the upcoming legislative session in North Dakota. Kristin Roers, VP of Government Relations, and Tammy Buchholz will be registering as lobbyists for NDNA. The Center for Nursing will be doing our bill tracking again for us this year. Kimberly Kuhlmann from the American Cancer Society Cancer Action Network presented information on a proposed bill to raise the tobacco tax in North Dakota. Please see Kristin's article elsewhere in this edition for more information on our platform and issues we will be following.

Bylaws revisions were centered on shortening notification time requirements and NDNA awards. Time frames were shortened since communication occurs much quicker in our current times. The awards were changed so that they "may" be conferred annually on deserving individuals instead of requiring them to be.

Other discussions on a variety of topics were held throughout the meeting. If you would like to know more please contact NDNA for a copy of the minutes. Action items for NDNA in the coming year are the development of organizational policies and procedures (we were left without any when we went to virtual office), hiring a Director of State Affairs and getting them up and running, collaborating with NSAND on various activities, increasing membership and participation, and promoting the CE program through the MSD. Please join us!!!

News Release

Xi Kappa-at-Large Chapter of Sigma Theta Tau International Honor Society of Nursing held its annual Induction Ceremony in conjunction with its 20th Anniversary Celebration on Saturday, November 1, 2014. The induction recognizes nursing students and community nurse leaders who have demonstrated achievements in nursing, leadership qualities and high professional standards.

Inductees consisted of graduate and undergraduate students from the following colleges: Concordia College, University of Jamestown, Moorhead State University Moorhead, North Dakota State University, and North Dakota State University at Sanford Health Bismarck. The Community nurse leaders are nurses with high achievement and reside in communities across North Dakota and Minnesota. Congratulations to the new inductees!

Concordia College - Undergraduate: Mikayla Carey, Kayla Doebbeling, Lindsay Erickson, Scott Flotterud, Abigail Haugen, Jennifer Hoyt, Erin Januschka, Nicholas Leen, Laura Mansell, Amanda Mikelson, Santiago Ocariz, Jenna Posch, Laura Prosinski, Marta Prosinski, and Laura Radig.

University of Jamestown - Undergraduate: Chelsey Cotney, Amber Fearnside, Shana L. W. Hall, Kayla Isaacs, Brittany Maasjo, Ashley Mueller, Andra Roorda, Makenzie Sell, Andrea Toepke-Floyd, Katie Stumpf, Keleigh Van Dyke, and Averee Zent.

Minnesota State University Moorhead - Undergraduate: Stephanie Danger, Amy Harding, Danelle Jones, Amy Peterson, and Jessica Stewart.

Minnesota State University Moorhead - Graduate: Jill David Jensen, Jessica Galbrecht, Jennifer Kastl, and Rachel Tushaus.

North Dakota State University - Undergraduate: Kacie Becker, Paige Bell, Tara Buss, Jessica Diaz De Leon, Bonnie Hemquist, Kaitlin Karsky, Bria Knaust, Austin Kutzer, Mitchell Lehn, Chelsea Lingle, Alexander Olson, Amber Riopelle, Alice Safe, Alexis Schauer, Danielle Simenson, and Jessica Webber.

North Dakota State University - Graduate: Michelle Brown, Dianne Kappelman Beyer, Allison Peltier, and Vanessa Skolness.

North Dakota State University at Sanford Health Bismarck - Undergraduate: Lindsey Miles, Erin O'Leary, Jerri Jo Sterna, Jessica Stober, Devin Doolittle Murphy, Julie Perkins, Christopher Coombe, Merry Kraft, Amy Meyer, and Megan Humann.

Community Nurse Leaders: Cheryl Anderson, BSN, MSSL, RN; Michelle Jetvig, BSN, RN; Sharri Lacher, MSN, RN; Rebecca Moch, BSN, MSSL, RN; Thomas L. O'Keefe, BSN, MSN, RN; Kristiana M. Oleson, AD, BSN, RN; Mary Jane "Janie" Olson, BS, MSN, RN; Michelle Pace, BSN, RN; Janet Riggins, BSN, MSN, RN; Patricia (Trish) Strom, BSN, M.ED, LPC, RN; Jacki Bless Toppen, BA, BSN, MSN, RN; and Nicole Lee Ueckert, BSN, RN.

Scholarships and awards were also given to the following recipients:

Xi Kappa Graduate Scholarship: Jenna Wallace - NDSU. Xi Kappa Undergraduate Scholarships: Jessica Diaz De Leon - NDSU, Andrea Toepke-Floyd - University of Jamestown, Abigail Haugen - Concordia, Chelsea Lingle - NDSU, and Alexander D. Olson - NDSU. Martha Vorvick Berge Memorial Scholarship: Katie Stumpf - University of Jamestown. Excellence in Nursing Education Award: Wendy Hournbuckle, MS, RN - University of Jamestown. Excellence in Nursing Practice Award: Crystal Nemer, RN, MSN, CNML - Fargo VA Health Care System.



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ANA Professional Issues Panels: An Opportunity for Nurses to Lend their Expertise and Knowledge to Address National Issues Related to Practice and Policy

Tammy Buchholz, MSN, RN, VP Membership Services for NDNA

Advisory Committee member representing ND for the ANA Workplace Violence and Incivility Professional Issues Panel, 2014-2015

I've shared in the past that I made a conscious decision to become a member of NDNA/ANA because I wanted my voice to join the voices of other nurses and to be heard. Not everyone is cut out for an active role in the organization they belong to, but many see becoming involved as a means to network and push themselves and their professionalism as nurses to new levels. NDNA and ANA both offer opportunities to be involved in varying degrees.

As I began increasing my involvement in NDNA and ANA, I learned about an opportunity for those of us involved in our professional nursing organization in North Dakota to become involved on a national level. This opportunity to become engaged in practice and policy issues was presented in the form of a **Professional Issues Panel**. This exciting and dynamic format seeks to draw on the knowledge and expertise of every ANA member. Let me explain the purpose of and the qualifications for Committee membership on an **ANA Professional Issues Panel**.

The purpose of the **ANA Professional Issues Panels** is to meet the new dynamics of care needs in every setting as the world of professional nursing practice and health policy is ever evolving. In order to effectively address these changes, ANA uses **Professional Issues Panels** to drive toward informed decision-making, member engagement and active dialogue with members. Panels are convened around specific practice and policy questions as approved by the ANA Board of Directors. Each Panel includes both a Steering Committee and an Advisory Committee to ensure sufficient rigor while also allowing for broad feedback from a full range of practice arenas and interests.

Allow me to share the differences between the Steering Committee and the Advisory Committee. The Steering Committee typically includes up to 15 ANA members who will do a deep dive into a topic. This committee will meet intensively via conference call for a three to six month period, depending on the topic. The Advisory Committee will provide additional information, feedback and advice to ANA and the Steering Committee by responding online to specific questions, documents and dialogue.

All positions on the **Professional Issues Panels** are on a volunteer basis. You must be a member of ANA and you must be an RN in order to apply for a **Professional Issues Panel**. The time commitment depends on the Committee you are a member of. Steering Committee members meet at least once a month for about 2 hours in addition to email dialogue for a 3 to 6 month period of time depending on the topic. The Advisory Committee requires about 1 hour per month and typically 2 conference calls during the duration of the panel. Applicant qualifications required for each panel are listed with the application information on the ANA website. The wonderful thing about the **Professional Issues Panels** is that all applicants who are not selected for the Steering Committee are placed on the Advisory Committee for the panel that they applied for.

When I began my term as VP of Membership in October of 2013, I applied to serve on the Code of Ethics for Nurses Revision **Professional Issues Panel**, 2013-2014. I was excited to be placed on the Advisory Committee, and was the only nurse representing North Dakota. I have followed and participated in the revision process throughout this past year. Final approval by the ANA Board of

Directors for the revised Code of Ethics for Nurses was given on November 12th. Plans are for it to be available in print and e-publication by early 2015.

This fall I applied to serve on the Workplace Violence and Incivility (WPVI) **Professional Issues Panel**, 2014-2015. I will be one of two nurses representing North Dakota as an Advisory Committee member, and one of 441 nurses on this committee. The goal of this **Professional Issues Panel** is to develop a position statement on workplace violence and incivility and detailed guidance for registered nurses and employers.

As a former faculty member at a college of nursing and as a staff nurse on an obstetrical unit, I have seen and experienced for myself many incidents in both settings of uncivil behavior from or between patients, colleagues and students. This work is necessary and timely given that statistics from surveys and research that have been conducted estimate as high as 89% of nurses, faculty and student nurses report having experienced incidents of uncivil behavior in the workplace.

This November a joint meeting of NSAND and NDNA was held prior to the NDNA Annual Meeting. This opportunity allowed the NDNA Board and the NSAND Board to discuss collaborative ideas and how best to foster interest and engagement by nurses in their professional organization. During the discussion, mention was made of my being an Advisory Committee member of the WPVI **Professional Issues Panel**.

One of the NSAND Board members, Andrea Boerger, shared that she and a group of student nurse colleagues at the University of Mary had worked on a project together that centered on disruptive and aggressive behavior by patients and the effects of those types of behaviors on staff caring for them. Andrea shared her written work with me, which included a proposal to use staff education as a means to provide nurses with the tools needed to effectively de-escalate these behaviors in patients. Andrea and her colleagues' work demonstrates that student nurses are aware of the environment that they will be entering upon

graduation and have a genuine concern for how best to navigate these situations.

I encourage you as a member of ANA and NDNA to follow the progress of the work of the WPVI **Professional Issues Panel** in the next few months. I also encourage you to take action and join me, in representing the nurses in our wonderful state of North Dakota on a **Professional Issues Panel**. We need your knowledge, expertise and guidance as we navigate the ever-changing health care environment and develop policy and practice guidance for registered nurses.

Acknowledgement: If you are interested in learning more about the project that Andrea Boerger and her colleagues completed, she can be reached at: acboerger1@umary.edu

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Being a Super HERO

by: Anne Virginia Lindstrom,
Communications Director, HERO.

Hero. A person who is admired for great or brave acts or fine qualities. Do you have what it takes to be a hero? Even a super hero? Here at HERO, Healthcare Equipment Recycling Organization, we work hard to living up to being real super HEROes. HERO's mission is to collect and redistribute donated healthcare materials to benefit those in need. In other words, HERO is here to help.

HERO started in 1996 when a group of operating room nurses from the Fargo-Moorhead area saw all the usable medical supplies discarded as waste at the hospitals. These nurses joined together and began saving the supplies they could in an effort to distribute them to those in need on a global level.

Within four years, HERO became established as a registered 501(c)3 nonprofit organization and by 2003, the nurses added a local aspect to their mission. Supplies were now also redirected within the local community to help those in need right here in Fargo-Moorhead. HERO was operating out of a small warehouse in Moorhead for a seven year span.

In 2005, the first full-time executive director was hired to help direct the mission. Only 5 years later, HERO moved to an even larger warehouse space in south Fargo, complete with offices and a storefront.

Today, HERO serves over 3,000 local individuals and agencies locally and provides supplies for 50 global medical missions. Since the start of HERO, nearly \$1,000,000 in economic impact has been felt in the local community due to HERO's work. From a 400 square foot garage to a 7,000 square foot warehouse and office space, HERO is continually growing and ready to help those in need.

HERO accepts donations of a variety of healthcare supplies from individuals and local hospitals and clinics. These materials are then



inventoried to the storefront where individuals and agencies can pick up supplies at low- to no-cost. Supplies range from bandages all the way up to hospital beds.

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The Midwest Multi-State Division Spring 2015

by: Jill Kliethermes,
Midwest Multistate Division Leader

It is a pleasure and an honor to be able to serve as the Midwest Multistate Division Lead of an amazing group of Midwest State Nurses Associations and to work with some of the most incredible, hardworking, distinguished, educated, and collaborative registered nurses. The second year of the Midwest Multistate Division (MSD) pilot is well underway. The MW MSD pilot has been both exciting and challenging as we try to come together to increase operating efficiencies in order to build membership and advocacy efforts in the state nurses associations. The following states are currently included in the Midwest MSD: Iowa, Kansas, Missouri, Nebraska, and North Dakota. There are two additional Multistate Divisions being piloted which includes the Northeast MSD (RI, NH, ME, CT and VT) and the West MSD (UT, CO, ID and AZ).

There have been many successes as a result of the pilot; however a notable success has been the Midwest Multistate Division Continuing Nursing Education Unit (MW MSD CNE Unit) being launched. To learn more about the MW MSD continuing education approval process, please contact the MW MSD Office at 573-636-4623 or email questions@midwestnurses.org.

Through our pilot we found several opportunities to increase operating efficiencies within the participating state nurses associations (SNAs) which have included:

- Launching a call center within the MSD to enable all SNAs to have a phone number and have the phone answered by an attendant.
- Offering financial and accounting services within the MSD and reducing individual SNA expenditures for these services with other service providers.
- Providing common policies and procedure templates to support SNA operations.
- Identifying nurse planners to help plan events co-provided within the MSD.
- Instituted a weekly Professional RN Update publication "Lighting the Way."
- Monthly leadership calls with the SNAs.
- Monthly membership/marketing taskforce calls with the SNAs.
- Obtained group purchasing/contracts for services discounts for the SNAs.
- MSD Lead participating in SNAs board meetings for consultation.

The Midwest MSD will continue to work on implementing a stream-lined business operations model that leverages common capabilities of the SNAs and ANA to enhance the multistate operations. Through this joint, collaborative effort the Midwest MSD will be more efficient and profitable, allow for more effective advocacy and membership recruitment, and retention efforts in the SNAs. ***The overarching goal is for the SNAs to grow and become more vital and visible in the future.***



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Advance Care Planning (Part I of III) The Evolving Paradigm

by Nancy Joyner, APRN-CNS, ACHPN and
Sally May, BSN, RN

Modern scientific capability has profoundly altered the course of human life. People live longer and better than at any other time in history. But scientific advances have turned the processes of aging and dying into medical experiences, matters to be managed by health care professionals. And we in the medical world have proved alarmingly unprepared for it.

(Atul Gawande, p.6, 2014)

Abbreviations

ACP - Advance Care Planning
AHA - American Heart Association
CPR - Cardiopulmonary Resuscitation
IOM - Institute of Medicine
NHDD - National Healthcare Decisions Day
NDACP - North Dakota Advance Care Planning Initiative
NDHCR - North Dakota Healthcare Review, Inc.
NDMA - North Dakota Medical Association
POLST - Physician's Orders for Life Sustaining Treatment

Advance Care Planning Background (1900-1950)

Over the past century, Americans have seen significant changes in how illness and death are experienced. These changes can be attributed to the advancement of healthcare and the national attention given to several legal/ethical cases in recent decades. In the past, physicians made decisions regarding patient treatment and care based on professional beneficence and authority. With the primary focus on saving and extending a patient's life, there was a reluctance to fully disclose a person's health status, in part, due to the limited life-sustaining interventions available at that time. The change in the patient experience occurred as the practice of full disclosure evolved. (Wilkinson, Wenger & Shugarman, 2007, Office of Assistant Secretary, 2008).

Generally speaking, patients were not only uninformed of their medical status but also were not included in medical decisions. The evolution of the patient experience is related to patients' ethical and legal entitlement to decision-making involvement. Though honoring patients' wishes and their right to choose health care and treatment options has been an accepted practice by most healthcare providers since the late 20th century, it was in 1914 that the ethical and legal right of patients to be involved in their health care decisions was first established. The case was *Schloendorff vs. Society of New York Hospital* in which the justice system asserted, "every human being of adult years and sound mind shall have the right to determine what shall be done with his own body..." (Brown, 2003, Green & MacKenzie, 2007).

Extensive advances in medical technology over the past 50 years have created ethical and legal ramifications of disclosure. Medical technology has provided numerous life-sustaining treatments but not without complexity. With the advent of cardiopulmonary resuscitation (CPR) and artificial ventilation in the 1930s-1950s, came the expectation of recovery (Young & Sykes, 1990, AHA, 2014). The modern era of surgically placed feeding tubes began in the mid to late 1800s and even more commonplace with the development of the percutaneous endoscopic gastrostomy (PEG) devices in the 1980s (Minard, 2006). With patients surviving and living longer, they required increasingly more care and interventions. Many patients experienced emotional and prolonged, often painful, end-of-life journeys. This prolonged suffering by patients also affected family members, caregivers and healthcare professionals. As more and more Americans experienced the burdens and diminishing benefits of invasive and aggressive medical care, the need to clarify end-of-life treatment preferences became evident.

Further Legal and Ethical Development (1960-1990)

In the 1960s, patients and families became interested in better end-of-life care including hospice. More legal and ethical issues began to arise

regarding life and death issues. In 1967, the first living will was conceived by Luis Kutner, a Chicago human rights attorney, whose goal was to facilitate "the rights of dying people to control decisions about their own medical care" (Wilkinson, Wenger & Shugarman, 2007). In 1968, the first living will legislation was presented to a state legislature. Living wills were created to maintain the patient's wishes when they could not speak for themselves in medical decision-making and empower individuals to direct the terms of their own medical care at the end of life.

The pivotal case of Karen Ann Quinlan (1954-1985), age 21, received national attention in 1976. Though she was successfully resuscitated after a cardiac arrest, she remained in a coma supported by artificial ventilation. Her parents were forced to turn to the courts to withdraw the ventilator support so Karen Ann could die naturally as there was no other method of making those critical decisions. In this case, the Court held that an individual's constitutional right to privacy outweighed the state's interest in preserving life. The court allowed the removal of artificial ventilation so Karen Ann could die, however she remained in a chronic, persistent vegetative state, kept alive with artificial hydration and nutrition and then died 9 years later. The national focus became the ethical issue of removing life-sustaining treatments from terminally ill patients or patients in a persistent vegetative state. The concept of 'being a vegetable' emerged (Brown, 2003, Sabatino, 2007).

In 1983, another significant case materialized. Nancy Cruzan (1957-1990), age 25, was ventilator-dependent due to the extensive brain damage she experienced from a motor vehicle accident. She was unresponsive, in a persistent vegetative state, and was also kept alive via artificial nutrition and hydration. When the Cruzan case was presented to the courts, they found sufficient evidence to prove she would not have wanted her life sustained, and ordered the artificial hydration and nutrition tube withdrawn. The courts determined that another person, i.e., healthcare agent, could make decisions for a patient if the patient was not able to mentally participate in his/her healthcare treatment decisions (Brown, 2003, Sabatino, 2007).

Both of these cases involved young adults who were physically strong, but who were in a persistent vegetative state with no hope of recovery. These cases stimulated extensive discussion about end-of-life care in the United States. As public and professional awareness increased, a national consensus emerged in three areas. First, that physicians should describe the nature of the proposed treatment, including the probability of recovery, the treatment options, and associated risks, allowing competent patients to exercise his/her right to self-determination. Secondly, the courts made the determination that life-sustaining treatment can be refused (CPR, ventilators, transfusions, dialysis, chemotherapy, artificial nutrition and hydration, etc.). And thirdly, that the wishes of a mentally competent patient with a living will or healthcare document requesting to withhold or withdraw medical treatment would be respected. Even in cases where there was no living will, most supported the family's rights to end life-sustaining treatment on behalf of an incompetent patient (Sabatino, 2007).

During 1980s-1990s, Dr. Jack Kevorkian (1928-2011), an American pathologist and euthanasia activist came into the public view. He was known for championing terminal patient's right to die via physician-assisted suicide. His actions brought the debate about the legal and ethical issues of assisted suicide and euthanasia to the public. In 1994, Oregon voters approved Measure 16, a Death With Dignity Act ballot initiative that would permit terminally ill patients, under proper safeguards, to obtain a physician's prescription to end life in a humane and dignified manner (Percels, 1993, Ersek, 2004).

Impact of the Patient Self Determination Act (1990-2000)

The U.S. House of Representatives in 1991 enacted the Patient Self-Determination Act. The Act stipulates that all hospitals receiving Medicaid or Medicare reimbursement must ascertain whether patients have or wish to have advance directives.

The Patient Self-Determination Act does not create or legalize advance directives but rather it validates their existence in each of the states (Sabatino, 2007, Sabatino, 2010).

By 1992, all 50 states, as well as the District of Columbia, had passed legislation to legalize some form of advance directive. The important elements of informed consent have since been further clarified. (Sabatino, 2007, Wilkenson, Wenger & Shurgarman, 2007). The issue of dying and death had been openly addressed and was beginning to be scrutinized.

In 1997, the Institute for Medicine published a 455-page *Approaching Death* report, which documented the state of end-of-life care. The report examined several dimensions of this the end-of-life care, which included:

1. Determining diagnosis and prognosis, and communicating these to patient and family.
2. Establishing clinical and personal goals.
3. Matching physical, psychological, spiritual, and practical care strategies to the patients values and circumstances (IOM, 1997).

With an increasing number of individuals and families identifying their preferences about end-of-life care, an urgent need to translate those preferences into medical orders surfaced. In the late 1990s, The POLST (Physician Orders for Life Sustaining Treatment) Paradigm developed an approach to end-of-life care planning that emphasized the importance of conversations between patients, loved ones, and health care professionals regarding end-of-life care preferences; patient/family involvement in health care choices; and a method for communicating those choices across the healthcare continuum through the use of a standardized medical order form, i.e., POLST form, that reflects a patient's wishes for end-of-life care. It is not for everyone. POLST is used for those patients with a serious illness or frailty, who have a life expectancy of a year or less (POLST website).

Contemporary Views and Activities (21st Century)

By the turn of the century, public attention turned from euthanasia and physician-assisted suicide to caring for patients at the end of life. The Robert Wood Johnson Foundation began a national initiative to improve care and caring near the end of life. With a 315-member group and chaired by former First Lady Rosalynn Carter, the Last Acts Campaign was dedicated to improving end-of-life care and involved more than 980 national and local organizations, focusing on palliative care aspects and advance care planning (Last Acts, 2002).

In 2005, when the case involving Terry Schiavo (1963-2005) went public, America's advance care planning discussion reignited. Like Cruzan, Schiavo was only 25 years old when she experienced a full cardiac arrest. She survived resuscitation but was left severely brain-damaged. She was sustained on artificial hydration and nutrition for 15 years. Schiavo's husband, through his attorneys, succeeded in obtaining a court order allowing the feedings to end. Schiavo's parents fought this decision unsuccessfully for 7 years. This conflict resulted in numerous legal actions and fostered public debate

Advance Care continued on page 8



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on the right to die (Hampson & Emanuel, 2005). The Schiavo case brought to light that most Americans believed that life-sustaining medical interventions, including artificial nutrition and hydration, should not be decided by politicians, but rather by individuals and their families.

Soon after the Schiavo case, there was an increased interest in completing healthcare directives. The ongoing advancement of medical care with its ever increasing complexity and ensuing legal and ethical dilemmas demonstrates the fact that advance directives, living wills, and healthcare agents, as important as they are, are only one aspect of the solution. The essential and often overlooked elements of advance care planning are the need for patients and families to have conversations regarding their wishes for end of life care and for healthcare providers to translate those wishes into medical orders (Hampson & Emanuel, 2005).

Having a conversation about end-of-life care preferences before the need arises enables easier decision-making when the time for decisions arrives. Though most Americans say that having a discussion with their family about wishes for end-of-life care is important, very few have had that conversation. National efforts encouraging conversations about end-of-life care preferences include the National Healthcare Decisions Day (NHDD) project, which emerged in 2007. The goal of NHDD is to encourage patients to express their wishes regarding healthcare and for providers and facilities to respect those wishes. The NHDD public campaign targets April 16th as the annual date for educating the public and providers about the importance of advance care planning. (NHDD website).

An additional organization that provides assistance to individuals and families having conversations about their preferences for end-of-life care is the national grassroots campaign, The Conversation Project, developed in 2010. The goal of The Conversation Project is to provide resources that help foster a common understanding between family members of what they as individuals value (The Conversation Project website).

Because of the importance of conversations between healthcare providers and patients about end-of-life care preferences, when the Affordable Care Act was drafted in 2009, a version of the bill authorized Medicare to pay physicians who counseled patients about living wills, advance directives, and options for end-of-life care. Due to the claims that were made suggesting that the provision would lead to government-sponsored euthanasia and “death panels,” the proposal regarding end-of-life care counseling never found its way into the final Patient Protection and Affordable Care Act (ACA) passed in March 2010.

In September 2014, the Institute of Medicine released its second consensus report regarding the status of end-of-life care in United States entitled,

Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. The current state of end-of-life care examined was in respect to:

- Delivery of medical care and social supports
- Patient family provider communication of values and preferences
- Advance care planning
- Health care costs, financing and reimbursement
- Education of health professionals, patients, families, and the public at large.

The report identified persistent major gaps in these areas that require urgent attention from numerous stakeholder groups. The consensus believes that compassionate, affordable and effective care near the end of life should be a high national priority. The following are the five recommendations to improve end-of-life care in America:

- Delivery of person-centered/family-oriented approach.
- Clinician-patient communication and advance care planning.
- Professional education and development.
- Policies and payment systems.
- Public education and engagement (IOM, 2014).

Evolving Advance Care Planning Paradigm in North Dakota

In 1991, the same year that the Patient Self-Determination Act was enacted nationally, the North Dakota legislative branch added chapter, 23-06.5 “Health Care Directives” to the Century Code, which currently states:

“Every competent adult has the right and responsibility to make the decisions relating to the adult’s own health care, including the decision to have health care provided, withheld, or withdrawn. The purpose of this chapter is to enable adults to retain control over their own healthcare during periods of incapacity through health directives and the designation of an individual to make health care decisions on their behalf. This chapter does not condone, authorize, or approve mercy killing, or permit an affirmative or deliberate act or omission to end life, other than to allow the natural process of dying (ND Century Code, 2014).”

From 1999 to 2003, the North Dakota Medical Research Foundation (an affiliate of the North Dakota Medical Association) organized a broad grassroots constituency to improve end of life care in North Dakota. The project created a substantial momentum for change. With grant monies from the Robert Wood Johnson Foundation, North Dakotans from numerous organizations and disciplines launched an effort called “Matters of Life and Death” to encourage conversations about their wishes for healthcare when they are unable to make or communicate decisions for themselves.

The accomplishments of the Matters of Life and Death effort were numerous including end-of-life care education for providers and nurses using the Education for Physicians on End-of-Life Care (EPEC) and End-of-Life Nursing Education Consortium (ELNEC) curricula respectively. An additional end-of-life care educational outreach included emergency medical technicians, attorneys, clergy and social workers. A community-level perspective was used when addressing the challenges of providing quality end-of-life care, e.g., the availability of hospice and volunteers, the level of coordination between agencies, to name a few. Public engagement and cultural awareness were vital aspects of these efforts. The activity of “Matters of Life and Death” ended in 2003 with the conclusion of the grant and its funding.

In 2005, the POLST paradigm was introduced in North Dakota by Altru Health System via its ethics committee. A POLST form was trialed as a method of communicating patients’ end of life care preferences between providers, departments and referring health care settings. The POLST moved out of the hospital setting into long term care facilities in the region. The North Dakota Medical Association (NDMA) endorsed the voluntary use of POLST by North Dakota providers in 2010. It continues to be used in several North Dakota communities.

In 2013, the North Dakota Medical Association’s (NDMA) goal to improve end of life care for North Dakotans was re-energized when North Dakota Health Care Review, Inc. (NDHCR, since renamed Quality Health Associates of North Dakota) facilitated the organization of an advance care planning initiative for North Dakota per request of NDMA. Twelve individuals from various agencies and backgrounds, some from the original 2003 project united, supporting the effort to improve advance care planning. NDHCR facilitated several conference calls with these individuals. The initial topics were on acute care utilization, and re-admissions, then specifically became the need for improved, quality end-of-life care. These activities led to the expansion of 37 partners and the creation of the North Dakota Advance Care Planning Initiative (NDACP) by the end of year.

This advance care planning dialogue piqued the interest of numerous healthcare/non-healthcare professionals and community members from across North Dakota. Face-to-face meetings and conference calls were held to determine where the work of the NDACP would be housed, what advance care planning model would best meet the needs of North Dakotans, how an individual’s preferences for end of life care could be communicated through the use of a standardized medical order, and what communication resources would be needed for coalition. At the end of 2014, NDACP had expanded to include over 70 members representing 42 different organizations and agencies. NDACP Coalition has established the following statements:

Vision: To create a culture across ND where continuous (on-going) advance care planning is the standard of care and every individual’s informed preferences for care are documented and upheld.

Mission/Goal: To assist statewide community partners with the development and implementation of a comprehensive advanced care planning program (NDACP website).

Summary

The advances in medical care and technology that were achieved during the latter half of the 20th century in the United States resulted in a prolonged life expectancy but also blurred the boundary between life and death. Challenging our expectations about how Americans (and North Dakotans) could or should experience the end of their lives. There is substantial evidence that the treatment people would choose at the end of life commonly is different from the treatment they receive. Too often individuals receive more aggressive care than they desire. Because of these ongoing needs, goal of the NDACP is to collaborate, identify, develop, create, communicate and educate relevant aspects of advance care planning across North Dakota and diverse settings.

Part II of this Advance Care Planning series will discuss where NDACP is in 2015 and its future goals. The continued use and dispersal of POLST in North Dakota to translate end-of-life goals, wishes and informed preferences into medical orders will be



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addressed. Part III will address the specific role of the nurse, bedside to advance practice.

"Talking about death helps us live more fully today."

(Marianne, The Conversation Project Blog, 2012)

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The Midwest Multistate Division is pleased to announce that organizations interested in becoming an ANCC/MW MSD Approved Provider Unit now have easy access to all of the materials they need to get started.

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Provided by:
District 1, North Dakota Nurses Association and Omicron Tau Chapter, STTI Honor Society of Nursing

Presenters

Lori Garnas, PhD, Associate Director of Development for the North Dakota Center For Persons with Disabilities (NDCPD) and Special Education Faculty Member, Minot State University

Barbara Johnson, Parent of two children with ASD

Gretchen Dobervich, LSW, BSW, North Dakota Field Director for the Minnesota-North Dakota Chapter of the Alzheimer’s Association

Nicola Roed, DNP, RN, CNE – Assistant Professor, Chairperson at the Dept. of Nursing, Minot State University

Teri Eckmann, PhD – Professor at Minot State University

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Conference Planning Committee
 Judy Beck, RN, MSN
 Susann DeForest, RN, BSN, MS
 Ashley DeMakis, RN, BSN
 Alona Jarmin, RN, MSN
 Rhoda Owens, RN, BSN, MS
 Mary Smith, RN, BSN, MS

Agenda

- 7:15am – 7:45am Registration**
- 7:45am – 8:00am Welcome**
- 8:00am – 9:20am Competence and Confidence: Strategies to Work with People on the Autism Spectrum**
Lori Garnas, PhD
Barbara Johnson, Parent
- 9:20am – 9:30am Break**
- 9:30am – 11:00am Alzheimer’s Disease: The Facts and Impact**
Gretchen Dobervich, LSW, BSW
- 11:00am – 12:00n Veterans and Their Hidden Wounds**
Nicola Roed, DNP, RN, CNE
- 12:00pm – 1:00pm Lunch (Provided)**
- 1:00pm – 3:15pm Brain Boosters**
Teri Eckmann, PhD
- 3:15pm-3:30pm Evaluations**

The purpose of this educational offering is to increase understanding of diseases and disorders of the brain and identify strategies to promote rehabilitation and brain health.

Contact hours for this continuing nursing education activity have been submitted to the North Dakota Board of Nursing. Please Contact Mary Smith for more information regarding contact hours.

Conference Objectives

Upon completion of this program, the participants will be able to:

1. Identify “red flags” or indicators that a person may have Autism Spectrum Disorder (ASD).
2. Identify three or more strategies that may aid communication with a person who has ASD.
3. Describe how to alter common practices to accommodate a person with ASD.
4. Differentiate between the three most commonly occurring forms of dementia.
5. Explain how Alzheimer’s disease affects cognitive domains and the implications for care.
6. Identify common causes of traumatic brain injury (TBI) in the veteran population.
7. Identify common causes of post-traumatic stress disorder (PTSD) in the veteran population.
8. Compare and contrast symptoms of TBI and PTSD.
9. Express understanding of the impact and treatment options for veterans suffering from hidden wounds of TBI and PTSD.
10. Identify six critical domains of brain health.
11. Explore current research of the brain on exercise.
12. Understand how twenty brain boosters affect the physiology of the brain.
13. Participate in twenty brain boosting activities.

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EVIDENCE BASED PRACTICE

Aromatherapy to Decrease Anxiety

Appraised by: Jerri Jo Sterna SN, Karli Olson SN, Rachell Feigitsch SN, & Racheal Valleroy SN, (NDSU Nursing at Sanford Health, Bismarck, ND)

Clinical Question:

In adult patients with anxiety and/or depression, does adding aromatherapy to current treatment regimens improve their overall quality of life and decrease their symptoms of anxiety and/or depression?

Articles:

- Lee, Y., Wu, Y., Tsang, H. H., Leung, A. Y., & Cheung, W. M. (2011). A systematic review on the anxiolytic effects of aromatherapy in people with anxiety symptoms. *Journal of Alternative & Complementary Medicine*, 17(2), 101-108. doi:10.1089/acm.2009.0277
- Mirkarimi, S., Najafi, L., Ghiasi, M., Kamalvand, A., Mahalleh, H., & Bahman, M. (2011). Studying the effect of aromatherapy inhalation on female students' anxiety living in dormitory complex of Tehran University of Medical Sciences. *International Journal of Pharmaceutical Science and Health Care*, 3(1), 105-110. Retrieved from <http://www.rspublication.com/ijpic/index.html>
- Takeda, H., Tsujita, J., Kaya, M., Takemura, M., & Oku, Y. (2008). Differences between the physiologic and psychologic effects of aromatherapy body treatment. *The Journal of Alternative and Complementary Medicine*, 14(4), 655-661. doi: 10.1089/acm.2007.0591. Retrieved September 20, 2014.
- Yim, V.C., Ng, A.Y., Tsang, H.H., & Leung, A.Y. (2009). A review on the effects of aromatherapy for patients with depressive symptoms. *Journal of Alternative & Complementary Medicine*, 15(2), 187-195. doi: 10.1089/acm.2008.0333

Synthesis of Evidence:

The systematic review by Yim, Ng, Tsang, and Leung (2009) reviewed six different studies: three nonrandomized studies, two randomized studies and one quasi-experimental design that was a clinical control trial that focused on using essential oils for patients with depression or depressive symptoms and examined their clinical effects. The findings were consistent across the studies in showing improved depression scores by utilizing multiple scales: Hamilton Depression Rating Scale (HAM), Profile of Mood States (POMS), Hospital Anxiety and Depression Scale (HADS), 10 cm visual analogue, and Structure Clinical Interview (SCID).

Mirkarimi, Najafi, Ghiasi, Kamalvand, Mahalleh, & Bahman (2011) performed a randomized control trial utilizing Spielberger's anxiety form. The finding of this study was that aromatherapy had a noticeable effect on decreasing the symptoms of anxiety among female students.

The study by Takeda, Tsujita, Kaya, Takemura, Oko (2008) is a quasi-experimental study that examined symptoms of anxiety at rest, during massage, and massage with essential oils. Findings were consistent throughout the trials. The State-Trait Anxiety inventory, Visual analog scale, Faces scales and IgA and cortisol secretions were tools that observed for symptoms of anxiety. Definitive conclusions were made with no adverse effects caused from aromatherapy and long lasting effects during stressful environments where anxiety and health can improve.

Lee, Wu, Tsang, Leung, and Cheung (2011) conducted a systematic review that examined the clinical effects of aromatherapy in adults

with anxiety or anxiety symptoms. The results were based on 16 randomized controlled trials (RCTs) that focused on the anxiolytic effects of aromatherapy. It is recommended that aromatherapy could be applied as a complementary therapy for people with anxiety symptoms. However, there is no evidence to show lasting effects of aromatherapy.

Overall, the studies were of good quality with a general consistency that aromatherapy can be used as an adjunct therapy for treatment of depressive and/or anxiety symptoms. Multiple studies that were reviewed had small sample sizes, which may have directly affected the quality of the results. However, other studies were of sufficient sample size. The collaborative finding from all studies is that aromatherapy has promising therapeutic effects when applied as a complementary and alternative intervention.

Bottom Line (findings):

Aromatherapy may suppress symptoms of anxiety and depression. By using aromatherapy, patients' clinical outcomes may be improved. It can be more cost effective and may improve patient satisfaction. There have not been any reported adverse effects associated with the use of aromatherapy.

Implications for Nursing Practice:

Nurses will be able to advocate for patients with depression and/or anxiety by suggesting aromatherapy as a complementary and alternative intervention when applicable. The studies that were appraised suggested that treating depression and/or anxiety with aromatherapy can increase quality of life. Aromatherapy is proven to be a safe and effective intervention.

The Use of Z-track Method for Intramuscular Injections

Appraised by: Alyssa Dahle, SN, Megan Humann, SN, Molly Kahl, SN, and Merry Kraft, SN (North Dakota State University, Sanford Health Bismarck, ND)

Clinical Question:

In the adult patient receiving a medication by IM, does using the Z-track method for administration increase medication absorption and decrease patient complications?

Articles:

- Engstrom, J. L., Giglio, N. N., Takacs, S. M., Ellis, M. C., & Cherwenka, D. I. (2000). Procedures used to prepare and administer intramuscular injections: A study of infertility nurses. *Journal of Obstetric, Gynecologic, Neonatal Nursing*, 29(2), 159-168.
- Kara, D., & Gunes, U. Y. (2014). The effect on pain of three different methods of intramuscular injection: A randomized controlled trial. *International Journal of Nursing Practice*, 1-8. Retrieved October 2, 2014, from the CINAHL database.
- Keen, M. (1985). Comparison of intramuscular injection technique to reduce site discomfort and lesions. *Nursing Research*, 35(4), 207-210.
- Nicoll, L. H., & Hesby, A. (2002). Intramuscular Injection: An integrative research review and guideline for evidence-based practice. *Applied Nursing Research*, 16, 149-162.

Synthesis of Conclusions:

Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities

Engstrom et al. (2000) conducted a level VI single descriptive study. The study consisted of 645 individuals listed as members of the Nurses Professional Group of the American Society for Reproductive Medicine. 219 members completed and returned the questionnaire. The questionnaire had 110 items addressing different methods of intramuscular injections regarding the selection of equipment, medication preparation and injection procedures. There was wide variation in the gauge

and length of needles used to administer the medications, with most nurses using a 22 g, 1 1/2 in needle for all medications. Most nurses changed the needle between preparing and administering medications; however, filter needles were seldom used. There was wide variation in the volume of diluent used to reconstitute medications. Most of the nurses used the dorsogluteal site for injections. Although almost all of the nurses indicated that they routinely rotated injection sites, they infrequently used sites other than the dorsogluteal site. Most nurses did not rotate the extremity distal to the injection site when administering injections and even fewer used the Z-track method. Many nurses did not use procedures that can reduce the pain and tissue trauma associated with intramuscular injections.

Kara & Gunes (2014) conducted a level II randomized controlled trial over a four month period. Seventy-five patients were selected from a university hospital in Zonguldak, Turkey who were undergoing surgery and would be receiving intramuscular injections of diclofenac sodium on an eight hour interval. The same investigator gave the injection to the patients to the dorsogluteal site, rotating between right and left sides. Injection techniques were randomly selected, between technique A, the patient in the prone position with his or her toes pointing

down, technique B, the patient in prone position with one foot internally rotated, and technique C, the patient in prone position with his or her toes pointing down, using the Z-track technique. The pain intensity was measured by a visual analogue scale (VAS). Kara & Gunes (2014) found that technique B (internally rotated foot) measured the least amount of pain intensity. Limitations of the study included: postoperative pain obscuring the pain intensity from the intramuscular injection, the three techniques were administered by the same investigator, and the sample size was small and more studies on larger samples should be researched.

Keen (1986) conducted a level II randomized control study consisting of fifty subjects who were 13 female, 37 male. Thirty were African American and twenty were Caucasian and excluded any other race. The ages ranged from 21 to 57 years old. Subjects were all inpatients on selected medical and surgical units of a university medical center hospital. The intervention was using the Z-track method in IM injections and using the standard method technique in IM injections to determine which one caused more pain and lesions. The patients were assigned to random treatment groups A and B. Treatment group A

The Use of Z-track continued on page 12



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The Use of Z-track continued from page 11

received the Z-track technique and treatment B received the standard technique. The researchers recorded the data using measurement tools such as, the four point Likert scale, discomfort questionnaire and site lesions were measured by the nurses using a scale of severity. They tabulated the data to determine the incidence of discomfort and lesions within four time intervals and both techniques were compared. The study showed the Z-track technique does not decrease the initial pain at the injection site but instead the Z-track method affects the discomfort secondary to leakage and deposition of the injected tissue into the subcutaneous tissue.

The level V systematic literature review conducted by Nicoll & Hesby (2002) addressed the proper administration of IM injections in the clinical setting. The purpose of this review was to establish an evidenced based clinical guideline for safe administration of intramuscular administrations that would improve patient outcomes and reduce errors. The study showed that use of the Z-track technique reduced leakage of medication into the subcutaneous space and resulted in less discomfort for the patient and decreased incidence of lesions at the injection

site. The review consistently showed that in two out of three studies, the technique of leaving an air bubble in the syringe when administering an IM injection, showed no benefit to the patient. The quality and strength of this study was compromised due to the lack of inclusion and exclusion data, research designs not clearly defined, and the number of participants in each study was not addressed. The quality of this systematic review was fair because it reported the findings of descriptive and qualitative studies, but did not integrate the information to draw comparative conclusions. A research based guideline was developed based on the review, but the study identified that there are many areas that need further research in regards to intramuscular injections.

Clinical Bottom Line:

A strength of three studies reviewed was that they had large sample sizes, which provided sufficient power to detect statistically significant results. Two of the studies were random controlled trials contraindicating each other. Keen (1985) stated that the Z-track method may not decrease the initial discomfort but decreases the secondary discomfort to medication leakage into the

subcutaneous tissue. Kara (2014) stated that having the patient internally rotating their foot is more effective in pain reduction than using the Z-track method. Another study, Engstrom et al. (2000) was a descriptive study that showed many nurses did not use procedures that can reduce the pain and tissue trauma associated with intramuscular injections. The last study was a systemic review of literature by Nicoll & Hesby (2002) that showed that use of the Z-track technique reduced leakage of medication into the subcutaneous space and resulted in less discomfort for the patient and decreased incidence of lesions at the injection site. Three out of the four studies concluded that the Z-track method was beneficial in increasing medication absorption and decreasing patient complications.

Implications for Nursing Practice:

The evidence from three out of the four studies supports the use of the Z-track method when administering intramuscular injections in adult patients. Incorporating the Z-track method during intramuscular injections would provide consistency in medication delivery. The Z-track method would also be effective in reducing pain, tissue trauma, and complications during intramuscular injections.

Pre-Op Education for Children

Appraised by: Chris Coombe, SN, Amy Meyer, SN, Lindsey Miles, SN, Jenn Rinas, SN (NDSU Nursing at Sanford Health Bismarck, ND)

Clinical Question:

Does pre-operative education decrease anxiety in children who undergo elective surgeries?

Articles:

Copanitsanou, P., & Valkeapää, K. (2014). Effects of education of pediatric patients undergoing elective surgical procedures on their anxiety - a systematic review. *Journal of Clinical Nursing*, 23(7/8), 940-954. doi:10.1111/jocn.12187

Fincher, W., Shaw, J., & Ramelet, A. (2012). The effectiveness of a standardized preoperative in reducing child and parent anxiety: A single-blind randomized controlled trial. *Clinical Nursing Research*, 21, 946-955.

Karimi, R., Fadaei, Z., Nikbakht Nasrabadi, A., Godarzi, Z., & Mehran, A. A. (2014). Effectiveness of orientation tour on children's anxiety before elective surgeries. *Japan Journal of Nursing Science*, 11(1), 10-15. doi:10.1111/j.1742-7924.2012.00223.x

Li, H., Lopez, V., & Lee, T. (2007). Effects of preoperative therapeutic play on outcomes of school-age children undergoing day surgery. *Research in Nursing & Health*, 30(3), 320-332.

Synthesis of Evidence:

Four articles were reviewed as evidence in this

report. Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melnyk & Fineout-Overholt (2005).

One study was a systematic review of randomized controlled studies, the other three studies were single blinded RCT. Copanitsanou & Valkeapaa (2013) conducted a level I systematic review of randomized controlled studies. The systematic review included 16 studies, 2168 total participants, that involved children aged 2-12 who were undergoing an elective surgery. The interventions included a variety of different teaching methods prior to surgery including: therapeutic play, preview and play with hospital equipment, formal preparation by a child specialist, education booklets, videotapes, educational tours, and role play. The findings were consistent in 12 of the 16 studies, showing that children in the education groups reported statistically significant lower anxiety scores, fewer negative emotions, fewer negative emotional behaviors, as well as less emotional distress than those that were not in the education groups.

The second study by Li, Lopez, & Lee (2007) was a level II randomized control trial. This study was conducted to examine the effects of therapeutic play on outcomes of children undergoing elective same day surgery procedures. This RCT included 203 participants, all children ages 7-12 years old. The interventions included: tour of reception area, tour of the induction room and operating room, along with the recovery room. The results conclude that children in the experimental group reported significantly lower state anxiety scores in pre and postoperative periods and exhibited fewer negative emotions at induction of anesthesia than children in the control group.

The study by Fincher, Shaw, and Ramelet (2012) set out to test the effectiveness of preoperative preparation in reducing child and parent anxiety. This was a level II single blind randomized controlled trial. The study included 657 children aged 3-12 that were eligible. Out of the 657 children, 73 were selected for the study, they were randomly selected for a control group, which consisted of 14 males and 18 females, and an experimental group, consisting of 19 males and 16 females. The control group followed standard practice and was sent home with no education. The experimental group received information by means of a photo file depicting the sequence of events, demonstration of the equipment used for surgery, and a tour of the preoperative bay and PACU. In this study, the overall anxiety score was

lower in the experimental group when compared with the control group, but the difference was not significant with $p=0.07$. Anxiety levels in parents showed a significant decrease in the experimental group with $p=0.009$. Although anxiety levels were not significantly lower in the experimental group, this could be explained by the fact that 35% of the families attended the preoperative visit outside the optimal predetermined time of preparation, which may have limited the effect of the intervention.

Karimi, Fadaei, Nikbakht-Nasrabadi, Godarzi, & Mehran (2012) conducted a level II single-blind clinical trial which looked at the effectiveness of an orientated tour in reduction of children's anxiety before elective surgeries. They randomly selected two groups of 35 children; the experimental group received an additional 20 min orientation tour of the operation room and all the relevant areas of same day surgery, as well as receiving an appropriate explanation of the surgery process. The nurse explained the purpose of the waiting area and the surgery room. Children were asked to explore and touch the relevant equipment and supplies such as the anesthesia mask, pulse oximeter, electrocardiogram leads, and IV catheter. Karmini et al (2012) found implementation of an orientated tour of the preoperative room can decrease anxiety levels in children before elective surgeries.

Bottom Line:

Of the four articles reviewed, all articles indicated a decrease in anxiety of the child in the experimental groups. The only article by Fincher, Shaw, and Ramelet (2012) had a p-value that was not clinically significant, however it did show positive results. The research evidence does address the problem and gives promising outcomes toward the children and even the parents.

There is sufficient evidence to implement a new practice with children and elective surgery. This possibility could help decrease the amount of negative emotional behavior postoperatively and decrease postoperative hospitalization. The effects on the children would be very beneficial not only for that specific surgical procedure but also for any future visits, scheduled or unscheduled.

Implications for Nursing Practice:

Evidence suggests that implicating a preoperative educational program for children undergoing elective surgery can reduce anxiety preoperatively and postoperatively, which can reduce patient recovery time and hospitalization. We recommend converting an unused operating room for pediatric education through preoperative tours and demonstration two days a week.



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EVIDENCE BASED PRACTICE

Nurse to Patient Ratio

Appraised by: Kaitlin Regan, SN and Sandra Hanly, SN (NDSU Sanford College of Nursing Bismarck)

Clinical Question:

Does increasing nurse to patient ratio decrease patient morbidity and mortality?

Articles:

Shekelle, P. G. (2013). Nurse patient ratios as a patient safety strategy a systematic review. *Annals of Internal Medicine*, 158, 404-410.

Aiken, L.H., Clarke, S. P., Sloane, D.M., Sochalski, J., & Silbert, J. H. (2002). Hospital nursing staff and patient mortality, nurse burnout, and job dissatisfaction. *JAMA*, 288, 1987-1993

Synthesis of Conclusions:

Critique of two studies concluded that the evidence supports design criteria and has scientific merit. Both studies discussed the issue of nurse to patient ratios in regards to patient morbidity and mortality. The studies helped answer the clinical question: Does nurse to patient ratios affect patient morbidity and mortality?

Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melnky & Fineout-Overholt (2005).

Shekelle (2013) conducted level V systematic review including studies published from September 2009-2012 and published in English. Eighty seven articles were reviewed along with 15 new studies. Shekelle included several cross-sectional studies, nine longitudinal and a systematic review. Articles published before 2009, articles not in English and any study that did not meet the assessment of multiple systematic reviews criteria (AMSTAR) were excluded from the review. With 87 articles reviewed including

one systematic review it covered a large number of articles that offered valid conclusion. This systematic review discussion concluded that the nurse staffing ratio is related to hospitalized patient morbidity and mortality. Limitations of the study is low response rates to surveys, potential poor matching on RN staffing to actual patients cared for and their risk for death and the fact that the one longitudinal study has not been able to be replicated.

Aiken et al. (2002) conducted a level four cohort study. 10184 surveys were sent to nurses and charts were reviewed of 232342 general, orthopedic, and vascular surgery patients discharged from hospitals in Pennsylvania between April 1, 1998 and November 30, 1999, and administrative data from 168 nonfederal adult general hospitals in Pennsylvania. The researchers did this study to determine the association between the patient-to-nurse ratio and patient mortality, failure-to-rescue (deaths following complications) among surgical patients, and factors related to nurse retention. Although the odds ratios reflected the nurse staffing effect was somewhat diminished by controlling for patient and hospital characteristics, they remained significant for both mortality and failure-to-rescue. An odds ratio of 1.07 implies that the odds of patient mortality increased by 7% for every additional patient in the average nurses' workload in the hospital and that the difference from 4 to 6 and from 4 to 8 patients per nurse would be accompanied by 14% and 31% increases in mortality. These effects imply that, all else being equal, substantial decreases in mortality rates could result from increasing RN staffing, especially for patients who develop complications. If the staffing ratio in all hospitals was 6 patients per nurse rather than 4 patients per nurse, an additional 2.3 deaths could be expected per 1000 patients and 8.7 additional deaths per

1000 patients with complications. The study lists one limitation as the potential for response bias. There was no evidence in the sample of nurses that they were not satisfied with their work relative to Pennsylvania staff nurses from the National Sample Survey of Registered Nurses.

Bottom Line:

Overall both studies found that there is a consistent relationship between higher number of nurses per patient and the reduction of hospital related mortality and morbidity. There is significant evidence to make changes in practice because there is statistical significance in all studies reviewed and patient morbidity and mortality is decreased with more nurses to fewer patients. Based on the conclusions of these studies we recommend that facilities implement staffing policies that limit the number of patients to no more than 4 to 6 for every nurse.

Implications for Nursing Practice:

Evidence based practice shows that nurse to patient ratios do affect patient morbidity and mortality. Patient acuity is increasing along with a shortage of experienced nurses to take care of them. With the ever increasing cost of health care the issue of nurse to patient ratio is a concern across the country. Nurses are frustrated by increasing patients to care for as hospitals try to cut costs. It is the best interest for hospitals reputations as well as financial security to take nurse to patient ratios seriously. Changes are not easy but evidence based research supports nurse to patient ratios which decrease patient morbidity and mortality. Nurses working on medical/surgical units should be key players in support practice change and implementation of evidence based practice nurse to patient ratios which are proven to decrease patient morbidity and mortality.

Use of Neuro Electrical Stimulation to Decrease Muscle Wasting in ICU Patients

Appraised by: Taylor Wanner, SN, Angela Wald, SN, Kayla Grewatz, SN, & Corey Wiede, SN (NDSU Nursing at Sanford Health, Bismarck, ND)

Clinical Question:

Does neuromuscular electrical stimulation of core muscle groups in critically ill patients reduce the percentage of muscle wasting?

Articles:

Gerovasili, V., Stefanidis, K., Vitzilaios, K., Karatzanos, E., Politis, P., Koroneos, A., ... Nanas, S. (2009). Electrical muscle stimulation preserves the muscle mass of critically ill patients: A randomized study. *Critical Care*, 13(5), R161-R161. Retrieved October 2, 2014, from EBSCO.

Karatzanos, E., Gerovasili, V., Zervakis, D., Tripodaki, E., Apostolou, K., Vasileiadis, I., & ... Nanas, S. (2012). Electrical muscle stimulation: an effective form of exercise and early mobilization to preserve muscle strength in critically ill patients. *Critical Care Research & Practice*, 1-8. doi:10.1155/2012/432752.

Maffioletti, N. A., Roig, M., Karatzanos, E., & Nanas, S. (2013). Neuromuscular electrical stimulation for preventing skeletal-muscle weakness and wasting in critically ill patients: a systematic review. *BMC Medicine*, 11(1), 1-10. DOI: 10.1186/1741-7015-11-137.

Meesen, R. J., Dendale, P., Cuypers, K., Berger, J., Hermans, A., Thijis, H., Levin, O. (2010). Neuromuscular electrical stimulation as a possible means to prevent muscle tissue wasting in artificially ventilated and sedated patients in the intensive care unit: a pilot study. *Neuromodulation* 2010; 13: 315-321. DOI:10.1111/J.1525-1403.2010.00294.x

Synthesis of Evidence:

Four studies on the use of electrical muscle stimulation to prevent muscle wasting were carefully assessed. Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melnky & Fineout-Overholt (2005).

Gerovasili et al. (2009) conducted a random control study to evaluate the effectiveness of electrical muscle stimulation (EMS) to prevent muscle wasting on sedated critical care patients, in an intensive care unit. Meesen et al. (2010) conducted level II a randomized controlled trial. The aim of this study was to explore if neuromuscular electrical stimulation could prevent muscle atrophy in critically ill patients in the ICU department.

Maffioletti et al. (2013) conducted a level 1 systematic review of 8 randomized controlled trials. A total of 172 participants were included in this review. It evaluated the effectiveness of neuromuscular electrical stimulation (NMES) for preventing skeletal-muscle weakness and wasting in critically ill patients, in comparison with usual care.

Karatzanos et al. (2012) conducted a level II posthoc analysis of a randomized parallel intervention clinical trial including 142 consecutive patients. The studies suggest that NMES therapy has been shown to be more effective than usual care and may prevent muscle wasting in critically ill patients. Three of the four studies had small population sizes as their limitations.

Bottom Line: (findings)

The evidence suggests that the use of neuromuscular electrical stimulation will help reduce muscle atrophy in critically ill patients but further research is needed to prove the significance.

Implications for Nursing Practice:

A protocol to be developed to include the use of NMES therapy in critically ill patients. Caregivers of critically ill patients can recommend NMES as an option to decrease muscle wasting and promotes earlier rehabilitation in the recovery process.



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EVIDENCE BASED PRACTICE

Curcumin for Patients with Depression

Appraised by: Kayla Dolyniuk, SN, Alexis Hogan, SN, Alexa Boyd, SN, and Kristen Greenstein, SN (NDSU Nursing at Sanford Health, Bismarck, ND)

Clinical Question:

Does the use of curcumin decrease depressive symptoms in patients with depression?

Articles:

- Kukarni, S., Bhutani, M., & Bishnoi, M. (2008). Antidepressant activity of serotonin and dopamine system. *Psychopharmacology*. 201 (3). 435-442. doi:10.1007/1500213-008-1300-4
- Lopresti, A., Maes, M., Maker, G., Hood, S., & Drummond, P. (2014). Curcumin for the treatment of major depression: a randomized double-blind, placebo controlled study. *Journal of Affective Disorders*. 167, 368-375. doi: 10.1016/j.jad.2014.06.001.
- Panahi, Y., Badeli, R., Karami, G., & Sahebkar, A. (2014). Investigation of the efficacy of adjunctive therapy with bioavailability – boosted curcuminoids in major depressive disorder. *Phytotherapy Research*. doi:10.1002/ptr.5211
- Sanmukhani, J., Satodio, V., Trivedi, J., Patel, T., Tiwari, D., Panchal, B., Bhanu Tripathi, C. (2013). Efficacy and safety of curcumin in major depressive disorder: a randomized controlled trial. *Phytotherapy Research*. 28(4), 579-585. doi:10.1002/ptr.5025

Synthesis of Conclusions:

Four research articles pertaining to the use of curcumin to treat symptoms of depression were appraised. Each study appraised was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. Two of the articles were random control trials, one was an experimental design, and the other

a quasi-experimental. All of the studies had limitations and the validity and reliability of the data collection was not reported in any of the studies, however they did appropriately describe the methods of collection and measurement tools used.

The first study by Kukarni, S., Bhutani, M., & Bishnoi, M. (2008) concluded that the use of curcuminoids increased dopamine and serotonin levels in mice. The second study by Lopresti et al (2014) conducted a level I randomized double-blind placebo-controlled clinical trial. This experiment tested the antidepressant effects of curcumin in people with major depressive disorder and concluded with partial support of curcumin due to the limitation of a small sample size. Sanmukhani et al (2013) conducted a level I randomized controlled trial over a 6 week period in which the efficacy and safety of curcumin was proven for patients diagnosed with depression. Lastly, Panahi et al (2014) conducted a level III quasi-experimental study to investigate the effect of curcumin in patients who were already receiving standard antidepressant medication. This study showed that curcumin is effective in adjunct to standard medications for patient with Major Depressive Disorder.

All 4 of these studies were included in this research, because they focus on the effects of curcumin on depressive symptoms, but with a wide variety of treatment styles and study designs. Each study showed positive evidence for the use of curcumin as a natural medication to decrease the symptoms of depression.

Bottom Line:

Evidence based research shows that curcumin was found to be safe and effective in treating

depressive symptoms. The natural supplement was studied by comparing it to placebos or current medications used to treat depression and/or in combination with these medications. The evidence found in researching this topic addressed the issue of depression, the symptoms experienced form the disorder, and the effects of multiple treatment options. With the background knowledge that natural supplements produce few side-effects, and the research showing that curcumin does decrease the signs and symptoms of depression and is as effective as the current medications used, there is sufficient evidence to suggest changing the current standards of treatment to improve clinical outcomes and patient satisfaction.

Implications for Nursing Practice:

Practice recommendations include an in-service with medical providers who work in the psychiatric field. A staff meeting for nurses working alongside these providers would also receive an in-service or online education about the benefits and plan for use of curcumin in patients diagnosed with depression. With these education opportunities nurses would be able to properly educate patients on the benefits of a holistic approach to treating depression. Ideally medical providers would implement the recommendation of curcumin gradually in their practice, and after one year at least 50% of patients with depression would have either curcumin prescribed to treat their depression primarily or prescribed in conjunction with their regular depression medication. Careful documentation would be integrated into prescribing curcumin to further enforce the evidence of positive patient outcomes. We would like to give the patient the option of a natural supplement to treat symptoms of depression with fewer negative side effects than standard antidepressant medications.

Delayed Umbilical Cord Clamping in Full Term Infants

Appraised by: Renata Hegle, SN, Chantel Kleinsasser, SN, and Erin O'Leary, SN (NDSU Nursing at Sanford Health, Bismarck, ND)

Clinical Question:

In full term newborn babies, does delaying umbilical cord clamping for greater than 60 seconds contribute to increased blood volume and subsequent increases in hemoglobin, hematocrit, and iron stores?

Articles:

- Andersson, O., Hellström-Westas, L., Andersson, D., & Domellöf, M. (2011). Effect of delayed versus early umbilical cord clamping on neonatal outcomes and iron status at 4 months: a randomised controlled trial. *BMJ*; 343: doi: http://dx.doi.org/10.1136/bmj.d7157.
- Hutton, E.K., & Hassan, S.E. (2007). Late vs early clamping of the umbilical cord in full-term neonates. *The Journal of the American Medical Association*, 1241-1252.
- Retrieved September 19, 2014. McDonald, S.J., Middleton, P., Dowswell, T., & Morris, P.S. (2013).

Effect of timing of umbilical cord clamping on term infants on maternal and neonatal outcomes. *Cochrane Database of Systematic Reviews* 2013, Issue 7. Art. No.: CD004074. DOI: 10.1002/14651858.CD004074.pub3.

Synthesis of Evidence:

The studies by Anderson, Hellstrom, Westas, Anderson, & Domellof (2011), Hutton, & Hassan (2007), and McDonald, Middleton, Dowswell, & Morris (2013) are significant and valuable in their contributions to the question of delayed umbilical cord clamping. Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melnky & Fineout-Overholt (2005). In the hierarchy of evidence, two of the studies were Level I systematic reviews and the third study was a Level II randomized control trial.

Anderson et al. found that in a sample of 400 babies, the late clamping group consisting of 200 babies experienced increased iron levels in the first four months. Hutton and Hassan, in their study of 1,912 mothers and their newborns, concluded that a delay of at least 2 minutes resulted in increased hematocrit and hemoglobin in the first 48 hours and increases in iron in the first 6 months. McDonald et al, with a total 3,911 mom/baby couplets and an average delay of 3 minutes in umbilical cord clamping, found that babies had increased hemoglobin and hematocrit in the immediate postpartum period and increases in iron stores in the first 6 months of life. In each trial, the population was clearly identified and inclusion and exclusion criteria were consistent. Any and all inconsistencies in the trials were identified and addressed. Potential bias was noted and accounted for. All studies concluded that by delaying the clamping of the umbilical

cord, infants will receive many benefits with no significant negative outcomes for either mom or baby.

Evidence for all three articles supported the question of delayed umbilical cord clamping and its numerous benefits to infants. In the immediate postpartum period of less than 48 hours, both systematic reviews found increases in hemoglobin and hematocrit in newborns. All three studies found increases in iron stores that last up to 6 months in infants, and all agreed that the benefits to babies merits a more enthusiastic approach to delayed umbilical cord clamping.

Bottom Line:

Delaying umbilical cord clamping takes less than five minutes. In full term, healthy infants, and without any emergent complications for mother or baby, it is a reasonable amount of time to offer the neonate in exchange for immediate increases in blood volume, hemoglobin and hematocrit, and for further benefit of an increase in iron stores lasting 3-6 months. The evidence in all included systematic reviews and studies shows a clear benefit for babies when umbilical cord clamping is delayed for 3 minutes.

Implications for Nursing Practice:

Changing institutional policy is one way that the practice of delayed umbilical cord clamping can become more consistent among health care providers. Nurses will be at the front lines in making this practice more widespread by encouraging patients to delay the clamping of the umbilical cord and educating them about the benefits. When parents are asked about birth plans, the topic of delayed cord clamping will fit seamlessly in with the education and birth planning process.



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EVIDENCE BASED PRACTICE

Fat Consumption in Relation to Cardiovascular Events

Appraised by: Jessica Stober, SN, Lisa Swanson, SN, Kaitlin Keeler, SN & Devin Murphy, SN (North Dakota State University Nursing at Sanford Health, Bismarck, ND)

Clinical Question:

In adults, does a low fat diet reduce cardiovascular events?

Articles:

Biong, A., Veierod, M., Ringstad, J., Thelle, D., & Pedersen, J. (2005). Intake of milk fat, reflected in adipose tissue fatty acids and risk of myocardial infarction: A case-control study. *European Journal of Clinical Nutrition*, 60(0954-3007/06), 236-244.

Howard, B.V., Van Horn, L., Hsia, J., Manson, J.E., Stefanick, M.L., Wassertheil-Smoller, S., &... Kotchen, J.M. (2006). Low-fat dietary pattern and risk of cardiovascular disease. *Journal of the American Medical Association (JAMA)*, 295(6), 655-666.

Kratz, M., Baars, T., & Guyenet, S. (2013). The relationship between high-fat dairy consumption and obesity, cardiovascular, and metabolic disease. *European Journal of Nutrition*, 52(1), 1-24. doi:10.1007/s00394-012-0418-1

Mead, A., Atkinson, G., Albin, D., Alphey, D., Baic, S., Boyd, O., &... Hooper, L. (2006). Dietetic guidelines on food and nutrition in the secondary prevention of cardiovascular disease – evidence from systematic reviews of randomized controlled trials (second update, January 2006). *Journal of Human Nutrition & Dietetics*, 19(6), 401-419

Synthesis of Conclusions:

Four articles discussing fat consumption in relation to cardiovascular events were carefully assessed. The evidence in each study reviewed was of high quality with sufficient sample sizes for the study design. The studies also had adequate control and definite conclusions. Each study was

rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melnyk & Fineout-Overholt (2005).

The first study, by Biong, Veierod, Ringstad, Thelle, & Pedersen (2005) is a case control study conducted in Norway. The purpose of the study was to relate dairy fat intake in relation to those at an increased risk of having a first myocardial infarction (MI). The study found that intake of dairy fat may in fact have protective properties against developing cardiac complications.

The second study, conducted by Howard, Van Horn, Hsia, Manson, Stefanick, Wassertheil-Smoller &...Kotchen (2006) is a random control trial. This study, conducted in forty U.S. clinical centers, compared lowering fat consumption and increasing servings of fruits and vegetables to a regular diet. The study focused on the incidence of cardiovascular events in relation to the interventional diet. The results of the study found that there was no significant influence on cardiovascular events when fats were lowered.

The third study was a systematic review performed by Kratz, Baars, & Guyenet (2013). There were sixteen studies which were conducted in the U.S., Europe, and Australia. It compared the consumption of high fat dairy products and the incidence of cardiometabolic disease. The findings concluded that there was no significant association between the amount of dairy fat consumed and cardiovascular events.

The fourth study by Mead, Atkinson, Albin, Alphey, Baic, Boyd &... Hooper (2006) was a systematic review comprised of thirteen studies. The research was based on the consumption of omega-3 and substituting saturated fats with unsaturated fats. In this study, the intervention

group was advised to increase omega 3 fats and decrease lipids. There were no significant findings between these diet changes and cardiovascular disease.

Bottom Line:

There is evidence to suggest that there is no correlation between fat intake in the diet and risk of cardiovascular events. The research supports that since there is no significant relationship between decreasing the fat, patients should not be restricted to a lower fat diet. In fact, some fats, especially dairy, have cardio protective properties. The change from a restricted, low fat diet to an unrestricted, regular diet is cost-effective, improves patient satisfaction, and may lower the occurrence of cardiovascular events. Therefore, implementing this type of diet would be beneficial not only to patients, but also to the health care industry.

Implications for Nursing Practice:

Nurses, cardiologists, and dieticians who care for patients in the health care setting should be aware of this new research to support the implementation of a unrestricted, regular diet. Since this topic is new to research, there is limited information; however, the health care team should be more proactive in conducting further research, ultimately advocating for their patients. Many hospitals in the region follow the American Heart Association guidelines which suggest a low fat diet. Therefore, the increased fat diet isn't being implemented. Nurses working with cardiac patients should be team leaders in incorporating this practice change into the health care setting with additional research.

Additional Evidence Based Practice abstracts will be published in the May 2015 issue.

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