The Never Ending Story of Staffing

by Kathleen Morris

More staff, less overtime. More PCAs, fewer extra duties. More time for charting, less pressure to do more with less. And let’s not forget more guaranteed lunch and bathroom breaks.

The results of the Ohio Nurses Association’s (ONA) 2012 survey of staff nurses employed in Ohio hospitals tells much the same story as it did last year, and the year before that. Of the 500+ nurses who completed the survey in March of this year, nearly three-quarters found that staffing levels were inadequate to provide safe and effective nursing care to their patients. Seventy-three percent stayed beyond normal working hours to complete charting while being pressured to avoid unnecessary overtime. Two-thirds of the respondents were unfamiliar with their facility’s staffing plan and/or lacked the opportunity to contribute to the plan.

House Bill 346, passed by the Ohio General Assembly in 2008, required Ohio hospitals to establish a hospital-wide nursing care committee consisting of at least fifty percent registered nurses in direct patient care positions. The task of the committee was to evaluate nurse staffing following certain parameters and to create an evidence-based staffing plan which, at the minimum, met current accreditation and government standards. The bill also required that the staffing plan be prominently posted, made available to all who wish to obtain a copy, and re-evaluated annually.

Since that time, the Ohio Nurses Association has collected copies of these staffing plans, both in 2009-10 and 2011-12. Some plans consist of one page, others are multi-paged treatises of evidence-based practice and principles of nurse staffing. Regardless, the majority of direct care nurses who were meant to participate and benefit from this process remained largely unaware of the staffing law and the process for participating in the development of the staffing plan. Thus, in 2011, ONA offered education sessions to staff nurses. The sessions took place in several locations around the state in an attempt to both better inform nurses about Ohio’s staffing law and to encourage participation in the process. Sadly, little seems to have changed. According to our most recent survey, nurses remain uninformed concerning their facility plan and have little opportunity to participate in the process.

In order to learn more about how we can help nurses to improve their staffing situations, ONA will conduct seven focus groups around the state. Participation will be open to 24-30 persons per site so that all participants have a chance to share their input.

Attention will be divided into small groups of 6-8 nurses for discussion purposes. The intent of these focus groups is to capture innovative ways to improve nurse staffing in Ohio hospitals and to increase nurse ownership of the staffing process.

Meetings will be held in local venues outside of workplace. Refreshments will be provided. Please think about joining us. Let ONA know how we can improve staffing conditions in your workplace.

To RSVP for a focus group in your area, go to www.ohnurses.org and click on the “RSVP for a Nurse Staffing Focus Group” button or by emailing rwolfe@ohnurses.org.

Focus Groups Dates and Cities:

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<td>October 3, 2012</td>
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Visit www.ohnurses.org and click on the “RSVP for a Nurse Staffing Focus Group” button if you’re interested in attending!

A Timeline: Staffing Legislation and Implementation in Ohio

- June 12, 2008: House Bill 346 signed into law
- December 9, 2008: Each hospital in Ohio must establish a hospital-wide nursing care committee
- March 9, 2009: Each hospital must create a written staffing plan; the staffing plan must be re-evaluated annually and posted in a prominent location.
- 2009-2010: ONA collects Ohio hospital staffing plans.
- Spring, 2011: ONA provides educational sessions regarding the staffing bill in Lima, Chillicothe, Akron, Columbus, and Cincinnati.
- Summer, 2011: ONA conducts a survey of registered nurses working in Ohio hospitals covered by an ONA collective bargaining agreement concerning comprehensive working conditions issues, including staffing and related matters.
- Spring, 2012: ONA conducts a survey of registered nurses employed in Ohio hospitals concerning staffing, nurse participation in the facility staffing plan, and other factors affecting safe staffing.
- Fall, 2012: Focus groups regarding staffing to be conducted in Perrysburg, Independence, Akron, Boardman, Franklin, Worthington and Piketon.
To help Ohio's nurses meet their obligation to stay current in their practice, three independent studies are published in this issue of the Ohio Nurse.

Instructions to Complete Online
2. Click on each study you want to take and add it to your cart. (ONA members will see a price of $10.00 after they are logged in).
3. Complete the check-out process. You will receive a confirmation email with instructions on how to take the test.
4. Log in and click on “View My New Studies.” Click on the study you want to take, and follow the instructions provided in CE4Nurses Exam Manager to complete the study.
5. Please read the independent study carefully.
6. Complete the post-test and evaluation form for each study.

Post-test
The post-test will be scored immediately. If a score of 70 percent or better is achieved, you will be able to print a certificate. If a score of 70 percent is not achieved, you may take the test a second time. We recommend that the independent study be reviewed prior to taking the second post-test. If a score of 70 percent is achieved on the second post-test, a certificate will be made available immediately for printing.

Instructions to Complete By Mail
1. Please read the independent study carefully.
2. Complete the post-test and evaluation form for each study.
3. Fill out the registration form indicating which studies you have completed, and return originals or copies of the registration form, post test, evaluation and payment (if applicable) to: Ohio Nurses Association, 4000 East Main Street, Columbus, OH 43213
4. References will be sent upon request.

Disclaimer: The information in the studies published in this issue is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

The Ohio Nurses Association (ONA) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
as inadequate coordination and function as seen in disabilities of the surgery may have an impact on the woman's ability to perform daily activities. Nurses can also be affected depending upon their role in the surgery. Teaching the patient about patient care have healthcare professionals focused on education individual spiritual well-being provide security for the patient. Positive teaching approaches encourage learning experience and described it as an emotional shock (Persson & Helistrom, 2002). The purpose of this continuing education (CE) study is to provide nurses with a comfortable nurse-patient relationship with ostomy patients utilizing education, evidence-based practice, and listening to the needs of the patient. The United Ostomy Association (UOA) reports approximately 1 million Americans now have some type of stoma. Each year approximately 120,000 people will undergo ostomy surgery. The patient, the health care professional, and the patient's family need to be prepared for effluent, flatulence, and water and requires continuous maintenance. Ostomy surgeries are required for different reasons. They may be due to cancer, colorectal disease, irritable bowel syndrome (IBS), ulcerative colitis, and Crohn's disease. Emergency cases of diverticulitis, trauma, and complications also require ostomy surgery to be performed (Dorman, 2009).

The most common reasons for the formation of a stoma are cancer, inflammatory bowel disease, and colorectal disease. Stoma formations impact the lives of patients causing many psychological problems ranging from fear and anxiety to the ability to maintain sexual relationships, sexuality issues, and spiritual well-being. It has been shown that the patient's experience and knowledge surrounding pre- and intra-surgery are most likely to have more positive feelings that promote perceived control in order to control psychological recovery through communication and education. The perception of negative body image is considered one of the largest effects of having stoma surgery. It can cause negative feelings such as shock, fear, and anxiety. The perception of negative body image is considered one of the largest effects of having stoma surgery. It can cause negative feelings such as shock, fear, and anxiety.

The American Cancer Society (ACS) has reported colon cancer as the third most common cancer in both men and women in the United States and the 2012 statistics reported 128,902 new cases of colon cancer in addition to 39,670 new cases of rectal cancer. The advancements in quality of care for healthcare professionals focused on education for their ostomy patients to promote independence and ensure holistic quality of care. Support groups and individual and family well-being promote security for the patient. Positive teaching approaches encourage learning and confidence in self-care. Teaching the patient about mastery of self-care is critical for an ostomy patient to perform successful self-care. As a result, the mastery of self-care is critical for an ostomy patient to perform successful self-care (Dorman, 2009). There are gender-related differences in the physical and psychological aspects of adapting through communication and education. Preoperative teaching session, patients view the pouching system and supplies that will be used at home. This is an important part of a new ostomate's rehabilitation is to self-care (Dorman, 2009). Self-care can be awkward for some, but when taught correctly, it can improve the patient's independence and self-confidence (Dorman, 2009). Preoperative teaching cannot prepare ostomates for those early reactions toward their stomas or for the physical attractiveness that is significantly decreased after the stoma is placed. The first adjustment for the first time, adjustment becomes more comfortable, but nevertheless, many patients reported an initial experience that the body had been significantly altered (Persson & Helstrom, 2002). Stoma patients reported that touching the skin around the stoma was unpleasant and painful; finding and determining the signs and symptoms contributing to stress and intensity of ostomy surgery. When a patient has been diagnosed and told about the surgical site, the patient is faced with a multitude of questions from all of the unknown expectations which hampers the initial learning process. Preoperative Teaching The certified Wound Ostomy Continence Nurse (WON) or wound nurse is the main site for the stoma. They mark the patient having ostomy surgery after the patient's abdomen is observed sitting, bending, and lying (Brown & Randle, 2003). The nurse's personal feelings toward ostomates play a significant role in patient outcomes (Dorman, 2009).

According to Simmons, Smith, Robb, & Liles (2007), an estimated one million cases of colostomy surgeries occur annually. Patients may be required to have a colostomy, ileostomy, or urostomy. For particular ostomates with a debilitating disease, the stoma surgery provides a better quality of life. However, many face significant physical, psychosocial, and emotional challenges that require lifestyle modification. Fluid intake must be given special attention during postoperative care. During the first 24 hours, only fluid that is well tolerated and provides a protective layer between the skin and urine, stool, or drainage (Mt. Carmel, 2009).

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Sexuality Concerns

The influence on ostomate’s sexual life suggests that their attractiveness had decreased since surgery. Because of the change in physical appearance, many stoma patients worry about sexual issues and claim their sexual attractiveness has decreased since having their ostomies.

In fact, preoperatively, many patients reported swimming on a regular basis followed by a sauna. Now, being naked in the shower with the stoma and the pouch hanging down, is impossible. Stoma patients reported a loss of functional abilities that instigated or exacerbated their multiple chronic illnesses (Persson & Helin, 2002).

Regardless of a person's age, diagnosis, or sexual preference, ostomy surgery infringes on the high values that society places on beauty, body, sexuality, cleanliness, and self-control. These changes to the ostomate’s body are not only visible to the ostomate themselves, but also visible to their sexual partner, altering any sexual desires as well as any sexual activity. Depression after ostomy surgery is usually normal, creating a loss of libido. Therefore, couples need time to adjust and recuperate psychologically as well as physically (Turnbull, 2010).

It is normal to feel sensitive about any changes which occur to the body; therefore, it is essential that ostomy patients express their feelings about how they feel to their spouses and friends. It is important to know that sexual relations cannot harm the stoma. For those who feel a little intimidated, there are specially made pouches designed just for intimate moments; furthermore, pouches may also be covered with specially designed underwear, such as lingerie, or pouch covers (Convatec, 2008).

Discharge Teaching

Post-discharge follow-up is frequently provided by a non-specialized home care nurse who focuses his or her attention mainly on stoma management than on what is happening to the patient’s psychological state of mind. One researcher suggested that most psychological problems for patients are related in some way to the individual’s inability to perform self-care and that an improvement in this area could have a positive impact on the psychological well-being of the patient (Turnbull, 2010).

Good nutrition and hydration play a key role in helping wounds and incisions heal. Nutrients and oxygen must reach the tissues of the wound in order for the healing process to occur. Key nutrients for wound healing include protein, carbohydrates, fats, vitamin C, vitamin A, iron, zinc, and fluids (Mt. Carmel, 2009). Ostomy patients must be careful to chew foods thoroughly and consume small portions during meals to avoid the dumping syndrome.

Certain dietary restrictions such as high-fat cereals, popcorn, raw vegetables, and nuts must be avoided initially after surgery because these foods cause obstruction during digestion (Dorman, 2009). Patients with an ileostomy usually have a very high output and thus there is a risk of dehydration (Wright, 2009). Ostomy patients should eliminate carbonated drinks completely, as these drinks are gas producing and may cause the pouching system to swell, which could potentially loosen the skin barrier seal and cause leakage.

Patient education begins before surgery and should continue after hospital discharge until the individual can perform self-care successfully. The patient teaching goal is for the patient to transfer information presented and the skill practiced to everyday life. Patient education is the single most important action toward independence, confidence, and rehabilitation (Turnbull, 2010).

Physical Issues and Quality of Life

Comorbidities are a significant predictor indicating how Health-Related Quality of Life (HR-QOL) affects stoma patients in the domains of physical functioning, general health and social functioning. Among some of these comorbidities, studies have found prevalence in patients that experienced a significantly higher occurrence of depression, loneliness, suicidal thoughts, feelings of stigma, and low self-esteem. Current studies are trying to evaluate whether this low quality of life is due to the presence of the ostomy itself or because of the comorbid disease that often accompanies stoma (Jain et al., 2007).

Colorectal cancer is not the only reason for placement of an ostomy. In some cases, non-cancerous diseases can also be the cause of the acquiring of an ostomy. Colostomies in non-cancerous patients are the result of complications stemming from inflammatory bowel disease and diverticulitis. No differences were found related to sexual function between the two groups, indicating that both cancerous and non-cancerous groups were less sexually active post-ostomy. In general, colostomy patients with cancer reported having a better quality of life compared to patients with benign diagnoses (Kroase et al., 2009).

Often people with disabilities use disengagement as a way of coping. For example, they may avoid certain situations that may arouse fear and distress because of concerns of not being accepted socially. Studies have suggested people who receive emotional support perceive less discrimination and have a higher self-esteem, whereas people with a colostomy who find it difficult to engage with family and friends are more likely to be poorly adjusted (Simmons, Smith, Robb, & Liles, 2007).

In most cases, patients undergo stoma surgery due to the fact that they have cancer; therefore, these patients cope with a physical life-threatening condition in addition to accepting an emotionally dramatic change in body image. Younger patients, on the other hand, usually have diseases that are not life-threatening such as ulcerative colitis or Crohn’s disease (Marquis, Marré, & Jambon, 2010).

Patients undergoing surgery for an ileostomy have the entire colon removed with the anus sewn closed creating liquid output from the stoma. This has the potential for additional difficulties associated with the stoma. Patients that have surgery for a urostomy may experience difficulties in coping with their stoma as a result of urine leakage that causes skin irritation and breakdown (Marquis et al., 2010).

Summer produces a great deal of anxiety for someone living with an ostomy, because body image often produces the fear of public embarrassment. Today, there is a broader selection of outfits made for summer than there has been in the past. Flowered or textured patterns that provide camouflage are now manufactured making everyday clothing attractive. Also, there are one piece and two piece swimming suits that are made appealing, while at the same time covering up any appearance of the pouch (Turnbull, 2010).

New advancements in pouching systems allows ostomy patients to choose from a closed-end pouching system that can be worn under a bathing suit that will prevent leaking onto the suit or switch to a drainable pouch for easier disposal while traveling on the road (Turnbull, 2010).

Ostomy pouches today are designed to lie flat against the abdominal wall making them almost unnoticeable beneath clothing so there is no need for a special wardrobe; however, here are some key points to consider before dressing. If the stoma is in a waistline, avoid pressure from tight belts or pants. If the patient is wearing a girdle, make sure it is soft and stretchy, and the supporter should be worn one size larger (Convatec).
Communicating with others is therapeutically beneficial. For these elderly patients, working part-time was the utmost importance to be psychologically and emotionally therapeutic. For those living with an ostomy, staying connected with others who also have an ostomy can lead to a more functional family life (Wong & White, 2002). The altered body image and the loss of power to control defecation can have a major influence on an ostomate’s quality of life. The quality of life has been defined as "the number of years lived in good health, or the degree to which life is satisfactory to the individual" (Shaw & Fawcett, 2009). The idea that hoping one’s circumstances will change precipitates a wide variety of problems deteriorating a person's quality of life. The quality of life has been defined as the "number of years lived in good health, or the degree to which life is satisfactory to the individual" (Shaw & Fawcett, 2009).

Psychological and Spiritual Support

Regardless of the disease process, a colostomy, ileostomy, or urostomy can place severe stress on an individual and his or her patient’s life. Patients must be encouraged to express fears, concerns, worries, and distrust regarding their ostomy. For example, if cremation services are held as appropriate referrals are made to various departments, such as the religious service, mental health, physical therapy, and the Wound Ostomy Continence Nurse (WOCN). According to Weinert, Cadney, and Spring (2008), the computer-based intervention is maturing and has provided an important link to bring ostomy patients together via the internet. Patients were encouraged to make new friends and share their knowledge and satisfaction experienced in everyday life as opposed to financial or material well-being” (Marquis et al., 2010). Research suggests females, more than males, are often afraid to venture out into restaurants or accept an invitation to dinner from friends. The idea of ostomy care is to optimize the quality of life for ostomy patients; we must investigate and identify the patient’s problems and use the principles of nursing to help resolve them (Turnbull, 2010).

Ostomy patients often become dietarily crippled because all daily activities involved considerable planning. The altered body image and the loss of power to control defecation can have a major influence on an ostomate’s quality of life. The quality of life has been defined as the "number of years lived in good health, or the degree to which life is satisfactory to the individual" (Shaw & Fawcett, 2009). The idea that hoping one’s circumstances will change precipitates a wide variety of problems deteriorating a person's quality of life. The quality of life has been defined as the "number of years lived in good health, or the degree to which life is satisfactory to the individual" (Shaw & Fawcett, 2009). Regardless of the disease process, a colostomy, ileostomy, or urostomy can place severe stress on an individual and his or her patient’s life. Patients must be encouraged to express fears, concerns, worries, and distrust regarding their ostomy. For example, if cremation services are held as appropriate referrals are made to various departments, such as the religious service, mental health, physical therapy, and the Wound Ostomy Continence Nurse (WOCN). According to Weinert, Cadney, and Spring (2008), the computer-based intervention is maturing and has provided an important link to bring ostomy patients together via the internet. Patients were encouraged to make new friends and share their knowledge and satisfaction experienced in everyday life as opposed to financial or material well-being” (Marquis et al., 2010).

The most significant observation was the limited ability to act spontaneously because all daily activities involved considerable planning. Nutrition and diet are essential in dealing with this medical procedure and peristomal skin breakdown being the most common. The negative aspects of living with a stoma were incontinence, fear of blood, and fear of leakage into the toilet, and toilets when in unfamiliar surroundings. The most limiting aspect to daily life was the inactivity to act spontaneously. Food of choice at one time was the utmost important to an individual and his or her emotional health. A stoma operation causes a person to feel like an outcast in his or her family life. People who successfully adapt to their condition will have more control over their health care and will live a healthier life (Weinert et al., 2008). Gaining independence and control provides a road to an emotional recovery and social stimulation necessary for the normal healthy adaptation. The patient who did not have the support of a spouse or their relative at home until the end (Stoltz et al., 2006). Patients experiencing their greatest challenges and acceptance (Krouse et al., 2007).

According to Simmons et al., (2007), talking with patients about the implications of the medical experience can have a significant impact on the individual’s psychological adjustment and self-image. There have been significant advances in stoma appliance technology that makes peristomal skin breakdown and incontinence a thing of the past. Being close to facilities provides an enormous relief to patients and allows for support for the caregiver. The network of home health nurses provide a great asset to the caregiver’s reassurance and support. The idea of home care has had to be made for care for their relative at home until the end (Stoltz et al., 2006). Mortality rates of ostomates have been declining and it is quite obvious that they can successfully manage their own stoma, which can minimize adverse outcomes. Adjustment seems to be better for patients with ostomies that are more frequently performed by a team with end-to-end bowel anastomosis for the seniors. In the qualitative research by Stoltz et al., (2006) care giving illuminated on the meaning of support as narrated by family caregivers.

Summary

There have been significant advances in stoma appliance technology that makes peristomal skin breakdown and incontinence a thing of the past. Being close to facilities provides an enormous relief to patients and allows for support for the caregiver. The network of home health nurses provide a great asset to the caregiver’s reassurance and support. The idea of home care has had to be made for care for their relative at home until the end (Stoltz et al., 2006). Mortality rates of ostomates have been declining and it is quite obvious that they can successfully manage their own stoma, which can minimize adverse outcomes. Adjustment seems to be better for patients with ostomies that are more frequently performed by a team with end-to-end bowel anastomosis for the seniors. In the qualitative research by Stoltz et al., (2006) care giving illuminated on the meaning of support as narrated by family caregivers.

Food that helps thicken the effluent and reduce the risk of dehydration include; applesauce, pretzels, bananas, yogurt, creamy peanut butter, white rice, and white bread.后台饮食管理可以减少患者的流出和溶解食物，如扁豆、坚果、水果和蔬菜被已知为触发问题。在照护病人时，这些类型的食物会被禁止，所以患者需了解此。这是否是至关重要和这些食物的健康收益（Dorman, 2009）。

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Research concerns by Simmons (2007) that suggest patients with a religious or spiritual belief can lead to more functional family life (Wong & White, 2002). The focus is on the patient’s social and leisure activities. None of these factors are able to impact an ostomate to maintain their social life and have told friends, workmates, neighbors, and others that they are able to feel normal again. According to a review of studies published in 1969 and 1992 the major impact involving a stoma placement is the psychological and social adjustment of the patient. The onset of numerous and debilitating health issues (Clark & Griffin, 2008).

According to Simmons et al., (2007), talking with patients about the implications of the medical experience can have a significant impact on the individual’s psychological adjustment and self-image. There have been significant advances in stoma appliance technology that makes peristomal skin breakdown and incontinence a thing of the past. Being close to facilities provides an enormous relief to patients and allows for support for the caregiver. The network of home health nurses provide a great asset to the caregiver’s reassurance and support. The idea of home care has had to be made for care for their relative at home until the end (Stoltz et al., 2006). Mortality rates of ostomates have been declining and it is quite obvious that they can successfully manage their own stoma, which can minimize adverse outcomes. Adjustment seems to be better for patients with ostomies that are more frequently performed by a team with end-to-end bowel anastomosis for the seniors. In the qualitative research by Stoltz et al., (2006) care giving illuminated on the meaning of support as narrated by family caregivers.

As more families are caring for their loved ones at home, there is a developing concern for the caregivers. The lived experience and sense of togetherness translates into support for the caregiver. The network of home health nurses provide a great asset to the caregiver’s reassurance and support. The idea of home care has had to be made for care for their relative at home until the end (Stoltz et al., 2006). Mortality rates of ostomates have been declining and it is quite obvious that they can successfully manage their own stoma, which can minimize adverse outcomes. Adjustment seems to be better for patients with ostomies that are more frequently performed by a team with end-to-end bowel anastomosis for the seniors. In the qualitative research by Stoltz et al., (2006) care giving illuminated on the meaning of support as narrated by family caregivers.

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to further inform nursing research, define research questions, and identify targets of interventions affecting nursing practice today. Research suggests the family with its strong supportive relationships and meaningful ties can help an individual member cope with the stress of life (Wong & White, 2002).

From current research, the ostomy patient’s perspective on quality of care is considered inadequate because the healthcare system gives little time or opportunity for consultation and does not address psychosocial and emotional issues related to colostomy and ileostomy concerns (Perssson & Hesselström, 2005). Today, there is a shift to address psychological education curricula into the academics to better prepare nurses to gain appropriate skills for helping stoma patients (Simmons et al., 2007).

Nursing has traditionally used a holistic approach to health care, blending curative and restorative treatment with disease prevention and health promotion (Nichols et al., 2005). Research has made it possible to produce beneficial findings and implement quality of care improvements that will better serve our nurses and patients in the future.

Support Groups

Nurses may refer ostomy patients to support groups within local hospitals and to the online United Ostomy Association of America at www.uoaa.org; the site has active discussion boards for various types of ostomy patients. The United Ostomy Association of America Inc. (UOA) at www.uoaa.org provides an e-mail discussion list for medical professionals. The National Association for Continence at www.nafc.org offers information about ostomy, such as avoiding embarrassing situations with an ostomy. Along with the physical care of the ostomy patient, it is critical to address the psychological and emotional care.

Our goal was to provide my father with the best quality of life possible. He felt confident to travel with the pouching system and by avoiding gas causing foods, he felt comfortable and unencumbered. He was able to enjoy the Ohio State Fair and the Columbus Museum of Art for the first time in 10 years. It was important to keep him connected with others by scheduling social outings. He loved to be in nature at the city parks and visit his favorite Italian restaurants. These social connections allowed my father to have a meaningful life with a sense of normalcy rather than being isolated. He enjoyed the last two years of his life with us because we encouraged confidence living with an ostomy. He certainly enjoyed talking with everyone and he was especially proud to have represented the United States Army in World War II.

Learning the intricacies of my father’s ostomy care was enlightening and will make us feel more comfortable caring for ostomy patients in the future.

There were many complications that we worked through one-at-a-time, day-by-day. My father had the finest specialist in Central Ohio that contributed to the quality of his life. Eventually, we learned that the best time to change the ostomy appliance was in the early morning hours while the peristalsis activity was minimal. This timing consideration increased the efficiency of the procedure.

To reduce the risk of dehydration that ostomy patients often experience, the nephrologist suggested drinking Gatorade and eating salty foods, like pretzels, to maintain the sodium levels. Appetizers is another helpful food to thicken the consistency of output and reduce the risk of dehydration. The primary care physician provided thoughtful solutions by prescribing sodium bicarbonate that would provide an added benefit in sodium level maintenance.

Ostomy patients experience symptoms similar to those with short bowel syndrome. In order to slow the peristalsis, his physician also prescribed Diphen/droperidol (Lormitil and Imodium giving the small intestine a longer period of time to absorb nutrients. Lying down after eating also reduced the peristalsis issues. We discovered that appetizers created a firm consistency reversing the liquid consistency. We took it upon ourselves to eliminate all artificial sweeteners and any foods containing artificial sweeteners from his diet because he experienced negative results with excessive effluent causing dehydration. This change significantly reduced the output volume and allowed him to return fluids and maintain electrolyte balance more efficiently.

When informing this dietary change to the primary care physician, he responded with a question to us “what is more important... dehydration or slightly increased glucose levels?” Of course, the answer to that question is dehydration, which is much more severe for someone with an ostomy. Along with the physical care of the ostomy patient, it is critical to address the psychological and emotional care.

On a Personal Note:

My father was diagnosed with colon cancer at 82 years of age, requiring three major surgeries over the next five years that eventually resulted in an ileostomy. These surgeries were devastating and life-altering, leaving independence and self-care unattainable for him. My mother dedicated her life caring for dad. After she passed away, my husband and I decided to care for my father in our own home. As registered nurses, this experience was the greatest gift and the most rewarding experience for both of us. My father thanked us daily for the care we provided and his approach was more than we expected. The biggest gift in life comes from caring.

September 2012
Introduction to the Physical, Psychological, Emotional and Spiritual Care for Ostomy Patients—Improving the Quality of Life

Post Test and Evaluation

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name: _____________________________________________
Date: ______________________ Final Score: ___________

Please circle one answer.

1. All the following are common reasons for ostomy surgery EXCEPT:
   A. Colorectal cancer
   B. Crohn's disease
   C. Bladder cancer
   D. Polyps

2. What is the most profound common negative aspect of having a stoma?
   A. Odor
   B. Body Image
   C. Leakage
   D. Noise

3. The American Cancer Society has reported colon cancer as the third most common cancer in both men and women in the United States.
   A. True
   B. False

4. The most beneficial time for ostomy education should begin:
   A. Before surgery
   B. After discharge
   C. Before surgery and after discharge until the patient can perform ostomy skills successfully
   D. With the home healthcare nurse

5. The post-discharge follow-up is frequently provided by:
   A. Non-specialized home care nurse
   B. Physician
   C. Psychologist
   D. Wound Ostomy Nurse

6. What foods are best to help prevent ostomy incurred odor?
   A. Parsley and Yogurt
   B. Onions and Broccoli
   C. Cauliflower and Carrots
   D. Asparagus and Nuts

7. Which of the following dietary foods is NOT a restriction due to intestinal obstruction?
   A. Popcorn
   B. Nuts
   C. Corn
   D. Creamy peanut butter

8. How much caffeine-free fluid intake is recommended daily for an ileostomate?
   A. 4 to 5 cups
   B. 6 to 8 cups
   C. 10 to 12 cups
   D. 15 to 15 cups

9. According to the United Ostomy Associations of America, what are two major concerns of the ostomy patient?
   A. Traveling and working
   B. Living alone and cooking
   C. Controlling odor and leakage
   D. Swimming and bathing

10. Who provides the greatest support for ostomates?
    A. Physician
    B. Nurse
    C. Family
    D. Ostomy Specialist

11. Research suggests males more than females are receptive to the health promotion of communication to manage their ostomy.
    A. True
    B. False

12. Approximately how often should an ileostomy pouch be emptied?
    A. 1 to 2 times daily
    B. 3 to 4 times daily
    C. 4 to 5 times daily
    D. 6 to 8 times daily

13. How often should an appliance be changed to prevent skin irritation and breakdown?
    A. Every 2 days
    B. Every 4 days
    C. Every 5 days
    D. Every 6 days

14. What function does a skin barrier treatment serve?
    A. Protect skin from getting sore and irritated
    B. Helps to heal skin that is already damaged
    C. Provides a protective layer between the skin and urine, stool, or drainage
    D. All the above

15. All the following can reduce stress for the ostomate EXCEPT:
    A. Packing extra ostomy supplies
    B. Wearing a support barrier when traveling
    C. Avoiding odor-producing foods and carbonated drinks
    D. Restricting fluids

16. From the list of websites, which listing has information for security undergarments?
    A. www.uoa.org
    B. www.options-ostomy.com
    C. www.rally4youth.org
    D. www.ostomyworld.com

17. For ostomates, the prediction is that overall life satisfaction and quality of life increases for those with:
    A. Permanent ostomy
    B. Temporary ostomy
    C. Part-time job
    D. Full-time job

18. All the following are odor producing foods EXCEPT:
    A. Eggs
    B. Fish
    C. Parsley
    D. Applesauce

19. Which of the following can help reduce bacterial growth with urostomates?
    A. Yogurt
    B. Cranberry juice
    C. Parsley
    D. Asparagus

20. What measurement warrants the need for emptying an ostomy pouch to reduce the risk of loosening the adhesive seal?
    A. One-third to one-half full
    B. Three-fourths full
    C. Half full
    D. Full

Evaluation

1. Were you able to achieve the following objective? __Yes __No
   a. Describe the needs of ostomy patients. __Yes __No

2. Was this independent study an effective method of learning? __Yes __No
   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?
   __________________

4. What other topics would you like to see addressed in an independent study?

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Using Preferred Practices to Palliative Care at End of Life

Preferred Practice 26: Recognize and document the transition to the active dying phase and communicate to the patient, family, and staff the expectation of imminence of death.

Preferred Practice 27: Educate the family on a time-based basis regarding signs and symptoms of imminent death in an age-appropriate, developmentally appropriate, and culturally appropriate manner.

Preferred Practice 28: As part of the ongoing care planning process, discuss with the patient and family wishes about the care setting for site of death and fulfill patient and family preferences when possible.

Preferred Practice 29: Provide adequate dosage of analgesics and sedatives to achieve patient comfort during the active dying phase and address concerns and fears about using narcotics and sedatives during the dying process.

Preferred Practice 30: Treat the body after death with respect according to the cultural and religious practices of the family and in accordance with local law.

Preferred Practice 31: Facilitate effective grieving by implementing in a timely manner a bereavement care plan after the patient’s death, when the family remains in the focus of care.

Mary’s family is an example of a patient and family whose loved one is dying. A patient with the diagnosis of COPD was deliberately selected for this article to cast light on an atypical example of the terminally ill patient. Typically, when talking about patients approaching death, we think of patients with diagnoses such as cancer, AIDS, but often overlook the unpredictable but no less fatal organ system diseases such as congestive heart failure or COPD. COPD is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms ‘chronic bronchitis’ and ‘emphysema’ are less often used, but are now included within the COPD diagnosis. COPD is not simply a “smoker’s cough” but an underlying disease that hastens death. At end of life, there are also unique challenges presented by COPD, including how to manage shortness of breath as well as the feelings of loss of control.

According to the guidelines developed by the American Thoracic Society and the European Respiratory Society:

- Chronic obstructive pulmonary disease (COPD) is a leading cause of morbidity and mortality worldwide and results in an economic and social burden that is both substantial and increasing.
- Prevalence and morbidity data greatly underestimate the total burden of COPD because the disease is usually not diagnosed until it is clinically apparent and moderate to severe obstruction is present. COPD is the fourth leading cause of death in the USA and Europe, and COPD mortality in females has more than doubled over the last 20 years.
- COPD is a more costly disease than asthma and depending on country, 50-75% of the costs are for services associated with exacerbations.
- Tobacco smoke is by far the most important risk factor for COPD worldwide.
- Other important risk factors are occupational exposures, socioeconomic status and genetic predisposition.


Physical/Medical aspects of care

As Mary begins to exhibit symptoms that are common at end of life such as increased secretions, restlessness, anxiety and the patient’s feelings of loss of control.

Examples: Dementia, etc.

Much education about the rationale for using opioids needs to occur for Mary’s family. There is often fear associated with the use of opioids. Mary’s son stated “are you trying to kill her?” It is the team’s responsibility to participate in caring for Mary and empower them to feel involved in Mary’s care. At the same time, utilizing medications such as an opioid, most commonly morphine sulfate, for her shortness of breath can provide added comfort. Preferred practice #29 reminds us that adequate doses of appropriate medications should be utilized in achieving comfort for the patient. Because adequate dosage can vary from patient to patient, utilizing the palliative care team for medication titration orders will assist in achieving comfort for Mary during the active dying phase. When withdrawal of life-sustaining treatment is planned, team members should review and adhere to organizational guidelines and if available, order sets. Whenev/ever a ventilator is weaned and discontinued from a conscious patient who is ventilator-dependent, opioid medication will be required for comfort. Concise and easy-to-understand education for Mary’s family will assist in addressing their concerns and fears about using narcotics, and of the misperception that the use of opioids hastens death. In fact, in this setting, opioids, properly titrated, do not shorten survival, but rather improve comfort and may actually prolong survival by reducing stress and discomfort.

Field & Cassel, 1997

Example: COPD, congestive heart failure, etc.

Field & Cassel, 1997

Example: End-stage cancers, etc.
reduce her family's distress and provide reassurance that utilization of opioids will assist in optimizing comfort and quality of life for Mary.

It is also important to emphasize that, when a life-prolonging treatment is discontinued in a terminally ill patient, the ultimate cause of death is the underlying disease, not the discontinuation of the life-prolonging treatment.

It is also imperative that a conversation regarding the location of death occurs with Mary if she is able to participate in the conversation and with her family as well. This is a conversation that should occur early in the disease trajectory. Most patients want to die in their home environment and we are reminded in preferred practice #28 that all attempts should be made to fulfill the patient and family's desires. All patients who are discharged to home or an extended care facility who are expected to die within six months or less should be offered a hospice referral. If the patient wants to die at home but is unlikely to survive long without life-sustaining treatment (for example, ventilator support), some hospices will care for these patients, so they can be transferred home before death. As the physician and nurses begin to see changes in Mary's physical condition such as mottling, periods of increased sleep, decreased oral intake and urine output, they need to educate the family that death is approaching. The goal should be to honor the wishes of Mary and her family to the extent possible. If it is unrealistic to move Mary because of imminent death, a simple and honest explanation should be provided.

Conflict is often the most common request that family members make as death is approaching. It is necessary to define what comfort means to each individual. For some it may mean relief of symptoms with medication, while to others it may mean something quite different. It is important to ask for clarification of goals and evaluate and support Mary and her family's desires for comfort. It is the nurse's responsibility to assist in providing all options for comfort as well as educational families about the benefits and burdens of each option. Preferred practice #29 encourages this assessment, followed by providing the benefits and burdens of each option. Preferred practice #30 reminds us that we should routinely screen for these symptoms and treat when appropriate.

As a Registered Nurse, you understand the importance of education. Your skills and knowledge are put to use on every shift. You also understand earning your Bachelor of Science in Nursing or Master's degree will make you an even better nurse.

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IWU Online
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- Certificate in Parish Nursing

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September 2012

Palliative Care continued from page 10

end-of-life-care discussions. However, many are not comfortable or skilled in this area, in which case involving a chaplain is often most helpful. It is important to keep in mind that some patients and families believe rituals at the time of death are just as important as beliefs concerning an afterlife, and these beliefs are particularly important to elicit for the patient who is quickly approaching death. Often simple encouraging a life review or asking the patient or family what stands out in their lives as being most significant can begin the conversation and help ease tensions.

In summation, in order to ensure the best quality of life for Mary and her loved ones, they need to have physical, interpersonal, psychological, and spiritual concerns addressed. It is critical to note that the nurse alone is not responsible for providing for all of Mary’s needs. End of life care demands an interdisciplinary approach, which can include a formal Palliative Care Consult Team or an informal group of clinicians coming together to meet Mary’s goals for the final phase of her life. With this team approach, the goals of care are defined by the patient and family, and there is a fluid exchange of team members’ professional strengths, knowledge and competencies that come together to best achieve those goals.

Grief & Bereavement

Preferred practice #31 indicates that post death bereavement requires a plan to support the survivors through the phase of grieving. The location of death and the type of care provided may influence the bereavement care plan that is initiated. A palliative care program in the hospital may not have the structure to provide bereavement care to the family. Caregiver responses can vary by institution as they can vary for deaths that occur in any acute care or long term care setting. If it is the case, then a suggestion would be that the palliative care team or healthcare provider should provide information to the survivors on available hospice or community bereavement resources in the area. Patients who die while under the care of hospice will receive bereavement follow-up for thirteen months after the death, and many hospices provide bereavement services to families of persons who did not inhospital care involvement. Bereavement care should be provided to the family following the patient’s death, slowly tapering as the family adjusts to life without the patient.

Regardless of the structure of the bereavement support, it is important for health care providers to keep in mind that the nature of the death, even of the type of disease the person dies from will often affect the grief process for the survivors. For example, when Mary’s Survivor's Guide to Coping with a Palliative Care Program. For example, for Mary’s survival is the significance of the disease was gradual, lasted for nearly a decade and had periods of exacerbation and dyspnea the family’s grief process. Her survivors may experience questions of doubt as to whether they should have fought harder and kept Mary on the ventilator longer. There may be regrets or anger as to Mary’s life style choices that ultimately contributed to her death with COPD. While these factors may have an impact on the grieving process, it is also important not to make assumptions about how certain aspects of a person’s illness or death will affect bereavement; instead one should explore the relatives’ concerns and assure access to appropriate resources for all family members.

Closing

The care of the imminently dying patient can be among the most challenging and rewarding care that a nurse can provide. The National Priority Partnerships equips providers with a clear framework to help guide professionals who encounter dying patients, but the preferred practices are only a starting place. There are many other resources available to nurses, one of the best of which is the End of Life/Palliative Care Fast Facts series. These resources are a series of over 200 short information sheets that detail different scenarios that professionals may encounter in providing palliative care, from how to recognize grief and depression to dealing with a hospice patient admitted through the emergency room. Each Fast Fact provides a brief summary of key points to keep in mind, and they are all available free online: http://www.eperc.mcw.edu/EPERC/FastFactsAndConcepts.

Furthermore, it is important that any professional working with patients nearing death closely examine his/her own preconceptions, beliefs and cultural values regarding suffering and death. It is best to undertake this work prior to being confronted with a clinical situation that evokes an emotional reaction and may impede the nurse’s ability to provide the best quality of care. Resources to assist with this exploration include one’s own religious community, colleagues who work in hospice or palliative care, or formal courses and seminars addressing such topics.

Dying is an intensely personal experience, for both the families involved and the professional caregivers who have the opportunity to shepherd these families during this difficult time. While a professional caregiver may encounter many dying patients over the course of a career, each patient only dies once. Many families remember the final moments of loved ones in vivid detail, and what

Palliative Care Post Test and Evaluation continued on page 12
Using Preferred Practices to Improve Palliative Care at End of Life

Post Test and Evaluation

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name: _____________________________________________
Date: ______________________ Final Score: ___________

Please circle one answer.

1. Domain 7 refers to:
   A. The preferred practices for the care of patients with COPD
   B. The End of Life/Palliative Education Resource Center's work on improving care of the dying
   C. The portion of the National Consensus Project which addresses care of the imminently dying patient
   D. None of the above.

2. An example of a disease trajectory which patients experience steady decline and a short terminal stage is:
   A. End-stage cancers
   B. Dementia
   C. COPD
   D. Congestive heart failure

3. The disease trajectory for COPD is characterized by:
   A. Steady decline over time & short terminal phase
   B. Slow decline & periodic crises
   C. Sudden death
   D. Lingering & expected death

4. Ideally, a conversation about end of life care preferences should first occur:
   A. At diagnosis
   B. On admission
   C. When a patient's status declines
   D. When the patient is referred to hospice

5. What is families' most common request when death is approaching?
   A. Emotional support
   B. Respite
   C. Assistance with financial planning
   D. Comfort

6. The most common psychosocial symptom for patients with COPD:
   A. Hysteria
   B. Depression
   C. Guilt
   D. Anxiety

7. A ___ is a written document that specifies a patient's individual preferences for medical treatment based on one's own values and goals that takes effect when the patient is terminally ill and unable to make decisions or is permanently unconscious. A ____ allows a patient to choose a surrogate decision maker to ensure that these preferences are carried out should Mary be unable to speak for herself.
   A. Living Will, Healthcare Power of Attorney
   B. DNR, Healthcare Power of Attorney
   C. Healthcare Power of Attorney, Living Will
   D. DNR, Durable Power of Attorney

8. Preferred Practice 29 recommends that caregivers provide adequate dosage of analgesics and sedatives as appropriate to achieve patient comfort during the active dying phase and ___.
   A. Monitor the patient for adverse drug reactions.
   B. Address concerns and fears about using narcotics and of analgesics hastening death.
   C. Titrate the dosage according to the patient's desired level of comfort.
   D. Prepare the family by discussing signs of approaching death.

9. The term Fast Facts refers to:
   A. The preferred practices outlined in the National Consensus Project.
   C. Statistics regarding death and dying in America.
   D. A series of worksheets covering various topics relative to palliative care.

10. Ideally, palliative care should be involved from:
    A. Diagnosis.
    B. Admission.
    C. Significant decline.
    D. When death is imminent.

11. One non-pharmacological intervention that can help relieve patients' feelings of shortness of breath is:
    A. A fan in the room.
    B. Yoga.
    C. Talk therapy.
    D. Distraction.

12. If caregiver burden is great, providers may first consider:
    A. Nursing facility placement
    B. Psychiatric referral
    C. Respite care
    D. Contacting Adult Protective Services

13. A survivor's bereavement process may be affected by:
    A. His/her own preconceptions, beliefs and cultural values regarding suffering and death.
    B. All of the available Fast Facts applicable to a patient's case.
    C. Religious rituals and cultural customs.
    D. All of the above

14. Prior to providing care for a dying patient, a nurse should examine:
    A. Nursing facility placement
    B. Psychiatric referral
    C. Respite care
    D. Contacting Adult Protective Services

15. Discussions of spirituality
    A. Are often difficult for providers to initiate.
    B. Should not be confined to a specific religion or church.
    C. May include a discussion of life purpose or meaning.
    D. All of the above

16. Many hospices provide bereavement services to families whose loved ones did not die in hospice care.
    A. True
    B. False

17. End of life care demands a ___ approach to service delivery.
    A. Medical
    B. Interdisciplinary
    C. Holistic
    D. Psychosocial

18. One way to initiate a spiritual discussion is to:
    A. Ask the patient what their religion is.
    B. Encourage life review.
    C. Ask the family at what church they plan to hold the patient's funeral.
    D. Ask the patient if s/he’d like a chaplain to visit.

19. It is courteous to ask a patient's family if they would like to partake in the bathing and preparation of a patient's body.
    A. True
    B. False

20. The interdisciplinary team may include:
    A. A specialty physician
    B. The hospital chaplain
    C. The social worker
    D. All of the above

Evaluation

1. Were you able to achieve the following objective? __ Yes __No
   a. Discuss preferred palliative care practices and adjuncts to care for the chronically ill patient and his/her family during their illness and end-of-life.

2. Was this independent study an effective method of learning? __ Yes __No
   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?

4. What other topics would you like to see addressed in an independent study?
Pathways to EHR through Nursing

Mary Zile, a nurse in Cincinnati, has transitioned from clinical nursing to becoming the Director of Clinical Consulting for the Tri-State Regional Extension Center. Tri-State is a REC that covers 67 counties in Kentucky and Indiana, and she works with the HIM HealthBridge. Mary’s nursing career began at Wright State University when she earned her bachelor’s degree in nursing; then later, she earned her master’s degree in healthcare services administration. Mary first worked in the cardiac and surgical ICU areas but moved into the ambulatory area as a nurse manager. During this time, Mary learned about electronic health records. In 2000, she helped the practice purchase a new EHR system at a time when little guidance was available on this topic.

Mary then combined what she had learned from the selected nursing degree with her interest in improving patient health for her master’s degree program. She worked on structuring an EHR study to show how the use of an EHR can have an impact on healthcare quality in ambulatory settings.

As part of Mary’s work, she constructed a project with diabetes measuring patients’ HbA1c before and after EHR implementation and then she became a leader in the Robert Wood Johnson Foundation and Cincinnati Health Collaborative Primary Care Initiative that will achieve a Level 3 NOQA Patient Centered Medical Home (PCMH) status. Like many people, I met in the HIT workplace, Mary had no formal training in HIT, but was successful. Through her hard work and self-training, Mary developed the skills to work with the technical team and the practices that were trying to adopt their products.

“The reason I wanted to implement an EHR so early is that I was inspired by the importance of the healthcare system, I realized that there were imminent problems in healthcare,” Mary said. “I wanted to be an example of how to ‘fix’ the primary care system. I wanted to be a part of the solution, to become a registered nurse in 2010. Kelly Cornett took a different path to develop her skills as a Clinical EHR Specialist for Knox Community Hospital. Working for many years from home managing not-for-profit organizations and helping with their online services and support areas. Already comfortable with computers, she understood how they could be used to support other aspects of health care. When she heard about the Workforce Development Program that combined clinical training with IT training to support EHR implementation, she felt that this would be a good fit, given her background.

Kelly enrolled in the Columbus State Community College (CSCC) site for its six-month program in healthcare information technology. She is now working at Knox Community Hospital on the EHR implementation team, customizing and transitioning primary care and specialty practices onto electronic health records and coordinating Meaningful Use adoption.

“First out started as a float RN in physicians’ practices,” Kelly said. “Being interested in computers, I also applied and was accepted into the Health IT grant program at CSCC. To enhance my training, I offered to float to the EHR team when they went live. It did not take long for the position to become permanent. Although I do not get to serve patients, I enjoy supporting the providers, nurses and clerical staff throughout their EHR experience.”

Workforce Development Program for Healthcare IT

CSCC’s program is part of the broader Midwest Community College Health IT Consortium. Included in this program are community colleges that have developed programs to train individuals about the workflow changes that must accompany the adoption of an EHR system. The team meets every six months. It did not take long for the Health IT Cuyahoga Community College in Cleveland; Columbus State Community College in Columbus; Sinclair Community College in Dayton, and Cincinnati State Technical and Community College in Cincinnati. The programs these schools offer combine training from the HIT perspective with IT so that graduates are able to better fill roles that bridge both areas. It is a requirement of the HIT Workforce Program that participants have a healthcare background, an IT background, or both. In Ohio, 43 percent of the program’s participants are from the healthcare sector, 41 percent are from IT (non-healthcare related) and only 12 percent have both. There are 730 successful graduates and 437 actively enrolled in the two programs. This success rate is a testament to the programs’ effectiveness at teaching healthcare IT. As of July 2012, more than 525 Ohio nurses and community members have built in security measures. In 2014, CMS will require new standards for interoperability of medical records called Stage 2 MU regulations. Under the new Stage 2 rules, there will be a greater emphasis on the ability to exchange medical records with other healthcare providers and health information locations. There will also be numerous new initiatives to educate and outreach to the patient population, including requirements for use of patient portals. In 2016 or 2017, the final phase of MU will occur with the adoption of the last set of MU standards—Stage 3. Not yet written, these Stage 3 standards will involve improvement of population health, including many areas of data analytics.

These areas of HIT development will include corresponding job growth. Clinical individuals will be needed to oversee patient education programs and extensive health and wellness initiatives, to work with IT individuals to assure that privacy and security concerns are addressed, to oversee necessary changes to workflows that will allow the capturing of data electronically, and to develop and monitor the data that arises from clinical and quality reporting initiatives. Definitely, there will be even increasing opportunities for nurses to use their clinical skills but combine them in a broader role in the HIT marketplace.
OBJECTIVE

1. Differentiate mild, moderate and severe traumatic brain injury.
2. Identify how traumatic brain injury affects children and the elderly.
3. List at least three sequelae to traumatic brain injury.
4. Identify nursing interventions and resources utilized to manage sequelae.

Traumatic Brain Injury: Types, Causes, Damages and Incidences

A Traumatic Brain Injury (TBI) can change someone’s life in an instant. In the snap of a finger, a person can go from being perfectly normal to becoming someone who is now incapable of caring for him or herself. In this educational activity we will explore the types of TBI’s and differentiate TBI versus post traumatic stress disorder. The ravages of TBI especially affect children and the elderly. We will highlight those effects. There has been a long-standing myth that children are more resilient to the effects of TBI. We will be busting that myth. The terms “post concussion” and “concussion” have not been used in this module, as these terms are not well defined and are controversial. “Concussion” often refers to a loss of consciousness; however an individual may experience a TBI without loss of consciousness. The bulk of this educational activity will focus on the life altering sequelae. Notice the use of the word “management” in that last sentence. In so many instances the sequelae become permanent, and are therefore not “cured”, but can be managed through a variety of methods. This module will not focus on the acute phase of caring for someone with a TBI. That discussion generally pertains to the critical care arena and deserves separate treatment. Last but not least, this educational activity will address the issues of community and technological assistance for the survivor of TBI and resources for the caregiver.

Incidence of TBI in the United States: In 2000, the Centers for Disease Control (CDC) were charged with the responsibility to determine the incidence and prevalence of TBI in all age groups. This was part of the Children’s Health Act of 2000 (Public Law 106-341) in an effort to address the long-term outcomes of TBI. Currently data is available for 1995 through 2004. Each year at least 1.4 million people sustain a TBI. Of these, approximately 50,000 die of the initial injury sustained; 255,000 are hospitalized; and 1.1 million are treated and released from an Emergency Department. Of the 1.4 million TBIs, 475,000 happen to children between the ages of 0 to 14 years of age. Ninety percent of the Emergency Department visits made by children are due to TBI’s. The table below illustrates the incidence of TBI by age, Emergency Department Visits, Hospitalizations and Deaths. Imagine the costs of all these Emergency Department visits and hospitalizations, let alone the emotional and monetary costs of any death as a result of TBI.

<table>
<thead>
<tr>
<th>Age</th>
<th>Emergency Dept Visits</th>
<th>Hospitalizations</th>
<th>Deaths **</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>260,000</td>
<td>15,000</td>
<td>1,099</td>
</tr>
<tr>
<td>5-9</td>
<td>122,000</td>
<td>11,000</td>
<td>628</td>
</tr>
<tr>
<td>10-14</td>
<td>113,000</td>
<td>11,000</td>
<td>957</td>
</tr>
<tr>
<td>15-19</td>
<td>129,000</td>
<td>25,000</td>
<td>4,756</td>
</tr>
<tr>
<td>20-24</td>
<td>79,000</td>
<td>18,000</td>
<td>5,092</td>
</tr>
<tr>
<td>25-34</td>
<td>146,000</td>
<td>30,000</td>
<td>7,728</td>
</tr>
<tr>
<td>35-44</td>
<td>129,000</td>
<td>29,000</td>
<td>7,619</td>
</tr>
<tr>
<td>45-54</td>
<td>75,000</td>
<td>20,000</td>
<td>5,776</td>
</tr>
<tr>
<td>55-64</td>
<td>35,000</td>
<td>14,000</td>
<td>3,927</td>
</tr>
<tr>
<td>65-74</td>
<td>29,000</td>
<td>16,000</td>
<td>4,188</td>
</tr>
<tr>
<td>75 +</td>
<td>54,000</td>
<td>44,000</td>
<td>8,895</td>
</tr>
<tr>
<td>Total</td>
<td>1,111,000</td>
<td>255,000</td>
<td>49,900</td>
</tr>
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</table>

Of the 49,900 total annual deaths due to TBI, one can see more males die of these injuries than females. This is because more males sustain TBI than females. There tends to be a propensity for boys and men to engage in riskier activities, thus the greater incidence of TBI.

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For the remainder of this independent study, please refer to CE4Nurses.org and click on Ohio Nurse Independent Studies.

Developed by: Barbara Walton, MS, RN

This independent study has been developed to provide nurses with an overview and introduction to traumatic brain injuries and the sequelae. The author and planning committee members have declared no conflict of interest. There is no commercial support for this independent study.

Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

2.5 contact hours will be awarded for successful completion of this independent study. The Ohio Nurses Association (OBN-001-50) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

On June 28, 2012, the U.S. Supreme Court declared in a 5-4 vote that the ACA is Constitutional. The most controversial provision—the individual mandate—was upheld when the majority of justices recognized the provision was permissible under the taxation powers of Congress. While many ACA supporters argued the Constitutionality on the basis of the Commerce Clause, that argument did not garner a majority of the justices’ support.

In his majority opinion, Chief Justice John Roberts wrote, “Congress' use of the Taxation clause to encourage buying something is... not new. Tax incentives already promote for example, purchasing homes and professional educations.”

The Court’s ruling addressed more than the mandate, however. The ACA extended Medicaid eligibility to an additional 16 million Americans through 2019. The states that opposed the ACA contended that their Medicaid programs had no choice but to participate in the expansion or forfeit their federal Medicaid funding.

“At issue were the partnership roles of federal and state governments. Medicaid exemplifies that partnership because it is administered by states but funded with both state and federal dollars. States argued the potential loss of funds was coercion to expand Medicaid, which they stated they would be hard-pressed to fund.” (Lowe 2012).

All of the justices except Sonia Sotomayor and Ruth Ginsburg agreed with the state officials that the threatened loss of existing federal Medicaid funds constituted unconstitutional coercion. However, Chief Justice Roberts joined Justices Sotomayor, Ginsburg, Elena Kagan, and John Breyer in ruling the flaw could be corrected by forbidding the federal government from withdrawing its federal contribution if a state opts out of the Medicaid expansion.

(Citation-Lowe, R. Supreme Court Upholds Affordable Care Act, Medscape Medical News. 2012 WebMD, LLC retrieved June 28 from www.medscape.com).
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