The North Dakota Nurse

NDNA
NORTH DAKOTA NURSES ASSOCIATION

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THE OFFICIAL PUBLICATION OF THE NORTH DAKOTA NURSES ASSOCIATION
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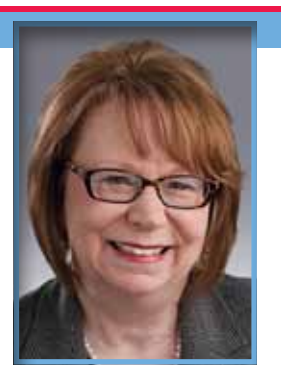
President's Message

Greetings Colleagues



Roberta Young

Roberta Young MSN, RN

I am so excited about this year's important theme for **Nurses Week- Culture of Safety: It starts with you**. This theme builds on 2015's Year of Ethics; the outcome of ethical practice should be a culture that breaths and lives safety.

ANA defines a culture of safety as "core values and behaviors resulting from a collective and sustained commitment by organizational leadership, managers, and health care workers to emphasize safety over competing goals." (http://www.nursingworld.org) The important call to action in that definition is choosing safety over competing goals. Think back to a recent day in your practice setting and the potential competing goals that could have been a barrier to safety. How did you navigate that? Did you speak up when a peer didn't do complete hand hygiene? Did you ask for help in repositioning a patient or decide to do it on your own? Did you take the time to listen with intention to how a patient was telling you how they are *really* taking their medications?

Culture is a difficult beast to tackle. It is not black and white; so you can't wrap it up in a nice policy and tie a bow around it. But at the same time can be hard as a rock to move. If you want to improve or change the culture of safety where you practice, start by identifying what supports decision making and actions of safety and what rivals that aim. Transparency, being willing to talk about what has not gone well and a robust reporting system of near misses and safety issues, is sometimes at odds with trying to avoid being embarrassed, or fear of retribution. Chassin and Loeb, speak about a key trait of a highly reliable organization is preoccupation with failure. They go on to discuss that highly reliable organizations resist the temptation to over simplify causative factors, but are willing to dig deep. They resist the easy path of blaming singular causative factors. Health care organizations with a robust culture of safety have attributes of trust, report and improve. There has to be the trust that as a nurse I will and can report safety issues without fear, meaning I trust my peers and supervisors to take me seriously and will act. In turn, as leaders are we promoting the trust to report by following through, communicating solutions and not trivializing concerns. Persistence and the continually to act to improve will feed the culture of safety. [M, Chassin, & J, Loab. The Milbank Quarterly Vol.91, No. 3, 2013, (pp459-490)]

Nurses are perfectly suited to observe, understand and identify safety issues. Our values and code of ethics demand that we observe, speak up, report and put ourselves in the middle of improving care practices including communication. We are compelled to be humble and open to learning from what went wrong, where we failed in our promise to the patients and families we are privileged to serve. Yep, hard work, but oh so worth it. If your practice culture allows for this work that means you are also in a trusting, caring, healthy environment.

I would say you are making Florence proud! Wishing you energy for keeping our commitment to a safe culture.

To learn more check out http://www.nursingworld.org search key words *culture of safety*.

NATIONAL NURSES WEEK 2016
American Nurses Association
Culture of safety
It starts with YOU

Our Life Chapters; When to Get Involved

Tessa VanDoorne, MSN, RN

Tessa VanDoorne

Greetings! Coming into 2016 as the VP for Membership I just want to share my story and reasons for getting involved in NDNA.

Most of our lives can be separated out into chapters. For many of us, there is a chapter where we decide it is the right time to get more involved in our profession as nurses. It comes at different times for all of us, and that is okay. Most importantly, if it is something that is important to you as a nurse, you will know when it's your chapter.

For as long as I can remember I have always been what I would consider myself "Suzie volunteer." As far back as kindergarten, the teachers would tell my parents I was always the first one to raise my hand or the student to volunteer to go first. Most of us in the nursing profession just know that it is our calling, and I did too.

Chapter one for me was when I was a CNA at a nursing home in Dickinson and entering college at DSU. I knew I wanted to be a nurse so this seemed to be the natural starting point for a high school job. I took a year of generals and worked hard as a CNA and needless to say this was not the chapter in my life to get involved.

The next chapter was nursing school. Personally, nursing school to me is like being pregnant. The time seems to go so slow and some days are such agony, but in the end when that baby or diploma arrives, you wouldn't have it any other way. Everything in the making was worth it. In undergrad, I got involved a little. I worked with our department of nursing nurse camp although I didn't get involved in NSAND, because this was my not my chapter either. To be honest it just wasn't something I thought about. I graduated with my AASPN in 2006 and my BSN in 2008. Shortly after graduating I took a leadership position at the ND state Women's prison and this is where I found my passion for leadership in nursing. I then had a son enter my life in 2010 and of course he kept me very busy and getting involved more into nursing just didn't fit in my schedule in this chapter.

The year 2012 is what I can consider was MY CHAPTER. I made a personal decision that no matter what I would go back to school and earn a Master's in Nursing before I turned 30. As a fulltime, single working mother I did it; I enrolled in grad school and I jumped in full force. Although one would think this was the worst time to get involved, this is when it was right for me. At the end of my program I needed to find a mentor to do hours with for my practicum. I reached out to an undergrad instructor and she directed me to the executive director of The Board of Nursing. I was terrified; most of us avoid the board of nursing at all cost. I remember thinking I can't just call this lady, she was a super star in my mind. But, I did it I called her and that was it from there. It was her that got me involved. I first got involved in The Center for Nursing on volunteer groups. I worked with them to log hours for my program. Once I was involved I was hooked and continued after I graduated in April of 2014 (at the age of 28 by the way). One of the projects we worked on was the 100th celebration of the Board of Nursing. I was then asked to be on the panel to represent past, present and future of nursing in ND. This of course all was amazing networking and I was able to meet a lot of people across the state in the nursing world. At this conference I met Carmen, our Director of State Affairs and that brings me to all of you. She encouraged me to look into NDNA and be a member, to be honest my first thought was "I have no idea what NDNA really does, but I think I should look into it." I got on the website and became a member. I was just a "dues paying member" for about a year. I utilized some CEU's and didn't get involved much. In July of 2014 I took a new job as Clinic Manager at Sanford Occupational Health where I am still working currently.

The last chapter is now. I received an email about board positions and just knew it was the right time for me. I contacted Carmen and got on the ballot for VP of Membership and was elected late 2015. One might think it's a good time because my son is almost 6, my job is steady but quite frankly I get bored fast. Today in February, my family and I have a week old baby girl, planning a wedding for October, and working full time; I still know this is my time and my chapter. Once I jumped in and made the commitment to my professional organization, I see the value; I see my value and I can't imagine no matter how crazy life gets having it any other way.

My message to all Registered Nurses in our state on ND, we need you! We need your voice, we need your expertise and we want to help fulfill your professional needs. If you have even a bit of curiosity, reach out and ask questions and get involved. We want everybody from young to old and from retired to PRN, to full time nurses. Just remember you don't need to be an executive in your field to join, you don't even have to know what NDNA is, just get involved.

http://www.ndna.org

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General Contact Information:
1-888-772-4179
info@ndna.org
Carmen Bryhn, MSN, RN
NDNA Director of State Affairs
director@ndna.org

Officers

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Writing for Publication in The North Dakota Nurse

The North Dakota Nurse accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and submitted electronically in MS Word to director@ndna.org. Please write ***North Dakota Nurse article*** in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. **Deadlines for submission of material for 2016 North Dakota Nurse are 3/17/16, 6/16/16, 9/15/16 and 12/15/16.**

Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don't know how or where to start, contact one of the NDNA Board Members.

The North Dakota Nurse is one communication vehicle for nurses in North Dakota.

Raise your voice.

The Vision and Mission of the North Dakota Nurses Association

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

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

Professor on the Prairie

Spring Cleaning

Trish Strom, BSN, M.Ed., RN, LPC, CNML
Assistant Professor of Practice -
NDSU School of Nursing

Trish Strom

"Spring won't let me stay in this house any longer! I must get out and breathe the air deeply again." – Gustav Mahler

When March finally arrives, my mind and heart start believing that winter is going to come to an end. My energy needs a boost, and my thinking needs some "spring cleaning."

I have been teaching an Interprofessional Education course this spring. I was completing the unit on Crucial Conversations. As usual, as I teach something, I am reminded to use the information, and continue my growth in the subject.

I am a Certified Crucial Conversation trainer, and admit that at times of low energy I forget to apply these critical skills. The skill I am going to use for "spring cleaning" is the ability to ask one's self about behavior when conversations start to fail (Patterson, Grenny, McMillan, Switzler, 2012). The bedrock of this skill is to approach this self-talk with a pure heart, and detective-like instincts. This is due to the fact that sometimes the person we are the least honest with is ourselves. So I will set the stage:

1. Thought: "I don't feel fulfilled in my job."
2. Insert the Crucial Conversation skill of Focusing On What I Really Want (Patterson, Grenny, McMillan, & Switzler, p. 114, 2012). It starts by asking a series of surprisingly hard questions:
   - What do I really want? For me. For others. For the relationship (whatever that may be).
   - What am I acting like I want?

To be honest, I sometimes hate the second question "what am I acting like I want?," as it ushers in the reality that I have responsibility associated with my behaviors and thoughts. Being a person who tries to live with integrity, I can see the work I have ahead of me!

On to the answers which will inform my plan to move toward a better outcome:

- What do I really want?
- For me: I want to feel like a valued member of my team(s).
  - ◇ For others: I want others to know I value their unique skills/talents.
  - ◇ For the relationship: That we understand the power of teamwork, and we take time to identify the things are teammates do to increase the power of our group.
- What am I acting like I want?
  - ◇ I am acting too busy to have one more thing put on my plate. I am withdrawing from group activities because I feel too exposed.

THE GAME CHANGING QUESTION!

- How would I act that would help me attain the goals I have identified?
  - ◇ I need to work on being more engaged.
  - ◇ Work at seeing the positive of situations – with sincerity.
  - ◇ Give detailed feedback to teammates – which goes beyond "good job." It is specific as to what your teammate did a good job at.
  - ◇ Ask for help. Ask for feedback, and be open to the feedback.
  - ◇ Create team goals through real conversation.

Sounds easy, right?

Now I am going to use a conversation that many nurses share with me. It starts like this . . . "Work is crazy." "There are so many negative people at work!" and "Nobody has time to do what they need to do!" If you recognize yourself in these statements, I challenge you to open your heart, and really look at what you want, and then ask yourself if you are acting in accordance with what you want. This process of focusing on what you really want is brave work – and the outcomes can lead to a whole new world.

Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2012). *Crucial conversations*. New York: McGraw-Hill.

Meet our New Director at Large: Recent Graduate!

Kayla Kaizer
BSN, RN

At the 2015 Annual Meeting in November, NDNA members voted to add a Director at Large: Recent Graduate to the NDNA Board of Directors.

Kayla Kaizer, BSN, RN, was appointed in January 2016 to Director at Large: Recent Graduate by the NDNA Board of Directors. Here is Kayla's bio!

"I served on my local Nursing Student Association Board at the University of Mary and the Nursing Student Association of North Dakota Board of Directors as a Graduate Consultant in 2015. Nursing is my passion and I love being involved in nursing at a higher level than just my job. I am very eager to serve on the NDNA board and get more people involved." We look forward to working with you Kayla!

NDNA Nominating Committee

The NDNA Nominating Committee for 2016 is Jami Falk, Karla Haug, and Sandy Boschee. These elected members will be looking for NDNA members who wish to serve on the NDNA board for 2017-2018. Board positions that will receive nominations are President, VP of Finance, VP of Practice, Education, Administration & Research and Director at Large: New Graduate. If you are interested in any positions or have questions about the positions email us at info@ndna.org. Make sure your email address is up to date with ANA/NDNA and watch for emails to follow this summer regarding nominations!

Meet your nominating committee!

Karla Haug

Karla Haug, MS, RN is a member of the Nominating Committee and is an Assistant Professor of Practice and Director of the LPN-BSN program at North Dakota State University. She served as the faculty advisor to the NDSU Student Nurses Association for 10 years. "Being a role model to students through active involvement in NDNA is very important to me. I believe that is it through that role modeling that we can shape the nurses of tomorrow as well as the profession of nursing."

Jami Falk

Jami Falk, RN, MSSL, CNML is the Veteran Health Administration's West Region Community Based Outpatient Clinic Nurse Manager and Acting VISN 23 Patient Medical Home Coordinator for North Dakota, South Dakota, Iowa, Nebraska and Minnesota. She works out of the VA Clinic located in Bismarck, ND and oversees the Primary Care clinical and administrative functions within four rural clinics in North Dakota. Over the past 13 years Ms. Falk has served as a front line Labor and Delivery RN, ICU nurse, ICU and Dialysis Nurse Manager, Inpatient Mental Health Nurse Manager, Acting Associate Chief Nurse of Primary Care and currently as the West Region CBOC Clinic Manager. Through these positions she has been involved in ensuring that front line staff has the education, training and knowledge they need to successfully take care of patients while working on ensuring quality nursing care is provided. She is a graduate of the University of Jamestown, certified as a Contracting Officer Representative, and also holds a Certification in Nurse Manager Leadership through AONE Association of Nurse Executives. She recently graduated with a Master's of Science in Strategic Leadership through the University of Mary in Bismarck, ND.

Sandy Boschee is the Director of Acute Care at Trinity Health in Minot, ND.

Welcome New Members

Jennifer DeJong
Amanda Kuntz
Holly Burgess
Taylor Peterson
Dawn Romfo
Roxanne Kasowski
Megan Dickmeyer
Nolen Keller
Robert Klink
Danaka Walz
Amanda Landphere
Julianna Martinson
Lindsey Holter
Jessica Pickle
Paula Grosinger
Brenda Ferguson
Adam Hohman
Sara Frantsvog
Greta Knoll
Kate Steinke
Jana Knutson
Melanie Fleming
Christie Odell
Shannon Blaisdell
Sandy Reagan
Chloe Van Lone
Kristen Hillebrand
Sharri Lacher
Martha Glatt
Kimberly Sklebar
Melinda Kraakmo

Member Spotlight

By Jacki Bleess Toppen
Featuring Lindsey Holter BSN, RN

For this Member Spotlight, we are getting to know more about Lindsey Holter. While most young nurses are just getting acclimated to the climate of the nursing profession, Lindsey is well on her way to making a mark for herself in the nursing world. Lindsey is passionate, driven, and despite her brief experience with the nursing profession; it is already clear to me that she has developed the maturity that she will need to be successful. Lindsey was kind enough to share some of her insights into what has gotten her to this point in her career, what continues to motivate her, and what she believes can define a nurse as being extraordinary.

Lindsey Holter BSN, RN

You just completed nursing school. Tell us a little about your training.

I had a remarkable overall experience at the University of North Dakota. I enjoyed working with professors who truly had a passion for what they were teaching. I was able to have experience in long term care, labor and delivery, cardiac/telemetry, critical care, and many more areas of nursing, which helped me to feel that my program wanted me to be a competent, well-rounded nurse.

When did you know you wanted to become a nurse? What other careers did you consider?

Prior to starting nursing school, I had several ideas of what I wanted to do – Physical Therapy, Occupational Therapy, and Psychology. One fateful day, however, as I was shadowing inpatient physical therapy, I brought a patient back to their room and saw the hustle and bustle up on the unit and had a chance to speak to the nurses. It was then and there that I realized PT and OT would not fulfill me in the same way that nursing would. I went on to get my BS in Nursing and BS in Psychology at UND.

You are just about to start your first nursing job. What made you decide to choose the area of nursing and facility that you did?

I was hired at Altru Health System in Grand Forks, ND in the Surgical Critical Care Unit (SCCU) following my senior preceptorship. I chose critical care because I feel that I work well under pressure, and I had always found the multisystem class content exciting. I find that critical thinking comes naturally to me, but I also consider myself very teachable and look forward to honing my skills in a critical care setting.

One of my professors particularly instilled in me the importance of a supportive and patient-centered unit culture. Altru's SCCU was an easy choice based on the teamwork, support, and collegial atmosphere that I noticed during my preceptorship. The unit also goes above and beyond to provide a comforting atmosphere for their patients.

What was your biggest challenge while you were in nursing school?

I think my biggest challenge was to become a person who can go with the flow. I had always been very Type-A, and in some instances, I still am. But I realized that nursing is not a contest that rewards those of us who are most stressed, and I tried in many ways to decrease my anxiety from being too busy. I realized that patients don't want a nurse who looks or sounds stressed, and at the end of the day, it benefits us to move more slowly because we will make less mistakes and have more face-to-face time with our patients.

What prompted you to join NDNA?

I strongly believe that if a person has the opportunity to offer their input, no matter how small it may seem, they should do that. In this spirit, I know that being a member of NDNA, ANA, and AACN is an opportunity for me to have a say in the policies and regulations placed on me in my practice. I hope that every nurse out there knows that professional organizations protect us and serve in our best interest, but especially so if we all have a voice in it.

How do you think NDNA can engage new graduate nurses who may not be knowledgeable about the benefits of a professional organization?

I believe NDNA should have representatives speaking to pre-nursing students and current nursing students at each school, each semester. It was not until my second semester of nursing school that I realized that professional memberships can have a great impact. We can work collaboratively to bring the best outcomes, not only for our patients, but ourselves as well by creating safe and supportive nursing environments. More education on legislation in school might help students realize their ability to impact the future of nursing.

What is an accomplishment that you are most proud of?

In summer 2015, I worked as a Summer III Student Nurse Extern on the Medical Cardiology ICU at Mayo Clinic in Rochester, MN. The experience was certainly the most career-shaping of my life. It helped me realize that a patient-centered, collaborative model of care is not only the cornerstone of a good hospital, but it is imperative for good outcomes. I was so proud to have the kind of attitude that fit in to the culture of a hospital like Mayo.

What do you think makes a nurse extraordinary?

I believe that nurses who understand the gravity of their interactions with patients tend to be the most extraordinary. I believe that extraordinary nurses understand that the patient does not care how many injections you gave them or what clinical skills you used; they care that you held their hand, or explained something better so they understood. It is easy to treat nursing as just a job – to get frustrated, angry, upset…but it is the best and most extraordinary nurses that can use failure and frustration to motivate change.

Who is someone who inspires you?

My professors from UND – honestly most of them, but especially Rennae Millette and Kelli Zeidlik. These two have helped shape my attitude toward nursing and have inspired me to go beyond the average and work toward a better nursing future that includes nurses as critical members of the healthcare decision-making team from the top down.

What do you like to do in your free time?

At this point, home renovations with my husband! I also like to read, and I'll be honest… Netflix was my best friend during the cold, cold months of this winter.

What goals do you have for yourself (personally or professionally)?

A personal goal that is close to my heart is to hope that I can make a difference. I hope I can be a light of humor and comfort for my patients and their families.

Professionally, I hope to one day be an NDNA board member, and even someday move toward the board of ANA to help shape our practice. As the Nursing Student Association of North Dakota said – our profession needs to be #beyondaverage – and it starts with us.

North Dakota Nurses Association Supports Raise it for Health Coalition's Efforts

The North Dakota Nurses Association's Advocacy Platform includes "collaborating with agencies for decreased tobacco use." On March 16th, NDNA joined the press conference announcing plans to pursue a tobacco tax increase through an initiated ballot measure on the General Election ballot in November 2016. The following information includes an article from the American Lung Association and the basics and benefits of this initiated ballot measure. Please help support these efforts across our state!

Tobacco Tax – A Winning Solution

AMERICAN LUNG ASSOCIATION. IN NORTH DAKOTA

Kristie Wolff
Program Manager
American Lung Association in ND

Kristie Wolff

On February 3, 2016, the American Lung Association released its 14th annual State of Tobacco Control Report. This report tracks progress on key, proven effective tobacco control policies at the federal and state level. Grades are assigned in a variety of areas - including strength of smoke-free laws, access to cessation services, support for comprehensive tobacco-prevention programs, and level of tobacco taxes - based on whether these policies are adequately protecting citizens from tobacco-related death and disease.

Amidst otherwise good "grades", North Dakota received an "F" for its current tobacco tax rates. At only 44 cents per pack, North Dakota's cigarette tax is among the lowest in the nation, a tax rate that has remained since its last increase in 1993.

Why Support Higher Tobacco Taxes?

Tobacco tax increases are one of the most effective ways to reduce smoking and other tobacco use, especially among kids.

When tobacco prices increase:

- Fewer people use tobacco
- People who continue to use tobacco consume less
- People who have already quit are less likely to start again
- Young people are less likely to ever start using tobacco

Tobacco taxes are widely accepted by the public and even supported by many tobacco users. Statewide public polling consistently shows this to be true here in North Dakota. Residents across all demographics - age, gender, political affiliation, and geography - overwhelming support tobacco prevention efforts, including those to increase tobacco taxes.

How Do We Compare?

The national average of state cigarette excise taxes is currently $1.61 per pack, but individual state rates vary widely, from just 17 cents per pack in Missouri to $4.35 per pack in New York.

To give a picture of current rates regionally, North Dakota still remains significantly lower than our neighboring states:

South Dakota - $1.53/pack
Montana - $1.70/pack
Minnesota - $3.00/pack

This puts our regional average cigarette excise tax at $2.08 per pack, putting North Dakotans, especially North Dakota kids, at a much higher risk of tobacco initiation, addiction, disease and even death.

What's the Cost of Tobacco in ND?

While the average retail price in the U.S. of a pack of cigarettes is $5.96 per pack, smoking-caused health care costs and productivity losses associated with just one pack of cigarettes is estimated to be a minimum of $19.16 per pack. That cost difference is often covered by non-tobacco using taxpayers. Higher tobacco taxes save money by reducing tobacco-related health care costs, including Medicaid expenses, over the long-term.

The true costs of tobacco use, however, reaches far beyond the monetary costs. Smoking continues to kill more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined, and thousands more die from other tobacco-related causes, such as fires caused by smoking (more than 1,000 deaths/year nationwide).

These numbers don't lie:

ND adults who die each year from their own smoking - **1,000**
Annual health care costs in North Dakota directly caused by smoking - **$326 million**
Portion covered by the state Medicaid program - **$56.9 million**
Residents' state & federal tax burden from smoking-caused government expenditures - **$823 per household**
Smoking-caused productivity losses in North Dakota - **$232.6 million**

(Amounts do not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking.)

Having one of the lowest tobacco taxes in the nation is not something that we should be proud of. Our state can achieve significant health and revenue gains by increasing tobacco taxes on cigarettes and other tobacco products like smokeless tobacco and cigars. It is time to raise the tobacco tax for the health of our citizens and to effectively protect our youth from a lifelong addiction to nicotine and the deadly consequences of tobacco. Please talk to your local, state, and federal officials about the impacts of low tobacco taxes and what they *can* and *will* do to move North Dakota's "F" grade to an "A"

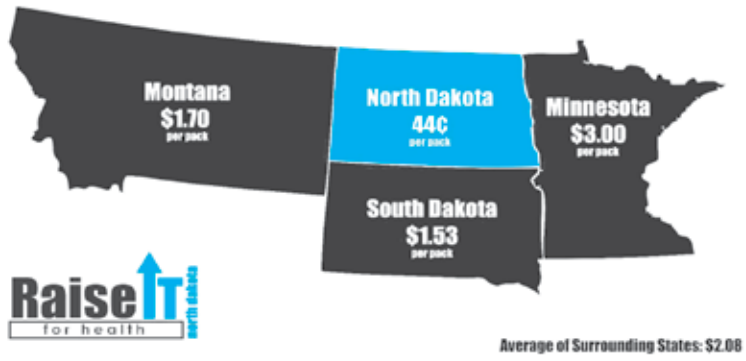
Source: WHO Report on the Global Tobacco Epidemic, 2008. The MPOWER package. Geneva, World Health Organization, 2008. Campaign for Tobacco Free Kids, www.tobaccofreekids.org. American Lung Association State of Tobacco Control 2016.

THE BASICS OF THE INITIATED MEASURE TO INCREASE ND'S TOBACCO TAX:

- **Creates a veterans' tobacco tax trust fund** to support a strategic plan for veterans' services and programs as approved by Governor-appointed Administrative Committee on Veterans Affairs (ACOVA).
- **Amends definitions** of tobacco products to include all tobacco products (still excluding cigarettes, as current code does), now also including liquid nicotine. Adds definition of "inhalation device".
- Treats **liquid nicotine dealers/distributors**, including taxing, licensing, and registration, the same as all other tobacco dealers/distributors in the state.
- **Increases the current tobacco excise taxes** as follows:
  - Cigarettes: from $0.44/pack (22 mills/cigarette) to $2.20/pack (110 mills/cigarette).
  - All other tobacco products: from 28% to 56% of wholesale purchase price, and eliminates special tax treatments (weight-based taxing) of some tobacco products.
- **Allocates** total tobacco product and cigarette excise taxes as follows:
  - **General Fund:** 20 mills/cigarette + 50% tobacco product collections *(holds current allocations harmless)*.
  - **Cities (based on population):** 2 mills/cigarette *(holds current allocations harmless)*.
  - **Veterans Tobacco Tax Trust Fund:** 44 mills/cigarette + 25% tobacco product collections *(50% of new revenues from increase)*.
  - **Community Health Trust Fund:** 44 mills/cigarette + 25% tobacco product collections *(50% of new revenues from increase)*.
    - 70% of these funds dedicated to **Behavioral Health Comprehensive Plan**.
    - 20% of these funds dedicated to **counties** (based on population) for **essential local health unit services** established by the state health council.
    - 10% of these funds dedicated to the Department of Health for support of **chronic disease** detection, prevention, treatment and control.
- Does not allocate any tobacco tax revenues, but protects current tobacco prevention and control funding through the Master Tobacco Settlement.
- **Repeals tax exemptions** on tobacco and cigarette for the ND State Hospital and ND Veterans Home (neither of which sell tobacco anymore).

BENEFITS OF PASSING THIS INITIATED MEASURE:

- **YOUTH PREVENTION*:** Tobacco tax increases are proven to be one of the most effective policies to prevent kids from using tobacco. This proposed increase is estimated to decrease youth initiation rates by 20% and prevent 5,800 ND youth under the age of 18 from ever starting.
- **HEALTH CARE SAVINGS*:** In long-term health care costs, the State of North Dakota is estimated to save nearly $246.57 million from reductions in adult and youth tobacco use.
- **HEALTH PROGRAM FUNDING*:** As North Dakota is faced with budget cuts and reduced revenues, this measure will protect and provide funding for crucial health care services and programs for our state's veterans and North Dakotans with chronic and behavioral health needs.
- **IMPROVE CURRENT STANDINGS:** North Dakota has not increased its tobacco taxes since 1993. At just $0.44/pack, our state ranks 47th in the nation for cigarette tax rates. We also fall significantly below the average of $2.08/pack cigarette tax rates of our neighboring states.



*Source: Campaign for Tobacco Free Kids,
Toll of Tobacco in North Dakota, updated January 6, 2015,
New Revenues, Public Health Benefits & Cost Savings, updated January 6, 2015

Honoring Choices North Dakota Update: What Matters Most

Nancy Joyner, RN, MS, APRN-CNS, ACHPN®
President, HCND

Having a conversation about future health choices before the need arises enables easier decision-making when the time for decisions arrives. Though most Americans say that having a discussion with their family about wishes for future medical care is important, few have had that conversation (Joyner, N. & May, S., 2015, Part I).

With increased attention given to reducing potentially avoidable hospitalizations (including admissions and readmissions), a renewed interest in advance care planning is developing in North Dakota. In 2010, the North Dakota Medical Association endorsed the Physician Orders for Life Sustaining Treatment (POLST) paradigm, which assists with the translation of patient's wishes into current medical orders. Honoring Choices North Dakota (HCND) was officially incorporated in 2015 as statewide initiative promoting advance care planning in North Dakota. The HCND **Vision** is "to create a culture across ND where continuous (on-going) advance care planning is the standard of care and every individual's informed preferences for care are documented and upheld. HCND's Goal is "to assist statewide community partners with the development and implementation of a comprehensive advance care planning program (Joyner, N. & May, S., 2015, part II, Choices North Dakota website, 2016)."

HCND has adopted the Respecting Choices® definition of advance care planning (ACP): "a person-centered, ongoing process of communication that facilitates individuals' understanding, reflection and discussion of their goals, values and preferences for future healthcare decisions (Respecting Choices®, Gunderson Health System, 2016)." A fundamental theme is advance care planning (ACP) is a **process**, with emphasis on earlier conversations. Three elements are fundamental to effective advance care planning: an individual's preferences for future health care decisions are discussed and communicated; those preferences are documented; and ultimately translated into medical orders.

According to the American Bar Association Commission on Law and Aging (2012), life transitions are remembered by the five "Ds":

- Reaching a new **Decade**
- **Death** of family or friend
- **Divorce**
- Receiving a new **Diagnosis**
- Experiencing a significant **Decline in health**

Advance care planning is not a one-time event in a person's life but rather a life-long conversation initiated in early adulthood. This implies that after age 18, the new **decade** in adulthood starts at age 20. Earlier discussions assist decision-making when unexpected injury or accidents occur, which renders one unable to speak for themselves, at those times, the individual perspective of what matters most is critical. For those who need to step forward to make decisions, earlier discussions can assist the process before distress occurs. (Joyner, N. & May, S. 2015, part III, Respecting Choices, 2016). Numerous efforts are being implemented within North Dakota and at a national level to get those conversations started. The number of ACP facilitators trained in Fargo area over the past year has grown to over 100 facilitators alone.

Another example of the growing interest in improving advance care planning in North Dakota are local National Healthcare Decisions Day events the week of April 10-16. National Healthcare Decisions Day exists to inspire, educate and empower the public and providers about the importance of advance care planning.

This year's theme for National Healthcare Decisions Day (NHDD), *It Always Seems Too Early, Until It's Too Late*, reflects the importance of early conversations about an individual's healthcare preferences. More information about NHDD and their resources are available on the Honoring Choices North Dakota website at www.honoringchoicesnd.org

Nurses in North Dakota and other states will have the opportunity to work with and become ACP facilitators as this significant role expands. By becoming aware of the importance of ACP through education and discussion nurses will be better informed to become highly skilled patient advocates.

For more information about advance care planning, ACP facilitator training and how to partner with Honoring Choices North Dakota in the important work of improving advance care planning in North Dakota or your community, contact:

Sally May, RN, BSN, CH-GCN
Honoring Choices North Dakota®
Program Coordinator
Quality Health Associates of North Dakota
3520 North Broadway
Minot, ND 58703
Phone: 701.852.4231
Fax: 701.857.9755
Email: sally.may@honoringchoicesnd.org
or
Nancy Joyner, MS, APRN-CNS, ACHPN®
President, Honoring Choices North Dakota
P.O. Box 12606
Grand Forks, ND 58201
Phone: 701.746.4728
Email: nancy.joyner@honoringchoicesnd.org

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It's Never Too Early

By Lois Ustanko, RN, MS, MHA

There's never a good time to talk about dying but death is inevitable for all of us. The 2014 Institute of Medicine Report *Dying in America* stresses the importance of conversations saying medical advances have complicated the dying process for so many people. Advance care planning is essential to improving quality of end-of-life care. This is not a onetime discussion; it's a dialogue that should happen again and again as a person's health status changes.

Registered nurses are required by the Code of Ethics to provide comprehensive supportive care for those who are dying and to acknowledge their right to autonomously make decisions (American Nurses Association [ANA], 2001). The best time to start the conversation is while the individual is healthy because most people are not physically, mentally, or cognitively able to make decisions about their care at the end of life (Institute of Medicine [IOM], 2014, p. 172). One of the greatest barriers for having these important conversations is waiting until the patient is hospitalized where there is not sufficient time to allow the patient to identify their personal, goals, values and beliefs (Kring, 2007). Once the patient loses capacity to speak for him or herself, patients in the later stages of their lives are at risk for receiving futile or unwanted interventions when preferences have not been defined (Brimblecombe, Crosbie, Lim & Hayes, 2014).

The best advance care planning includes clear and open discussion between the individual doing the planning and his or her loved ones. The person who will serve as the healthcare agent should be included. All registered nurses should develop basic competency in talking with patients about the care they do or do not want to receive as these discussions are associated with better quality of life for patients and their family members (Lachman, 2011).

Certified advance care planning facilitators are trained to use an evidence based process to explore patient's values and to confirm understanding about current health conditions. These facilitators can answer questions about how current health conditions might impact life going forward. The facilitator assists the patient with conveying preferences to the healthcare agent and family members. They also help with writing these preferences within a healthcare directive and ensure this plan is placed on the patient's medical record so it is accessible to all health care providers. The ANA (2010) identifies the nurse's role includes discussions about preferences for end-of-life care as they promote comfort, relief of pain, and support for families.

The guidance trained nurse facilitators provide honors patient autonomy and prepares them and those who may need to speak on their behalf to make difficult decisions that may lie ahead as health status declines. Nurses are particularly effective in the role of advance care planning facilitator as they excel in using presence (Messinger-Rapport, Baum & Smith, 2009). Active listening is used to explore the patient's expectations, hopes, and concerns. The facilitator starts by asking the patient, "What does a good day look like for you?" Once this is defined they can discuss medical treatments and how each alternative intervention might help the patient achieve their personal goals. The decisions are very personal and are unique for each individual. Two different people with the same advanced medical condition might make very different decisions.

The Center for Medicare and Medicaid Services believes these conversations are so important that effective January 1, 2016 they are paying physicians and other qualified health professionals for engaging in advance care planning with their patients (CMS, 2015). This is not just a conversation for seniors or those at the end of life, all adults can benefit from thinking about what their healthcare choices would be if they are unable to speak for themselves. Waiting for a crisis or waiting for the healthcare provider to bring up the topic is not an effective plan. Proactively discussing preferences before an emergency protects the patient and family from more difficult uninformed decisions in the future. The ANA (2012) identifies nurses must initiate these discussions with patients, families, and members of the health care team. Since nurses are leaders and vigilant advocates for provision of dignified care, they should strongly advocate for reimbursement from all insurance plans for proactive discussion of these sensitive issues AND to extend this reimbursement to all trained facilitators without limitation to billable providers.

More than 65 organizations are partnering with Honoring Choices North Dakota to create a culture across our state where continuous (on-going) advance care planning is the standard of care and every individual's informed preferences for care are documented and upheld. Sanford Health and Hospice of the Red River Valley are collaborating with Honoring Choices North Dakota to make *First Steps® Facilitator Training* available. As a result, there are over 100 Certified Advance Care Planning facilitators in North Dakota. All nurses are welcome to attend the bi-annual Honoring Choices ND meeting which will be held in Bismarck on April 14th. For more information about Honoring Choices North Dakota or to locate a trained facilitator contact Nancy Joyner, President of the HCND Board of Directors at nancy.joyner@honoringchoicesnd.org or (701) 746-4728.

The social campaign, National Healthcare Decisions Day, observed on April 16th, provides an opportunity to make community members aware of the importance of advance care planning. Honoring Choices North Dakota is facilitating community events across the state in April because it's always too early to have the conversation until it's too late.

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A Culture of Compassion in Nursing

Whitney Fear RN, BSN, TNCC

Whitney Fear is the RN Case Manager and Shelter Outreach Nurse at Homeless Health Services in Fargo.

Over the past several months, I have been encouraged by colleagues to consider writing an article on patient advocacy in vulnerable populations. While this was quite humbling, I struggled to think of a way to convey this concept in a manner which hasn't already been utilized. What words would be compelling enough to explain just how important defending the rights of vulnerable populations can be?

Ethics, advocacy and social justice are already concepts embedded into our nursing education. However, they are completely useless in the face of societal stigma. The harsh fact of the matter is that a great deal of the difficulty in working with this population lies within broken systems and colleagues who lack the understanding of their situations. I don't blame them. We all experience an intense amount of pressure from society to conform. How can one expect to empathize with something they don't understand? I suppose you could say I am lucky in this sense. Their world is my world. I grew up on the Pine Ridge Indian Reservation in South Dakota, a region which is riddled with poverty, mental illness and chemical dependency. Statistically speaking, I was more likely to end up an alcoholic than I was to graduate high school. It is just as challenging for me to understand that lack of empathy from colleagues, as it is for them to process what it might be like to be a slave to a substance or have absolutely no control over your own mind due to mental illness.

I am often asked how I can do what I do, or if I am afraid. I am certainly afraid. My heart sinks every time I know I will have to tell a patient that they can't access care that they need due to financial barriers. I cringe every time poverty is demonized in the media, because I know how absolutely insignificant my patients already feel.

"The garbage can. That's where I belong. With the trash. I'm going to die, don't you realize that?! Might as well just toss me away now."

This is the verbalization of one patient's feelings, and how I suspect many others feel as well. Unworthy. Trash. Give up. Toss aside. Die alone. Junkie. Drunk. Psycho. Prostitute. Criminal. Unacceptable.

The only thing I find unacceptable is ignoring those who need the most help. I have a lot of hope that at any time, with any opportunity, their lives could change. I use that hope to attend community workgroups, shelter visits, awareness events and where ever else my Outlook calendar has me going. I was introduced to a concept at one of these workgroups that felt so refreshing to me. The concept of a compassionate community. Compassionate communities strive for reducing stigma, increasing awareness, designing care that works people instead of care that works for systems and ensuring that the community is all inclusive.

I saw my chance to act on this concept by increasing my availability to nursing students as a preceptor. I want to help build compassionate nurses with a tenacity to demand social justice and ensure health care equality. I see an opportunity to nurture students that have that certain je ne sais quoi for patient advocacy. I know, like many nurses in my position know, that advocating for vulnerable populations cannot be taught completely from a book. I am willing to be honest. They have to get angry about injustices. They have to decide to be unrelenting. They have to learn how to be assertive, really assertive. When the rest of the crowd is moving backward, they have to find the courage to push against them to move forward. I will tell them they might cry and eat a lot of chocolate. Colleagues might make you feel like an outcast. And if you are still angry, unrelenting, assertive and moving forward, then you are probably just the right kind of person for the job. They will have good company, with the most amazing group of professionals that I have ever had the privilege of working with.

I have no scientific design or data to corroborate what I feel has been an absolute success. I will share that I saw students with reluctance and fear transition to students who truly understood the strife of my patients. Their scope of the world was expanding. Students shared experiences like challenging their peers for talking poorly about the homeless. Many were noticing, for the first time, the prevalence of poverty in the community. All of those ah-ha moments had a common theme, they had connected with one or more of my patients by spending time with them. I feel strongly that spending time with my patients humanized mental illness, chemical dependency and poverty for them. Never before had they had a face, name and story to associate with alcoholism, drug addiction, etc. Now that those conditions were associated with people they grew fond of, the conditions and their complications were what became unacceptable. In less than 3 months, I precepted approximately 25 ASN and BSN students. I consider each and every student that will walk across the stage in a few short months to not only be a colleague in nursing, but an ally as well.

Creating nurses that react to mental illness, chemical dependency and poverty with the same compassion as they would feel for those suffering from cancer or diabetes is of great importance to me. It is essential to my patients receiving holistic care. In North Dakota, we are in a crisis with mental health services and experiencing a severe drug epidemic. For the first time, drug overdose has surpassed all other causes of accidental death. My patients are in labor and delivery, the ED, long term care, medical surgical, the OR and everywhere that healthcare is offered. Medicaid and Medicare recipients are the majority of my patients, and the largest group of healthcare consumers. They have increased risk for complications of chronic health conditions and high mortality rates. I cannot be at all places, at all times for my people. To my colleagues, dear nursing students and wise educators, I ask that you help to care for my people. Make them your people too. They need anyone they can get. Consider clinicals with nurses doing work similar to mine. Offer unique clinical experiences at your facilities. Reach out to those who want to share about their work in your classrooms. See a daughter or son, instead of a drug addict. Learn about trauma informed care. Challenge your peers to see mental illness and chemical dependency with the same urgency as they would when dealing with DKA or an MI.

Whether you work alongside me, or in a completely different setting, do not allow apathy and fear to direct your nursing practice. I will be here, if you do decide to make my people, your people. Nurses are the most trusted professionals in the nation. If nurses can support comprehensive, unwavering compassion for others, I am confident that we can inspire others to do the same.

"Were there none who were discontented with what they have, the world with never reach anything better." -Florence Nightingale

Use of Chlorhexidine Gluconate with Critically-Ill Patients

Appraised by:
Shawntai Cook, SN; Brandi Davidson, SN; Shawna Dietz, SN; Jordan Taghon, SN
(NDSU Nursing at Sanford Bismarck, ND)

Clinical Question:

In critically-ill patients, does the use of daily chlorhexidine gluconate bathing compared to regular soap and water decrease the risk of bloodstream infections?

Articles:

Bleasdale, S.C., Trick, W.E., Gonzalez, I.M., Lyles, R.D., Hayden, M.K., Weinstein, R.A. (2007). Effectiveness of chlorhexidine bathing to reduce catheter-associated bloodstream infections in medical intensive care unit patients. *JAMA International Medicine*. *167*(19), 2073-2079.

O'Horo, J., Silva, G., Munoz-Price, L., Safdar, N. (2012). The efficacy of daily bathing with chlorhexidine for reducing healthcare-associated bloodstream infections: a meta-analysis. *Infection Control and Hospital Epidemiology*, *33*(3), 257-267.

Popovich, K., Hota, B., Hayes, R., Weinstein, R., & Hayden, M. (2010). Daily skin cleansing with chlorhexidine did not reduce the rate of central-line associated bloodstream infection in a surgical intensive care unit. *Intensive Care Medicine*, *36*(5), 854-858. doi:10.1007/s00134-010-1783-y.

Septimus, E. J., Hayden, M. K., Kleinman, K., Avery, T. R., Moody, J., Weinstein, R. A., & ... Huang, S. S. (2014). Does chlorhexidine bathing in adult intensive care units reduce blood culture contamination? A pragmatic cluster-randomized trial. *Infection Control & Hospital Epidemiology*, *35*S17-22. doi:10.1086/677822.

Synthesis of Conclusions:

The first study reviewed was a randomized control trial conducted by Bleasdale et al, in 2007. The study took place in a 22-bed medical intensive care unit (MICU), which comprises 2 separate yet similar 11-bed units of the John H. Stroger Jr. Hospital in Chicago, IL. Only patients that had an intravascular catheter and were admitted for at least 48 hours were included in this study. Bleasdale et al separated this study into two separate arms. The first arm was titled MICU A and ran the CHG intervention from June 8 through December 20. The second (MICU B) 11-bed unit continued with the soap and water intervention. After this period was over, there was a two-week clearing period then the arms switched and MICU B ran the CHG intervention. The CHG intervention was more successful in the reduction of CLABSI throughout this study as the end results were 4.1 per 1000 infections when using CHG compared to 10.4 per 1000 infections when using soap and water. Strengths in this study included the "use of a concurrent control group, crossover design, intention to treat analysis, large number of patient days and comprehensive capture of infection events by dual manual and electronic surveillance" (Bleasdale, 2007, pg 2078). Limitations and weakness in this study were that the sample size may not have been large enough to identify a statistically significant reduction, all nursing staff could not be blinded to the intervention, only one of three physicians investigators were blinded, and the CHG arm had fewer patients but equal patient days which exposed a vaguely longer length of stay. (Bleasdale, 2007).

A second article, by Septimus et al, (2014), conducted a randomized control trial that consisted of adult ICU patients that were admitted from July 1, 2009 to September 30, 2011. The study was taken from 43 hospitals that contained 74 ICUs that were chosen from the Hospital Corporation of America. The sample consists of 7,926 patients tested in the first six months, which was implemented as the baseline. Following that was an 18-month intervention period that consisted of 9,878 patients. The study consisted of three strategies (arms): arm 1 (screening and isolation), ICU patient that have a history of MRSA or positive test for MRSA were put into contact precautions; arm 2 (targeted decolonization), ICU patients with MRSA were put into contact precautions. Patients treated twice daily CHG cloth baths for 5 days, arm 3 (Universal decolonization), and ICU patients with or without MRSA were put into contact precautions. Patients treated with twice daily intranasal Mupirocin ointment for 5 days plus daily CHG cloth baths for the entire duration of their ICU stay. At the end of the study, arm 3 (universal decolonization) had the greatest decrease in contamination rate during the intervention period. "The strength of this study was a large sample size and rigorous design as a pragmatic compared to effectiveness trial implemented primarily through the hospital processes" (Septimus et al 2014, pg. S21). Implications of the study were not being able to account for the method of blood draw and not capturing clinical signs or symptoms that could be associated with a clinical infection (Septimus et al, 2014).

Another study reviewed was a meta-analysis, consisting of one randomized-control trial and eleven nonrandomized or quasi-experimental trials, conducted by O'Horo, Silva, Munoz-Price, and Safdar (2012). They reviewed studies relating to the use of chlorhexidine gluconate baths in critical-care settings, such as medical, surgical, trauma, coronary, respiratory, and combined units of the previously listed; most of the hospitals founded in the United States of America but there was also one hospital in both France and southern Israel respectively. In total, there was a whole of 137,392 patient days reviewed, which is a large population size. The independent variable implemented in the studies was the use of CHG versus soap and water, which is the control group; the dependent variable depended on whether the patients' obtained a bloodstream infection or not. O'Horo et al. (2012) found that the studies revealed that the use of CHG impacted favorably in the decrease of BSIs compared to the regular utilization of soap and water. They found the results of BSIs by using cultures with polymerase chain reactions to identify if there was a positive or negative culture. The inclusion criteria was that it had to be related to critical-care patients, adult patients only, with exclusion criteria being that the studies had to not relate to patients in the perioperative period. For limitations, the meta-analysis only included one RCT with the other articles being quasi-experimental trials, which are always open for the risk of bias and unaccountability (O'Horo et al, 2012).

The final article by Popovich, Hota, Hayes, Weinstein and Hayden in 2010 conducted a quasi-experimental, pre-post study. The study took place in a 30-bed surgical ICU at Rush University Medical Center. It consisted of a soap and water intervention period from September 2004 to October 2005 and a Chlorhexidine Gluconate period from November 2005 to October 2006. The study did not show any significant difference in the rates of central line associated bloodstream infections (CLABSI) during the two intervention periods. However, there was a significant decline in the rates of blood culture contamination during the CHG intervention period. One strength of the study was long intervention periods. Limitations and weaknesses were no formal monitoring of how thorough the CHG bathing were and a possibility of improper CHG bathing. There was also no detailed patient data collected on patients such as the use of antibiotics. The sample size was large enough to determine if the failure of CHG bathing affected CLABSI rates (Popovich et al, 2010).

Bottom Line:

With a full review of the evidence, it suggests that the use of daily chlorhexidine gluconate bathing in critically-ill patients decreases the risk for bloodstream infections compared to the average use of soap and water as three articles supported the CHG soap. Only one article did not indicate CHG decreased the chances of bloodstream infections compared to soap and water but also did not show CHG had an increased risk of infection either. This improves patient prognosis, decreases duration of stay, and reducing the rate of nosocomial infections, focusing especially on bloodstream infections, for patients in critical-care settings.

Implications for Nursing Practice:

Based on the research articles and the evidence presented, facilities with critical-care units, healthcare providers, and infection control teams, should consider implementing the daily use of chlorhexidine gluconate bathing in critically-ill patients. To facilitate this, the facility would be required to change cleansing protocols, buy the CHG soap, and instruct the nursing staff with how to properly administer the intervention.

More Nurses, Better Outcomes

Appraised by: Clancy Hennessy SN, Laken Kittelson SN, Carly Nordstrom SN, Raquel Wehri SN
NDSU at Sanford Bismarck

Clinical Question:

Does decreasing the patient-to-RN staffing ratio to 4-to-1 improve patient outcomes and decrease medication errors?

Articles:

Aiken LH, Clarke SP, Sloane DM, Sochalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA*, 2002;288(16):1987-1993. doi:10.1001/jama.288.16.1987.

Frith, K. H., Anderson, E. F., Tseng, F., and Fong, E. A. (2012). Nurse staffing is an important strategy to prevent medication errors in community hospitals. *Nursing Economics*, *30*(5), 288-294. Retrieved from EBSCOhost.

Needleman, J., Buerhaus, P., Pankratz, V. S., Leibson, C. L., Stevens, S. R., & Harris, M. (2011). Nurse staffing and inpatient hospital mortality. *New England Journal Of Medicine*, *364*(11), 1037-1045. doi:10.1056/NEJMsa1001025.

Zhu, X., You, L., Zheng, J., Liu, K., Fang, J., Hou, S., & ... Zhang, L. (2012). Nurse staffing levels make a difference on patient outcomes: a multisite study in Chinese hospitals. *Journal Of Nursing Scholarship*, *44*(3), 266-273. doi:10.1111/j.1547-5069.2012.01454.x

Synthesis of Evidence:

Four studies were reviewed; three studies appraised the practice of decreasing the patient-to-RN ratio to decrease adverse patient outcomes, and one study compared nurse staffing of RNs and LPNs and the occurrence of medication errors.

Aiken, Clarke, Sloane, Sochalski, and Silber (2002) conducted a cross sectional analyses of linked data, level IV quantitative study based on data collected from 210 nonfederal adult general hospitals in Pennsylvania that determines the relationship of nurse staffing levels on patient outcomes and factors that influence nurse retention, burnout, and job satisfaction. Data was collected using cross sectional analyses of linked data from 10,184 staff nurses surveyed; 232,342 general/orthopedic/vascular surgery patients discharged from the hospital between April 1, 1998 and November 30, 1999. Aiken et al (2002) found that by decreasing the RN-to-patient staffing ratio, the likelihood of readmission and dying within 30 days of admission dramatically decreased. There also was a decrease in nurse burnout and job dissatisfaction, as it had been increased in the past. So, in hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30 day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction.

A retrospective, correlational study was conducted by Frith, Anderson, Tseng, and Fong (2012). This study analyzed secondary data from administrative databases of one hospital containing 801 weekly staffing intervals and 31,080 patient observations from July 2008 to June 2010. Nine units, all from a single hospital met criteria for this analysis. The hospital had a variety units where medication errors occurred, but only medication errors that occurred in the medical-surgical units were included in the analysis because nurse staffing was similar in these areas and that was the variable of interest. This study had an adequate sample size of 801 weekly staffing intervals and 31,080 patient observations from July 2008 to June 2010. This study found that as the RN hours increased, the medication errors decreased. Conversely, as the LPN hours increased, the medication errors increased. The relationship between nurse staffing of RNs and LPNs and the occurrence of medication errors was examined. According to Frith, Anderson, Tseng, and Fong, "the current study shows that increasing the number of RN hours and decreasing or eliminating LPN hours can be a strategy to reduce medication errors" (p. 288).

Needleman et. al (2011) conducted a retrospective, observational study where they used data from large tertiary academic medical center. The study involved 197,961 admissions and 176,696 nursing shifts of 8 hours each in 43 hospitals units to examine the correlation between mortality and patient exposure to nursing shifts during which staffing by RNs was 8 hours or more below the staffing report (Needleman 2011). They also looked at the association between mortality and high patient turnover owing to admission, transfers, and discharges. They determined that there was a high correlation between RN below target level with increased mortality, and high patient turnover.

Zhu, X et al (2012) conducted a cohort study that focused on the relationship between nurse-to-patient staffing ratios in relation to patient outcomes. They conducted a study using the China Nurse Survey tool and the Hospital Consumer Assessment of Healthcare Provider and Systems to analyze the nursing care and patient outcomes. The results showed that inadequate nurse staffing results in missed but needed nursing care and negative patient outcomes. The research also supported that better staffing levels is an effective strategy for improving patient outcomes. This study included a sufficient sample size of 7,650 nurses and 5,430 patients.

Bottom Line:

Of the four articles reviewed, three articles suggested that a decreased patient-to-RN drastically improves patient outcomes and decreases medication errors. This is a huge part of patient safety in today's hospital settings. The last article strongly suggests that an increase in RN vs. LPN staffing decreases medication error incidence.

Implications for Nursing Practice:

As a nurse or unit manager, take into consideration the staffing ratios and patient safety. It is important to have quality care given to patients, even if that means hiring more RNs. When assigning patients, take into consideration the patient's acuity. Try to equally disperse the patient load between nurses on your floor in order to improve patient outcomes and decrease med errors. When hiring, take into consideration licensure and education. A higher rate of RNs will improve quality of care.

Subcutaneous Fluid Rehydration vs IV Fluid Rehydration

Appraised by: Amanda Ketterling SN, Lea O'Connell SN, Glenda Snyder SN, Joseph Vetter SN (NDSU Nursing at Sanford Health Bismarck, ND)

Clinical Question:

Is subcutaneous fluid rehydration an effective alternative to IV rehydration in treating mildly-moderately dehydrated patients?

Articles:

Allen, C., Etzwiler, L., Miller, M., Maher, G., Mace, S., Hostetler, M., . . . Harb, G. (2009). Recombinant human hyaluronidase-enabled subcutaneous pediatric rehydration. *Pediatrics*, *124*(5), E858-E867. doi:10.1542/peds.2008-3588

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Slesak, G., Schnürle, J. W., Kinzel, E., Jakob, J., & Dietz, P. K. (2003). Comparison of subcutaneous and intravenous rehydration in geriatric patients: a randomized trial. *Journal Of The American Geriatrics Society*, *51*(2), 155-160. doi:10.1046/j.1532- 5415.2003.51052.x

Spandorfer, P. R., Mace, S. E., Okada, P. J., Simon, H. K., Allen, C. H., Spiro, D. M., & ... Lebel, F. (2012). A Randomized clinical trial of recombinant human hyaluronidase-facilitated subcutaneous versus intravenous rehydration in mild to moderately dehydrated children in the emergency department. *Clinical Therapeutics*, *34*(11), 2232-2245. doi:10.1016/j.clinthera.2012.09.011

Synthesis of Evidence:

Four studies were reviewed to answer the PICO question which included 3 randomized control trials and one systematic review. This first study is a randomized control trial done by Allen et al. (2009). This was to assess the efficacy, safety and clinical utility of recombinant human hyaluronidase (rHuPH20) facilitated subcutaneous rehydration in pediatric patients 2mos -10yrs, when IV access is problematic to achieve. rHuPH20 is a spreading enzyme that decreases the tissue resistance to subcutaneous fluid administration that quickens the absorption of subcutaneous fluids by momentarily heightening tissue absorbency. The pediatric patients that were involved in study were closely monitored as the rHuPH20 was pump-facilitated via subcutaneously infusion of 20mL/kg isotonic fluid over 1hr. Infusion would be continued up to 72 hours. The study included 52 pediatric patients with mild to moderate dehydration symptoms that were seen in the ER of 9 different hospitals. Forty-eight of the fifty-two pediatric patients were considered rehydrated through the use of rHuPH20, a success rate of 94%. One of the fifty-two needed to be admitted to the hospital because of continued IV rehydration. The clinical effectiveness was well received by clinicians and parents due to the ease, usage and safety of administering rHuPH20.

Infusion sites were monitored for signs and symptoms of redness, swelling, irritation, and site pain was assessed. A weakness of the study included the child's perceived pain and parental recollections of the child's pain due to the difficulty in providing reliable recollections of the event. Another weakness noted in this study is the lack of close monitoring of oral replacement therapy (ORT) in the children. Finally the other weaknesses include a small group and no control group for a closer comparison.

In conclusion 94% of the pediatric patients that were seen in the ER for mild to moderate dehydration were successfully rehydrated using subcutaneous infusion using rHuPH20. It seemed to be safe and effective when oral rehydration therapy was not an option and IV access was not obtainable due to poor IV access in children when dehydrated.

The second study reviewed was a randomized trial conducted by Spandorfer et. al. (2012) in twenty-four United State hospitals. Seventy-three randomly assigned patients were assigned to the rHFSC therapy while 75 patients were assigned to the IV therapy.

A strength of the study is that it is a randomized trial. Multiple measurement tools were used in this study to assess patients before receiving hydration therapy, while receiving therapy, and after receiving therapy. Tools that were used were the Gorelick 10 item scale (Dehydration score); weight change at the end of infusion; a survey at patient discharge from the health care provider who performed the assessment, number of attempts and time required for catheter placement, pain was assessed by using the FLACC scale (Face, legs, activity, cry, consolability scale; for those <3 years old), and the FACES pain scales for those 3 years old and older, a questionnaire was administered to patients' parents/legal guardian(s) to assess their satisfaction with therapy and The National Cancer Institute's Terminology Criteria for Adverse Events and Common Toxicity Criteria. Seventy-three patients participated in the rHFSC group and all 73 of them had a SC line placed successfully on the first try when only 59 out of the 75 patients receiving IV therapy had gotten a successful placement on the first attempt. No side effects were shown from patients receiving rHFSC treatment; however, it had multiple positives by requiring less time for rehydrating the patients, having patient and parental satisfaction and ease of performance.

Limitations of the study included the FDA limiting the total SC fluid volume augmented with recombinant human hyaluronidase in a single infusion to 200mL in infants and children under 3 years old and most centers did not have protocols allowing use of an SC line in the inpatient setting, which limited data on rHFSC compared to IV therapy which caused an imbalance in the amount of fluid received by the subcutaneous route.

The third study was a randomized trial conducted by Slesak et.al. (2003) over a 20 month period. The purpose of this study was "to compare the acceptance, feasibility, and adverse effects of subcutaneous and intravenous rehydration in dehydrated geriatric patients and clinical changes exhibited by the patients" (p. 155). The study included 96 patients aged 60 and over in the geriatric ward of the Geriatric Department of the Tropenklinik Paul-Lechler-Krankenhous in Tubingen, Germany that presented with signs of mild to moderate dehydration needing parenteral fluids on admission or during their stay in the geriatric department. The intervention in this case was receiving SC rehydration vs. IV rehydration. The interventions were randomly assigned using sealed envelopes, kept at the nurses' station, which contained one intervention or the other. The study data was collected using a standardized patient record form, a Likert-like scale, as well as doctors and nursing scoring. The patient form was used to collect the information regarding the patients' comfort level throughout the treatment. The Likert-like scale was used to measure the effectiveness of the treatment. The nurses provided the care the treating doctors separately scored the overall feasibility of the therapy with regard to the practical implementation and occurrence of complications. The doctors assessed for signs of dehydration upon admission and again the

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American Nurses Association

National Nurses Week 2016

"Culture of Safety: Safety 360 Taking Responsibility Together"

Key Messages

In recognition of the impact nursing has on patient outcomes and the quality of care, the American Nurses Association (ANA) has designated 2016 as "Culture of Safety" and the tagline is "Safety 360 Taking Responsibility Together." Keeping with this focus, the theme for National Nurses Week 2016 (May 6-12) is "Culture of Safety—It Starts with You."

Overarching Key Messages

- Safety is everyone's responsibility. There is no hierarchy. Safety requires empowering every voice.
- A culture of safety is one where nurses feel supported, listened to and understood. A culture of safety fosters transparency, accountability and results.
- Nurses foster open conversations about safety issues, such as fatigue, stress, safe patient handling, workplace violence, incivility and bullying.
- Nurses prioritize safe staffing and help connect individual, team and organizational safety goals.
- National Nurses Week celebrates the contributions nurses make every day to make positive changes for patients.
- Nurses ensure the delivery of quality health care to patients, families and society.
- Nurses are recognized by the public for upholding high ethical standards. An annual Gallup survey shows that the public has ranked nursing as the top profession for honesty and ethical standards for 14 years straight.
- Nurses have a critical responsibility to uphold the highest level of quality and standards in their practice, including fostering a safe work environment.
- Nursing leaders ensure resources are available to achieve safety results, providing resources for adequate staffing, equipment and education.
- Nurses use quality measurements to improve patient outcomes.
- The American Nurses Association (ANA) has a long-standing commitment to ensuring the health and wellness of nurses in all settings. ANA supports improving the work life of health care providers: what's good for nurses is good for patients.

Additional Background and Examples

It has been 15 years since the Institute of Medicine (IOM) issued the call for a safer health care system in its landmark reports To Err Is Human and Crossing the Quality Chasm.

To Err Is Human found that between 44,000 and 98,000 hospitalized patients die each year from preventable medical errors. Many nurses were shaken by the report, as "do no harm" is at the core of nursing.

The follow-up report, Crossing the Quality Chasm, had a broader focus and suggested a roadmap for reforming the nation's health care system. Taken together, these two reports have shaped the modern patient safety conversation.

ANA endorsed the National Patient Safety Foundation report which reiterates the importance of establishing and sustaining a culture of safety. The report emphasizes "the wellbeing and safety of the healthcare workforce." ANA supports the concept that a healthy nurse leads to a healthy community.

Recent studies suggest U.S. patients experience a far greater number of adverse events each year than even suggested by the IOM 15 years ago. A 2013 study published in the Journal of Patient Safety revealed that preventable adverse events accounted for 210,000 to 440,000 deaths of hospital patients every year. There is still work to be done and nurses will play a key role.

Nurses have been instrumental in improving the quality and safety of health care particularly when it comes to hospital-acquired conditions. According to the Agency for Healthcare Research and Quality (AHRQ) these conditions declined 17 percent between 2010 and 2014. There were 2.1 million fewer hospital-acquired conditions, 87,000 saved lives, and $20 billion in savings.

In 2010, the Institute of Medicine released a landmark report, *The Future of Nursing: Leading Change, Advancing Health*, which recommended increasing the number of nurse leaders in pivotal decision-making roles on boards and commissions that work to improve the health of everyone in America. The Nurses on Boards Coalition (NOBC) was created in response to this, as a way to help recruit and engage nurses to step into leadership roles.

The NOBC represents nursing and other organizations working to build healthier communities in America by increasing nurses' presence on corporate, health-related, and other boards, panels, and commissions. The coalition's goal is to help ensure that at least 10,000 nurses are on boards by 2020, as well as raise awareness that all boards would benefit from the unique perspective of nurses to achieve the goals of improved health in the United States.

We encourage each and every one of you, over 3 million strong, to visit **www.nursesonboardscoalition.org**, sign up to be counted if you are on a board and read more about the efforts being made to help build the future of our profession.

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next day. Patient diagnosis, sex, weight, height, duration of stay blood pressure, pulse, hematocrit, serum sodium, serum creatinine, and signs of dehydration were all recorded upon admission and reassessed after they received the SC or IV rehydration. This study was looking at hydration success, acceptance, feasibility, and adverse effects of both methods of rehydration. There was not a significant difference in the effectiveness of rehydration between the IV method and the subcutaneous method. The only extraneous variable that could not be controlled in the trial was any underlying medical condition the patient may have had. After review the evidence, if was suggested by Slesak et. al. that the two forms of rehydration, IV and subcutaneous, are equally effective, safe, feasible, and well tolerated by the patient with the only more punctures and more time involved in placing IV catheters, which is less economical.

The fourth study was a systematic review conducted by Remington and Hultman (2007) to compare hypodermoclysis (HDC) to IV methods of fluid replacement. Eight studies were reviewed including two randomized control trials (RTC) and 6 cohort studies. The search included hypodermoclysis, clysis, fluid therapy, subcutaneous, dehydration, and rehydration. They searched the databases Medline, CINAHL, the Cochrane Library, Embase, and the Joanna Briggs Institute for literature published between 1996 and 2006. Dissertation abstracts were included in the search in order to find unpublished research. Data was independently extracted by each author and any disagreement was discussed without any 3rd party involvement. Weaknesses of the studies noted in the review included: small sample size, nonstandardized evaluation methods, non-randomized assignment, limited conclusions related to baseline differences, and intention-to-treat analysis. According to Remington and Hultman (2007), "When administered properly, HDC is as effective and safe as IV hydration and potentially less expensive. Advantages include lower cost and greater patient comfort." It is also suggested that more research be done on this topic.

Bottom Line:

Based on the four studies we reviewed one can conclude that subcutaneous fluid rehydration is as effective as IV fluid rehydration. Advantages of subcutaneous fluid rehydration include: ease of placement, less pain and distress, and fewer resources utilized. This would warrant a change of practice to utilize subcutaneous fluid rehydration more or to further study subcutaneous fluid rehydration in order to make a change in practice.

Implications for Nursing Practice:

Evidence suggests that subcutaneous rehydration is an effective alternative to IV rehydration in treating mildly-to moderately dehydrated patients. In addition, subcutaneous rehydration is less painful, is more cost effective, and promotes patient-nurse trust. Considering the advantages, we encourage implementing a pilot project in the ED.