We are half way through our year and what a great year it has been! I would like to start by congratulating Kim Froehlich, INA’s new Vice President as of July 1st. She comes with great leadership experience and passion for nursing. Thank you to all of the members of INA who voted!

Robert F. Kennedy® once stated, Few men are willing to brave the disapproval of their fellow men, the censure of their colleagues, the wrath of their society. Moral courage is a rarer commodity than bravery in battle or great intelligence. Yet it is the one essential, vital quality for those who seek to change the world which yields most painful to change.

In ANA’s 2015 “Year of Ethics,” many stories of moral courage and bravery amongst our peers are surfacing. This is important because it gives those who fear the disapproval of their fellow men and colleagues the added strength to act on behalf of their personal convictions, their profession, and, most importantly, their patient’s. I thank all who continue to direct the true moral and ethical compass for our profession.

In this edition, I ask that you read Susan Trossman’s article, “Conscientious Objection: When Care Collides With Nurses’ Morals and Ethics.” She is a senior reporter from ANA and clarifies the very important question, “Am I objecting because I truly do not believe in what is taking place, or am I objecting because of an ulterior motive?” Being able to differentiate between reasons for objecting to an action is vital to your patient’s recovery and your professional longevity. It will either place you on the side of advocating for your patient, or put your job in jeopardy because your objection is unjustifiable.

I wish you all well and thank you for the care you provide to our patients.


Conscientious Objection
When Care Collides with Nurses’ Morals, Ethics
by Susan Trossman

Last winter, two high-profile — and very tragic — cases pitted family members against hospital administrations and stirred debates nationwide about brain death, policies and laws, and ethics. No matter where they practice, nurses may have wondered what they would do if they found themselves in similar circumstances — whether they could object to providing patient care. The answer is a qualified “yes.”

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Dealing with Moral Distress and Ethical Dilemmas in Nursing
Rick Basset, MSN, APRN, ANCS-BC, CCRN

2015 National Nursing Workforce Survey
Will you be one of the 260,000 nurses chosen through a nationally randomized sampling to complete a national survey that will provide information critical to ensuring an adequate nursing workforce and high quality patient care? Be on the lookout for a postcard followed by a paper survey. The survey is being conducted by The National Council of State Boards of Nursing (NCSBN). The National Forum of State Nursing Workforce Centers is conducting the 2015 National Nursing Workforce Survey. If you receive the survey we encourage you to participate as your responses will contribute to a national study.
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Published by: Arthur L. Davis Publishing Agency, Inc.

RN Idaho is published by the Idaho Nurses Association 1850 E. Southern Ave., Ste. 1, Tempe, AZ 85224
Toll-free Phone: 888-721-8904
Direct Dial: 404-760-2803 Extension: 2803
Email: rnidaho@idahonurses.org
FAX: 404-240-0994
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RN Idaho welcomes comments, suggestions and contributions. Articles, editorials and other submissions may be sent directly to the INA office via mail, fax or e-mail. Please call the INA office if you have any questions.

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Continuing Education - Patients Deserve Nothing Less

Robin Schaeffer, MSN, RN, CAE
Multistate Division Leader, Western Multi-State Division

Health care is evolving quickly. During my 37 years as a nurse, I’ve seen our field change in ways I couldn’t have imagined. Technology, protocols, specialization and much more – nurses today have greater challenges than ever before when it comes to staying current.

That’s why Continuing Education (CE) is so important. The American Nurses Association has defined CE as “learning activities designed to augment the knowledge, skill and attitudes of nurses and therefore enrich the nurses’ contributions to quality healthcare.” CE is a simple and effective way to keep current and acquire additional skills and knowledge that are essential to our everyday practice of nursing.

Organizations that sponsor CE benefit by demonstrating to the public, to nursing professionals and to state licensing boards the organization’s commitment to high standards of performance and a well trained workforce. Ultimately, patients benefit most of all when nurses take it upon themselves to keep up-to-date with the latest in the nursing profession.

Nurse educators and trainers work hard to develop meaningful, needs based programs that merit approval to award continuing education credits.

Nurses who attend CE programs recognize their professional commitment to lifelong learning as well as fulfill their criteria for certification and re-certification in their specialty field of practice.

In 2014 the nurses associations of Arizona, Colorado, Idaho and Utah formed a nursing collaborative known as the Western Multi-State Division (WMSD). As an ANCC Accredited Approver of CE, the WMSD works across state lines to support nurses, educators, organizations and institutions acquire CE credits for their educational programs.

ready to get started? Taking the next step is easy. Visit www.idahonurses.org/Education to determine if your program is eligible for CE.

Nursing professionals are in high demand. Nurture your craft and stay ahead of the curve when it comes to the latest innovations in health care. Our patients deserve nothing less.

1 References available upon request.
Conscientious Objection continued from page 1

First, the Two Cases

According to published reports, Jahi McMath, 13, was admitted into a California children’s hospital for surgical procedures to address sleep apnea. Following surgery, she developed a complication, went into cardiac arrest, and was declared brain dead by two hospital-associated physicians and ultimately a court-ordered physician. Her family fought to have her remain on a ventilator until she could be transferred to an undisclosed facility where she could be given additional “life-sustaining” measures.

Marlise Munoz was 14 weeks pregnant when she was found unconscious at home. She was declared brain dead and carrying a nonviable fetus; her family wanted her taken off life support, noting her wishes, the media reported. But this time, the hospital where she was admitted objected — citing a Texas law it believed required them to keep her on life support until her fetus could be delivered. Again, a legal battle ensued. A judge ultimately ruled that the hospital was misapplying the law, and the hospital removed her from life support.

Confronting Difficult Decisions

Nurse ethicist Anita Catlin, DNSc, FNP, FAAN, followed the Munoz case in the national press. “Nurses have a right to conscientiously object to participate in technologically supported treatment of a brain-dead person,” shared Catlin, a member of ANA’s ethics advisory board. “Additionally, when a woman and her surrogate have made their wishes known, it is unethical treatment of a brain-dead person,” she said.

Members of the American Nurses Association (ANA) Ethics and Human Rights Advisory Board were not aware of whether or not RNs objected to providing care in these specific cases. However, nurse ethicists did find it crucial to ensure that all RNs understand that they can conscientiously object to participating in interventions if certain criteria are met.

Additionally, many sensitive cases that might have been kept private in decades past are now being played out in the media, according to Fowler. “Most of the time, nurses just remain silent and do not make their objections known. They experience moral distress, emotional and physical fatigue, and burnout. Therefore, organizations must provide nurses with the staffing necessary to maintain their moral integrity, and nurses need to participate only in patient care that is not morally compromising.”

Parting Words

To make a conscientious objection, Fowler said nurses should follow the lines of authority and the structures that are in place in their facilities. They also can contact their organization’s ethics committee or patient ombudsman.

And although it may take courage to conscientiously object — particularly given some workplace cultures — not doing so can have dire consequences for the individual nurse and for the nursing profession. “Most of the time, nurses just remain silent and do not make their objections known. They also worry that their decision will place a burden on colleagues by giving them more work,” Lachman said. “If nurses cannot move away from these situations, it becomes intolerable. They experience moral distress, emotional and physical fatigue, and burnout. Therefore, organizations must provide nurses with the staffing necessary to maintain their moral integrity, and nurses need to participate only in patient care that is not morally compromising.”

Fowler added, “Nurses need to accommodate and support colleagues who conscientiously object and provide an environment that preserves professional integrity.” — Susan Trossman is the senior reporter for The American Nurse. Reprinted with permission of The American Nurse.
Completing Your Professional Puzzle

Where do you fit in?

Agenda

7:30am  Breakfast & Registration Opens
8:00am  Welcome & Announcements
8:15am  Keynote: "Nurses Transforming Healthcare"
        Maria Weston, PhD, RN, FAAN
        CEO, American Nurses Association
9:15am  "When Family Says 'Do Everything' and We Believe that the Requested Treatment is Futile"
        Alex Chamberlain, Ethicist
10:45am Excellent Care Provided Presentation
11:45am Lunch & Exhibits
12:45pm "What Is Your Personality Animal?"
        Rick Kerr, Chaplain
1:45pm "Life Should be an Adventure: How to Overcome Change and Beat Stress"
        Sharon Lacey, Corporate Comedian
2:45pm  Break
3:00pm  "Elevating Your Efforts so That You Can Elevate Your Excellence"
        Brandon Kelly, Master at Triumphing Against All Odds
4:30pm  Closing & Evaluations

Featuring:

Maria J. Weston, PhD, RN, FAAN
CEO, American Nurses Association
Dr. Maria Weston is a distinguished and visionary leader for nursing, who has dedicated her career to improving the work and public policy environment for nurses and the quality of care for patients.

This focus has included leadership in a broad range of roles, including direct patient care in intensive care and medical-surgical units, nurse educator, clinical nurse specialist, director of patient care support, and nurse executive.

As a committed and influential leader for nursing, Dr. Weston’s is not only helping to prepare and position nurses to improve the quality of health care in the United States, she is also making sure that policy makers understand and recognize the important contribution nurses make to quality health care.

Dr. Weston has been chosen as one of Modern Healthcare’s 100 Most Influential People in Healthcare.

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Nurses working in all care environments including hospitals, public health clinics, private health clinics, and employer work settings have a responsibility for competently administering all types of medications including temperature-sensitive medications such as vaccines. A key aspect of medication safety is the nurse’s oversight of the proper storage and handling of the vaccines to guarantee medication potency and effectiveness. Nursing education curricula today may not include content about the best practices for proper storage and handling of vaccines.

Vaccine Cold Chain

The Centers for Disease Control and Prevention (CDC) estimate that among children born in the last 20 years vaccinations will prevent more than 21 million hospitalizations and 732,000 deaths (CDC, 2014b). However, those impressive numbers would be even higher, says the CDC, if vaccines were better monitored and protected during storage (CDC, 2014a). In a major report of a study involving 45 providers in five states who offered free immunizations as part of the Vaccines for Children (VFC) Program, the researchers found that 76 percent of providers stored their vaccines at temperatures that were either too hot or too cold (Department of Health and Human Services [DHHS], 2012, p. 14). According to that report (pp. 14-15), a percentage of vaccine doses were at risk due to inappropriate storage temperature and consequently “may not provide children with maximum protection against preventable diseases.”

Vaccine cold chain, or cold chain, is a system that is designed to “protect and maintain vaccine viability” (Rogers, Denison, Adepoju, Dowd, & Uedoi, 2010a). In vaccination programs, this process (as shown in Figure 1) requires vaccines to be stored properly from the time of manufacture to the time of administration. An effective

Supporting Safe Patient Care Through Cutting-Edge Vaccine Monitoring Technology: Nursing’s Role and a Case Scenario

The purposes of this article are to 1) explain nursing’s role in promoting a culture of safety in the “vaccine cold chain” process and 2) to examine features and implications of the cutting-edge vaccine monitoring technology of PharmaWatch™ applied to an actual nursing scenario.

Vaccine Cold Chain

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Cold chain violations or “excursions” are the primary reason for vaccine waste. Excursions include storing vaccines outside of the minimal and maximal temperature range, unsafe monitoring of temperatures, incorrect storage containers or improper storage within a refrigerator, equipment failure, and inadequate staff training (Rogers et al., 2010b, p. 341). For example, during the 2009 H1N1 (Swine flu) pandemic, a refrigerator malfunction causing temperatures to fall dramatically over a weekend in a Pennsylvania public school resulted in thousands of lost doses of vaccine (WPXI News, 2009). Rogers et al. (2010b) noted that all agency participants in the Vaccines for Children program were “mandated” to replace unreliable dormitory-style refrigerators because of vaccine damage caused by this type of refrigerator.

Nursing’s Role in the Vaccine Cold Chain Process

CDC Guidelines. CDC’s (2014c) comprehensive guidelines comprise 109 pages of recommendations and best practices to ensure vaccine storage and handling safety. For example, the CDC specifies that a vaccine coordinator and a backup staff person should be assigned to oversee adherence to the cold chain process from transport to shipping to receipt of the vaccines. In some settings, the vaccine coordinator and the staff’s backup coordinator may be registered nurses e.g., an occupational or environmental health nurse working in an employer setting. Detailed instructions and written guidelines for the vaccine coordinator are found in the CDC’s (2014c) comprehensive, best practices document, Vaccine Storage & Handling Toolkit.

Vaccine Coordinators and Staff Training. Vaccine coordinators should be knowledgeable about routine and emergency policies and procedures. However, all staff handling vaccines should have ongoing training on proper vaccine storage and handling using the latest authoritative guidelines. Detailed training guidelines and resources for all vaccine personnel are included in the CDC’s (2014c) Toolkit.

Vaccine Storage Temperature Monitoring and Documentation. CDC (2014c) guidelines require that vaccine storage temperatures be monitored twice a day with those readings recorded and maintained for three years. Excursions must be corrected promptly with documentation of both the nature of the excursion and the corrective action taken. To comply with such regulations, many health care providers still use paper, pen and thermometer and respond to audits by gathering together paper-based logs and notes. However, these tedious, labor-intensive manual efforts by nursing staff can often involve human error, confusion and frustration.

New Technology Features for Vaccine Monitoring

New technology is beginning to dramatically simplify and streamline the process of monitoring vaccine safety. Automated “continuous monitoring” systems are available to provide highly accurate readings every five minutes—a tremendous advantage when trying to determine with a vaccine manufacturer the extent to which a vaccine inventory may be damaged.

In the event of a temperature excursion or deviation from the optimal temperature range, cutting-edge systems can immediately alert staff by text, email, smartphone or pager. Newer cloud-based systems are able to store data indefinitely, providing all documentation needed for an audit at the touch of a key and enabling administrators to view all data anywhere and anytime via laptop, tablet or smartphone.

The new cloud-based vaccine monitoring systems are fully secure and use encryption technology. Users can easily access raw data and reports showing temperature trends and documenting compliance with CDC requirements. For example, PharmaWatch™ developed by a local Boise-based company, AmericanPharma Technologies, LLC, may be the industry’s most advanced system. The PharmaWatch™ system allows users to view all refrigeration units at all facilities on one web page and satisfy the twice-a-day CDC requirement of recording and documenting storage temperatures by simply clicking a box in the top right corner of the computer screen.

Idaho Success Cases. In Idaho, the most advanced vaccine storage monitoring systems have demonstrated benefits. For example, a faulty refrigerator at a local pediatricians unit was briefly but repeatedly subjecting its polio vaccines to freezing temperatures, rendering them useless – a fact that a more traditional monitoring process would not have detected. Fortunately, their newly installed state-of-the-art monitoring solution caught the excursion. The bad vaccine was disposed of and patients were protected.

In another case, a local clinic that was excluded from the state-funded Vaccines for Children (VFC) program, after losing over $60,000 worth of vaccine due to temperature excursions, installed a new-cloud based system. The facility was allowed subsequently to re-join the VFC program and its temperature-monitoring activities are now considered “Best-In-Class.”

**Vaccine Monitoring continued on page 8**
Figure 1. Vaccine Cold Chain Flow Chart*

*Figure 1. Adapted from: CDC (2014c). Vaccine storage & handling toolkit, p. 11.

Nursing Case Scenario: Cutting-Edge Continuous Vaccine Storage Monitoring with PharmaWatch™

Scenario

On a Friday evening, after closing the pediatrics clinic, the lead RN received an alert on her cell phone from PharmaWatch™. The RN returned to the clinic to discover the door of the refrigerator was not fully closed and latched. The RN immediately acknowledged the alert on the PharmaWatch portal via her smartphone and quarantined the inventory.

On Monday, the RN called the vaccine manufacturer. Using the data provided by the PharmaWatch™ Alert History Report, the manufacturer determined that the vaccines were still good and could be used that day. The clinic saved over $40,000 in inventory by not disposing of the vaccines mistakenly that the vaccines were still good and could be used that day. The clinic saved over $40,000 in inventory by not disposing of the vaccines mistakenly.

All events for this incident including corrective actions were easily documented on the PharmaWatch portal with time stamps for each action. The actions taken for remediation of this incident are now available as a permanent record if needed.

Analysis: In this scenario, the nurse took appropriate actions in line with CDC guidelines. The clinic utilized PharmaWatch™ which is a wireless, cloud-based 24/7 service to continuously monitor vaccine storage temperature and other environmental factors such as light, humidity and pressure that might damage vaccines. As noted in the scenario, after leaving the clinic, the nurse was alerted via her smartphone to a temperature excursion at her clinic. The nurse did not have to be physically on-site for the alert and was able to take quick, corrective actions. Using her smartphone, she accessed the PharmaWatch™ portal through the Internet and took immediate action to quarantine the vaccine and to notify other staff and engineering of the incident. In analysing the PharmaWatch™ report data, the vaccine manufacturer could determine that the vaccine was viable. The nurse followed standard policies and procedures for ensuring vaccine storage safety. In doing so, the nurse also complied with the most recent Code of Ethics for Nurses with Interpretive Statements (American Nurses Association [ANA] Provision 33.4, 2015):

Nurse must participate in the development, implementation and review of and adherence to policies that promote patient health and safety, reduce errors and waste, and establish and sustain a culture of safety. (p. 11)

Conclusions

Knowledge about vaccine storage best practices, prevention of temperature excursions, and actions to take when discovering emergencies and breaks in the vaccine cold chain are essential for all nurses as well as staff involved with handling of vaccines. Guidelines from the CDC present current recommendations and training resources for healthcare staff.

New technology is now available for more complete and accurate real-time, continuous vaccine storage monitoring. Alerts to deviations from optimal vaccine storage temperatures can take place off-site and via smartphone, text, email or pager. Nurses are quickly alerted to cold chain problems and can take essential actions to report and remedy problems. Instead of labor-intensive monitoring and documenting of vaccine storage temperatures, nurses can focus on the important client and patient needs and core operations. Today’s new technological innovations in continuous temperature and environmental monitoring such as with PharmaWatch™ will enable the ability of nurses to provide patients with viable vaccines that have been stored and protected according to the highest safety standards.

References


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Update from the Idaho Board of Nursing

by Sandra Evans, M.A.Ed, RN, Executive Director
Email: Sandra.evans@ibn.idaho.gov

“The Board of Nursing believes continuous measurement of performance fosters achievement of desired outcomes and demonstrates respect for the public’s trust” (from the Board’s Philosophy of Governance, adopted 1/09/15 as revised). Consistent with this belief, at their April 9-10, 2015, meeting, the nine Governor-appointed Board members completed their annual self-assessment in which they determine how well they accomplished benchmarks related to strategic goals and objectives; acted consistent with their values of accountability, collaboration, integrity, leadership and respect; and adhered to elements of their governance philosophy.

Board Actions
In addition, Board members Susan Odom, RN, Moscow, Chair; Vicki Allen, RN, Pocatello, Vice Chair; Jill Howell, RN, Jerome; Whitney Hunter, consumer member, Boise; Christopher Jenkins, RN, Homedale; Jan Moseley, RN, Coeur d’Alene; Carrie Nutsch, LPN, Jerome; Rebecca Reese, LPN, Post Falls; and Clay Sanders, APRN, CRNA, Boise:

- Granted initial LPN licensure conditioned on terms of an agreement whereby the applicant agreed to a formal reprimand, fine of $500 and completion of specific courses related for providing false information on an application for licensure;
- Reinstated a previously disciplined LPN license to include conditions for monitoring for up to five years;
- Revoked two RN licenses based on substantiated findings of violations of the Idaho Nursing Practice Act;
- Upheld the January 2015 Board action denying reinstatement of a license previously disciplined by the Board;
- Adopted the revised Board core belief statement related to Practice;
- Affirmed the Board’s 2010 “Interpretive Statement Regarding Midwifery” in which the Board concludes that a licensed nurse (RN, LPN) who is also a licensed midwife (L.M.) “will, either intentionally or unintentionally, exceed the scope of his/her nursing practice while performing as a midwife because of inherent disparities between the two disciplines;”
- Endorsed the “Multi Board Statement of Understanding: Regarding the Prescribing of Controlled Substances in Idaho” developed by a subcommittee of the Office of Drug Policy Prescription Drug Abuse Workgroup;
- Accepted notice from Eastern Idaho Technical College of revision of the PN program curriculum; and
- Granted continued provisional approval to the RN program administered by ITT Technical Institute, Boise, for the period ending June 2016.

Board Appointments
At the April 2015 meeting, the Board appointed APRN Advisory Committee Members Allie Gooding, APRN-CNS, Betty Brosch-Schoenecker, APRN-CRNA and Charlotte Salinas-Wilkes, APRN-CNM to continuing 3-year terms; and appointed Heather Nasker, APRN-CRNA to an initial 3-year term on the PRN Advisory Committee.

Other Board Actions
The Board reviewed and provided comments on the revised NCLEX-RN® Test Plan in anticipation of its presentation to the National Council of State Boards of Nursing 2015 Delegate Assembly for adoption.

The Board also considered potential legislation and administrative rules for presentation to the 2016 Idaho Legislature. As a result of that discussion, “Notice of the Delegate Assembly for adoption.

Other Board News
Of note, Shasta Kilminster-Hadley, JD, the Board’s prosecuting attorney, presented “Beyond Appropriate Boundaries: Why Boards Need Clarity in Rules Prohibiting Sexual Misconduct” at the 2015 National Council of State Boards of Nursing Discipline Case Management Conference in Indianapolis.

Next Board Meeting
The next meeting of the Board is tentatively scheduled for October 1-2, 2015, in Boise at a location to be determined. For further information, visit the Board’s website at www.ibn.idaho.gov or contact Lyn Moore at lyn.moore@ibn.idaho.gov or 208.577.2500.

As always, the Board invites the public to attend scheduled Board meetings and participate in the Open Forum held on the second day of each meeting. The Open Forum provides the opportunity to dialogue with the Board on issues of interest that are not necessarily included on the published agenda. The Board will not take action on issues introduced during the Forum, but may choose to address them at a later scheduled Board meeting.

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Evidence Summary: Hand Hygiene Compliance Studies Validate Only Short-Term Effectiveness of Strategies to Decrease Nosocomial Infection Rates

by Tamara Carpenter RN, BSN, CCRN FNP Track, MSN Program, Gonzaga University, Spokane, WA
Email: tcarpenter@zgmial.gonzaga.edu

At any given time, about one in every 25 inpatients has an infection related to hospital care (U.S. Department of Health and Human Services, 2015, page 1 para 3). Simple measures such as handwashing may reduce the frequency of healthcare-associated infections (HAIs) by 50% (World Health Organization, [WHO], 2015). Although hand hygiene is effective for preventing infection, rates of compliance with the established recommendations are poor and intervention outcomes are short-lived (Gould et al., 2010; Cherry et al., 2012). Hand hygiene compliance is the healthcare professional’s “ability to wash their hands at the recommended points of contact.” Non-compliance with evidence-based protocols may result in increases in hospital-acquired infections, costs, extended lengths of stay, morbidity, and mortality. The Joint Commission has challenged hospitals to decrease healthcare-associated infections through improving hand hygiene compliance (White et al., 2012). Provider compliance with proper hand hygiene is essential for improving patient safety (Shekelle et al., 2013). While there is research evidence supporting clinical guidelines on effective hand hygiene methods, less is known about ways to effectively promote and sustain hand hygiene compliance among healthcare professionals. This evidence summary was initiated to determine if increased hand hygiene access by healthcare providers in the ICU would improve hand hygiene compliance rates and subsequently lead to reduced nosocomial infection rates.

Overview of the Evidence Search Process
After generating a PICOT (population, intervention, comparison, outcome and timeframe) statement and conducting a comprehensive and systematic literature search (strategy available by contacting the author), eight studies were reviewed. The reviewed studies were chosen with pre-set inclusion criteria as shown in column two in Table 1. The eight studies included two systematic reviews (Gould et al., 2010; Cherry et al., 2012), two randomized controlled trials (Fisher et al., 2013; Martin-Madrazo et al., 2012), two quality improvement project reports (White et al., 2012), and the use of larger sample sizes.

While there is research evidence supporting clinical guidelines on effective hand hygiene methods, less is known about ways to effectively promote and sustain hand hygiene compliance among healthcare professionals. This evidence summary was initiated to determine if increased hand hygiene access by healthcare providers in the ICU would improve hand hygiene compliance rates and subsequently lead to reduced nosocomial infection rates.

Study Characteristics and Findings
Overall, the eight studies had similar findings (see column three in Table 1) and recommendations. All showed improved hand hygiene compliance after interventions were applied, but only for the short term. Those that evaluated intervention rates concluded that compliance with hand hygiene practices decreases nosocomial infections (Cherry et al., 2012; Garus-Pakowska et al., 2013; Helder et al., 2010; White et al., 2012; & Yin et al. 2014). When comparing infection rates pre and post-hand hygiene, there was a decrease in infection rates with the increase of hand hygiene compliance. Across studies, there were variations in the nature of groups, interventions, and products used for hand hygiene (see Table 1). Several authors recommended further longitudinal research on hand hygiene compliance and the use of larger sample sizes.

Table 1. Author’s Inclusion Criteria for Selecting Studies and Characteristics of Reviewed Studies

<table>
<thead>
<tr>
<th>PICOT Elements</th>
<th>Pre-Set Search Inclusion Criteria</th>
<th>Characteristics of Reviewed Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>(P) Populations and Settings</td>
<td>Nurses, physicians, respiratory therapists, and healthcare students providing care in the ICU.</td>
<td>Populations addressed in all studies, long-term clinical care units and the hospital.</td>
</tr>
<tr>
<td>(I) Intervention</td>
<td>Hand hygiene practices and post patient contact. Per protocol use of hand sanitizers or sinks available in each patient room, outside patient rooms, and in general use areas in the ICU.</td>
<td>Single or multiple hand hygiene practices per unit protocol before and after patient care with or without reminder or feedback regarding hygiene education. Studies reported use of aqueous and/or alcohol-based solutions, hydro-alcohol solutions with education, reminder posters, alcohol gel or wipes, and use of technology alert reminders.</td>
</tr>
<tr>
<td>(C) Comparison Intervention</td>
<td>Hand sanitizer and sinks available in patient rooms only.</td>
<td>Not addressed in studies.</td>
</tr>
<tr>
<td>(O) Outcomes</td>
<td>Hand hygiene compliance rates and infection rates.</td>
<td>Hand hygiene compliance rates and infection rates.</td>
</tr>
<tr>
<td>(T) Timeframe</td>
<td>At least one year follow-up.</td>
<td>10 weeks, several months, six months, and over one year.</td>
</tr>
</tbody>
</table>

After reviewing the studies, this author was surprised to find that hand hygiene compliance levels were alarmingly low at baseline and then after short-term improvements following varied interventions. The health professional’s behavior, attitude, and hand hygiene habits seemed to influence hand hygiene compliance on average. Unexpectedly, infection prevention was not the motivating factor for healthcare professionals to increase hand hygiene compliance rates.

Best Practices for Hand Hygiene Compliance
In itself, hand hygiene is a best practice standard in WHO guidelines (WHO, 2015) and is included in the Healthy People 2020 (2014) initiative to decrease hospital-associated infections. According to Martin-Madrazo et al. (2012), the Centers for Disease Control and Prevention (CDC) promote using alcohol solutions and multimodal strategies for improving hand hygiene compliance. The use of alcohol solutions in conjunction with hand hygiene protocol compliance are the best practices as confirmed in six of the studies reviewed.

According to the National Institute for Health and Care Excellence (NICE, 2012, pp. 2-3), the guidelines for prevention of health-care associated infections included: “hand hygiene: handwashing” technique, use of decontamination agents, including liquid soaps and alcohol handrubs, which should occur before patient contact and care and after patient contact or care.” The CDC (2011) also published guidelines that promote hand hygiene programs with the use of alcohol-based products, which were initiated in the reviewed eight studies. The guidelines were published to increase hand hygiene compliance among healthcare workers and to decrease nosocomial infection rates.

These national practice clinical guidelines directly support the importance of hand hygiene, yet the findings in this review of studies show that healthcare providers are not compliant with the recommendations. As reported in the study by Garus-Pakowska (2013) of 188 physicians and nurses at three hospitals, there was an overall average baseline rate of 5.2% hand hygiene compliance (handwashing before patient contact) using CDC and WHO guidelines. Nurses were noted to be less compliant with CDC and WHO hand hygiene protocols than physicians.

Implications for Practice
This author’s research reaffirmed the known difficulty in measuring true hand hygiene compliance of healthcare workers. The Hawthorne effect (a tendency to change behavior in response to being observed) was repeatedly used in many studies; it was difficult to observe the behavior of workers covertly over a long period. This research also revealed that despite guidelines and recommendations from the CDC, WHO, and Healthy People 2020, hand hygiene compliance continued to be alarmingly low. While the initial PICOT question for this evidence summary was focused on the outcome of decreasing infection rates, a new starting point for understanding hand hygiene compliance should focus on the individual worker’s behavior, attitudes, and habits of hand hygiene. Although the evidence shows that increased compliance will decrease infection rates, there is no current evidence that identifies a single or multimodal method that maintains continuously high hand hygiene compliance rates over time. This is a safety concern for all patients receiving care.

As recommended in several studies, a multifaceted approach was the most successful strategy for increasing hand hygiene compliance. Examples of multifaceted approaches included the combined use of educational sessions with feedback, reminders, or audits. Hospitals should promote and implement follow-up strategies for hand hygiene. There are several strategies or “continuous interventions” (Cherry et al., 2012) that should be considered for implementation in order to sustain increased hand hygiene compliance among all healthcare workers. Some of these strategies include regularly scheduled, short inservices; awareness campaigns planned throughout the year; and placement of reminders or alerts in patient care areas. Hospitals must ensure that adequate hand hygiene products and sinks are available for all their employees. In addition, there is a need to monitor hand hygiene compliance rates on a regular basis. All healthcare workers are personally accountable for adhering to clinical practice guidelines, which will decrease nosocomial infection rates.

References
Cherry, M., Brown, J., Bethell, C., Neal, A., & Shaw, N. J. (2012). Features of educational interventions that lead to compliance with hand hygiene in healthcare professionals.
The Role of the Palliative Care Team

Palliative care teams provide services in a variety of settings such as inpatient hospital stays, skilled nursing facilities, long-term acute care facilities, in the home, and in outpatient settings. A key component to providing quality palliative care is excellent clinical skills, but outstanding communication skills are as important. Communication with the patient and loved ones requires the ability to allow expression of emotions, fears, and questions about the patient’s illness and potential outcomes. Specialized education and training are crucial requirements for members of a palliative care team.

Benefits to Patients and Families

Palliative care teams have the time and resources to hold family conferences or engage in other modes to communicate, which allow patients and their loved ones to discuss the plan of care for the patients. Palliative care does not decide for the patient what the best plan of care is, but rather determines with the patient and loved ones what the patient desires. Often times it can come as a relief for family members to hear what the patient wants. This allows the family to determine what the patient would want for care if unable to express what he/she wants in the future.

Palliative care increases patient satisfaction with care (Parker, Remington, Nannini, & Cifuentes, 2013). Palliative care also has been found to be a cost saving in the inpatient setting, especially when utilized early in the patient’s hospital stay (McCarty, Robinson, Huq, Philastre, & Fine, 2015). Palliative care is about patient choice and self-determination as exemplified in the following scenario.

An 88 year old patient with chronic anemia due to a non-obstructive colon cancer was seen by the palliative care team. The patient had previously seen a colorectal surgeon who said that surgery was not an option and the patient had declined chemotherapy and radiation as a treatment option. Through talking with the patient, the palliative care team discovered that she was experiencing fatigue, shortness of breath, and vision problems. The patient discussed her goals with the team, which were to live as long as possible as long as some of her symptoms could be alleviated.

The MD on the palliative care team ordered blood and iron transfusions for the future, which alleviated the patient’s fatigue. Her shortness of breath was not alleviated and she was started on an inhaler, which she said helped. Her vision problems were found to be due to glaucoma and the social worker from the team contacted the assisted living center where the patient lived. An assessment of her room was initiated to determine safety issues and the needed community resources for someone with impaired sight.

Conclusion

Palliative care is a growing part of many healthcare settings and meets the needs of patients across the lifespan. Its role in improving the quality of life, not only for patients but also for their families and other loved ones, is integral to delivering holistic care. As a nurse, if you are encounter a patient who need symptom control or a discussion about goals of care for their health situation, determine if palliative care is available in your healthcare setting and then seek out how to refer the patient for this type of valuable care.

References


Five emerging national nursing trends were identified:

1. The Affordable Care Act requires nurses to develop skills to practice acute care nursing outside of traditional institutions.
2. There is a national movement by accreditors and certifying bodies, as well as the Department of Education, to cap associate degree education at 60 credits.
3. Academic progression in nursing is slow due to personal motivation, costs and time, even though opportunities are available to continue to a BSN.
4. For the first time in history, the national nursing BSN population is at 55.2% of all RNs.
5. Diversity in the nursing workforce is difficult to achieve and sustain.

Idaho Nursing Workforce Data

Bob Uhlenkott, from the Idaho Department of Labor, presented the January 2015 nursing workforce data. Following the national trend for more BSN-prepared nurses, 53.4% of RNs in Idaho have a BSN or higher nursing degree. The job market maintains near equilibrium with the number of Idaho graduates, almost 800, meeting the annual job demand of about 600. Idaho continues to see about 65% of new graduates seeking employment in Idaho. While Idaho seems to be doing well today, the next five years could pose some issues because 9.3% of nursing faculty intend to leave their positions, more Idaho licensed nurses today (14.7%) practice outside of Idaho than in 2010 (10.6%), and almost 50% of the nursing workforce is over 45 years old, with the greatest number of RNs over the age of 55.

State Implementation Grant (SIP-3)

Information on the current Robert Wood Johnson Foundation (RWJF)/AARP State Implementation Grant (SIP-3) was presented with respect to three major goals: (1) establish a work plan for career-long education to meet future workforce needs, (2) create resources that facilitate educational progression and lifelong learning, and (3) create opportunities for lifelong learning among underrepresented populations. Mary Dickow, MPA, FAAN, who is the Statewide Director for the California Action Coalition for RWJF’s Future of Nursing initiative, reported on the California experience and how they are driving the workforce to meet the target of 80% BSN preparation by 2020 and identified the new roles nurses will take on in a changing healthcare environment. Maureen Sroczynski, DNP, RN, presented the Massachusetts experience, which identified competencies in nursing and supported academic progression. A general discussion followed that examined how Idaho could learn from the experiences of these two states, as well as other states that have similar issues and barriers to academic progression in nursing and that have developed state based strategies to meet the 2020 BSN goal of 80%.

Next Steps

Regional meetings in Idaho will be held beginning in September to broaden stakeholder engagement and to facilitate and support regional opportunities for academic progression and lifelong learning. Please contact Randy Hudspeth (rhudspeth@nurseleaders.org) or Margaret Henbest (mhenbest@nurseleaders.org) if you are interested in participating in these regional planning sessions.

We want to thank the attendees of the summit for their presentations, attention, and recommendations, which have become the blueprint for action as we move forward.
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For some time, researchers have known that consuming protein in balanced amounts at each meal is beneficial to improving overall health. Some of the benefits of distributing protein throughout the day include feeling satisfied after a meal or snack that features protein, which helps reduce mindless eating. Plus, meals with high-quality protein help build muscle and reduce body fat.*

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Dealing with Moral Distress and Ethical Dilemmas in Nursing

by Rick Bassett, MSN, APRN, ANCS-BC, CCRN
Cardiovascular Clinical Nurse Specialist
St. Luke's Medical Center, Boise/Meridian, Idaho
Email: bassett@slhs.org

In today’s increasingly complex clinical environment, we more frequently encounter moral distress and ethical dilemmas. Regardless of the workplace such as acute care, rehabilitation, long-term care, surgery center or ambulatory clinics, our nurses and clients present with unique issues. In some circumstances, these issues present healthcare professionals, the patient/client and their families with difficult decisions for which the resolution seems unattainable. Whether the patient is the child with cancer or a father who has had a devastating head injury or a grandmother who has struggled with end stage disease and now faces imminent death, nurses are there to provide care and support for these patients, their families and for each other.

Complex situations create a challenging work environment that can lead to moral distress or ethical dilemmas. Andrew Jameton (Epstein & Delgado, para 2, 2010) first defined moral distress as “a phenomenon in which one knows the right action to take, but is constrained from taking it.” This state of moral distress can result when nurses experience numerous challenging clinical situations. According to the American Association of Critical Care Nurses [AACN], moral distress is a critical issue in nursing which contributes to a loss of integrity and dissatisfaction with their work environment. Furthermore, studies demonstrating that moral distress is a major contributor to nurses leaving the work setting and the profession.

Moral distress is not an uncommon occurrence in critical care and other intense workplace care settings. However, as nurses, we have resources to help confront the feelings of moral distress and find an acceptable resolution. In the role as a Clinical Nurse Specialist and Clinical Ethics Consultant at St. Luke’s Hospital, the author has encountered many nurses and other healthcare colleagues struggling to deal with these feelings. It is important that these feelings be shared with colleagues in order to facilitate a resolution. Nurses should identify resources that are in their organizations such as Spiritual Care providers, nursing and physician colleagues, leaders, ethics committee members and others. Many professional organizations also have online resources that identify and present solutions to dealing with moral distress.

In addition to experiencing moral distress in the work environment, nurses may also have encountered an ethical dilemma(s). Most ethical issues in healthcare today involve the core ethical principles of autonomy (right to choose), beneficence (to do good), non-maleficence (to do no harm) and justice (the moral obligation to act). Some of the most frequent ethical dilemmas arise in settings where patients have complex disease processes and are unable to provide their input into treatment decisions. As a result, health professionals encounter difficulties or disagreements in determining which treatments are in the best interest of the patient. Inadequate communication or incomplete information is often at the core of these difficulties or disagreements. Identifying and addressing the ethical issues early can improve patient outcomes, reduce staff stress, decrease avoidable complex ethical dilemmas, and change potentially irreversible outcomes.

Dealing with moral distress and ethical dilemmas is not infrequent in healthcare today. With an ever-growing number of patients, an increasing patient acuity, and a nursing shortage, nurses need to take action for self-care, must support the health of our workforce and improve our relationships with our patients by proactively addressing moral distress and ethical dilemmas in the workplace. Continually educating ourselves and utilizing our resources will help us to be better patient advocates and more effective healthcare professionals.

References

In Memoriam

INA is pleased to honor deceased registered nurses who graduated from Idaho nursing programs and/or served in Idaho during their nursing careers. Included, when known or when space allows, will be the date when deceased and the Idaho nursing program. The names were submitted to the American Nurses Association for inclusion in a memorial held in conjunction with the ANA House of Delegates. Please enable the list’s inclusiveness by submitting information to midaho@idahonurses.org.

Dickey, Melva “Jeanie” Holtzclaw, 6/23/2015. Jeanine worked at St. Luke’s Medical Center. One of her strong traits was her ability to “quietly take care of people.”

Erickson, Tana Dawn, 6/26/2015. Tana graduated from Idaho State University and worked at the California Men’s Prison and then St. Luke’s Hospital in Boise. Her passions were caring for the elderly and her career in nursing. She was a compassionate and loving family member and friend.

Gardner, Anna Louise, 4/29/2015. Anna obtained her R.N. license in 1944 and joined the U.S. Army Nurse Corps. She was stationed on the hospital ship, Marigold, the first ship entering into Japan just prior to the Japanese signing of the treaty to end World War II in the Pacific. During her service on the hospital ship and in Japan, she assisted in the repatriation of Allied prisoners and toured the devastation in Hiroshima. Contracting TB and remaining seriously ill, Anna traveled back to the U.S. Although she then had to take an early medical retirement from nursing, Anna continued her spirit of adventure and interest in healthcare. She was generous and kind towards everyone she met and will be greatly missed.

Mayerka, Sharon L. Van Caren, 5/28/2015. Sharon attended Boise Junior College and cared for others for several years at the Ada County Nursing Home. She loved family and the outdoors.

Miskin, Virginia Crooks Palmer, 6/5/2015. A 1944 graduate of the LDS Hospital in Idaho Falls, Idaho, Virginia worked as an office nurse, a special-duty nurse in Idaho Falls and as a school nurse until her retirement. Her hobbies included gardening and ham radio operator. She was devoted to her family

Nevin, Catherine Pickett, 6/3/2015. Catherine received her nursing degree from Deaconess Hospital after completing one year at the College of Idaho. She worked for many years at Good Samaritan Hospital in Portland, Oregon and engaged in mission fieldwork in Thailand and in ministering at her church. She cultivated beautiful roses and many friendships throughout her 104 years.

Olsen, Alice Olavarria, 2/18/2015. Alice graduated from St. Teresa’s Academy in Boise with her degree in nursing. She worked for 29 years at St. Alphonsus Medical Center and in 1975, she humbly accepted the “Employee of the Year” award. Her dedication to nursing was recognized.

Perez, Mary “Sue” Chantrill, 6/30/2015. Susan graduated from Ricks College with a nursing degree and became the youngest applicant accepted into the Treasure Valley School of Anesthesia. She worked as a registered nurse at St. Luke’s Hospital in Boise. She was selfless in giving to others.

Raney, Cindi Kay, 5/26/2015. Cindi received her BSN from Boise State University and began her career at Mercy Medical Hospital (now Saint Alphonsus Medical Center). She was devoted to nursing, earned a “Forever Fighter” button, and completed the 2015 Komen Race for the Cure. Her family, friends, and patients recognized her strength.

Thomas, Marianna G. Boehmer, 01/13/2015. Marianna enlisted in the Army Nurse Corps and served as an Army officer in World War II. She later worked as a school nurse and at several Veterans Administration hospitals. In the last interest of her life, she worked at the Boise Veterans Administration Medical Center in Boise, Idaho. Her dedication to nursing and serving others was unwavering.

Tibbs-Wideau, Mary Lee, 4/24/2015. Mary Lee completed the St. Luke’s Nursing Program in 1962 and worked at St. Luke’s Medical Center, Boise, Nampa’s Mercy Hospital, and the Idaho State School and Hospital. She was a nurse for her kindness, strength and courage throughout her life. She was dedicated to nursing and to her family and is missed by all she touched.

Ward, Tamara Louise, 6/12/2015. Tamara graduated from Boise State College and worked in nursing for over 35 years until her retirement in 2010 from Saint Alphonsus Medical Center in Boise. She nurtured her family and those around her and will be remembered for her kindness, acceptance, and welcoming nature.

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Evidence Summary continued from page 10


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