Safe Staffing.

This is such a hot topic in the nursing world right now, and should be! ONA is working tirelessly on safe staffing, and has been for quite awhile! Our first round of legislation passed in 2008 (after 8 years of hard work) with the promise to Ohio’s nurses that we’d be back if the law needed amending. After many years of focus groups, surveys and talking with nurses across the state, the time has come to revisit the issue of safe nurse staffing in Ohio. We (as in ONA members) passed 3 staffing-related reference proposals at the last ONA Convention, and a member-led Staffing Task Force has been hard at work since December of 2015 to start the fire of change. Important and exciting things are coming, Ohio nurses! Safe staffing saves lives!

APRN Legislation.

Many nursing organizations are pushing to give Advance Practice RN’s more autonomy which will improve access to care in many settings. Recent areas of focus include giving increased authority in

From the Blog continued on page 3
Greetings to you from the Board of Directors of Ohio Nurses Foundation (ONF). "What is the ONF?" you may ask. ONF is a non-profit, 501 (c)(3) organization and a component of the Ohio Nurses Association. ONF was created in 2002 for the purpose of promoting the profession of nursing. As stated in our Mission Statement, we exist "to provide the funding to advance nursing as a learned profession through education, research, and scholarship." How do we do this? In several ways, including fund raising, donations, investments, etc., as well as through the awarding of scholarships to nursing students, funding nursing research, and providing various means of continuing nursing education.

One major means by which we achieve our mission is through the publication you are currently reading - "OHIO NURSE." The Ohio Nurses Foundation, in collaboration with Ohio Nurses Association (ONA), and the generosity of Arthur L. Davis Publishing Agency, Inc., publishes "OHIO NURSE" 4 times a year. Every licensed Registered Nurse in Ohio, nearly 190,000, receives this publication free of charge! Each issue contains a wealth of valuable information and useful resources. Continuing nursing education offerings with contact hours are available, very relevant and timely articles and news items regarding professional nursing can be found and much more. I know we all receive a great deal of junk mail. "Don't make the mistake of treating "OHIO NURSE" as such. It is a valuable, informative, and very useful nursing resource which will help to keep you current in your ongoing professional development. I urge you to look forward to receiving and reading each issue of "OHIO NURSE" when it arrives in your mailbox.

The ONF is currently engaged in some in-depth strategic planning for the future. In up-coming issues of "OHIO NURSE," there will be more information including the many exciting ways in which the Ohio Nurses Foundation is helping to promote and enhance professional nursing in Ohio.

Davina J. Gosnell, RN, PhD, FAAN Chair, Ohio Nurses Foundation
Ohio Nurse

Page 3

From the Blog continued from page 1

Veteran's Affairs care settings, and the APRN's role in treating the opioid epidemic.

The Opioid Epidemic.

Opioid abuse, addiction, and related fatalities are at an all-time high. According to the American Society of Addiction Medicine, "prescription pain reliever overdose deaths among women increased more than 400% from 1999 to 2010, compared to 237% among men." Drug overdose is currently the leading cause of accidental death in the United States. Nurses in many care settings witness the effects of these startling statistics, especially in emergency departments. Addiction is complicating the assessment and treatment of many patients, and nurses are struggling to meet the demands of these patients. Things like concern for withdrawal and "drug-seeking" are problems nurses today are facing.

Mental Health.

Approximately 43.8 million Americans experience mental illness in a given year (National Alliance on Mental Health). Similar to addiction, nurses are seeing mentally ill patients at an alarming rate. Substance abuse is even more prevalent among these patients, often complicating their care. Proper assessment and screening by nurses can help identify those at risk, and nurses can also facilitate getting patients the resources they need. Increasing the number of psychiatric care facilities and improving access to care can help this growing problem.

The nursing shortage.

With the steadily increasing elderly population, the US will need more nurses than ever. Additionally, more and more Americans are living with chronic diseases, and often not just one. Nurses are working more hours for more years, and yet there is still a need. Some nursing schools are offering incentives and scholarships to attract more students, however care facilities often turn their cheek at hiring "new graduates." The field of nursing is, and always has been, an attractive career choice for both young students and those looking for a second career. Hospitals and other facilities may need to adjust to the demands of the community and offer different training programs for newer nurses in order to hire the amount of staff to care for all of these patients. View more blog posts at connect.ohnurses.org/blogs!

Jessica Tucci, RN

RN CVOR - Operating Room

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- Family Nurse Practitioner

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- Clinical Nurse Leader

MBA - Nurse Executives

Outcomes: The nurse planner will have knowledge to plan, develop, and implement educational activities according to 2015 ANCC Accreditation Program criteria and requirements.

2017 Dates

Wellness Conference
March 23-24, 2017 (location to be determined)

Provider Update
4/17/17, Ohio Nurses Association, 4000 East Main Street, Columbus, OH 43213
2/20/17 OCLC, 6600 Kilgour Place, Dublin, OH 43017
4/27/17 Henry Ford Health System, 2799 W. Grand Blvd., Detroit, MI.
5/16/17, Franciscan St. Francis, Indianapolis, IN
5/18/17, NorthShore University Health System, Glenbrook Hospital, Glenview, IL
5/22/17, Decatur, IL

12th Annual Nursing Professional Development Conference
4/21/2017 OCLC, 6600 Kilgour Place, Dublin, OH 43017

The Retired Nurses Forum of the Ohio Nurses Association
June 6-7, 2017 (Location to be determined.)

The Ohio Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation (OBN-001-91).

Ohio Nurse Page 3
The Institute of Medicine emphasizes the need for improvement of patient care and the need for the development of methods to enhance the collaboration of all healthcare professionals for the provision of safe, quality and competent patient care. The Agency for Healthcare Research and Quality (AHRQ) has also been instrumental in the support of research and development of training programs which are focused on the development of interdisciplinary safe patient care practices.

One method that has been utilized across the healthcare professions for several years has been the initiation of interprofessional education (IPE) and the utilization of both high-fidelity and case study discussion clinical simulation in both an academic as well as clinical practice. The use of simulation case studies and interdisciplinary practice is proposed to enhance the art of communication, decrease the perception of professional role stereotyping, promote a coordinated provision of safe care in various settings do not practice the provision of care teams that typically care for patients in a variety of settings. The development of simulation of actual healthcare situations can be through the utilization of high-fidelity realistic interactive mannequins, equipment, audiovisual recording and physical environment mock-ups. In this simulated point-of care environment, team members can practice their care interventions, techniques of communication and advance in technical skills that can be developed in this safe environment.

Although the use of simulation can be viewed as potentially cost prohibitive, particularly if high-fidelity equipment is utilized, the cost is outweighed by the potential increase in the provision of cost-effective, appropriate patient care. Coordinated teams of health care professionals working together can be developed through understanding and hands-on training. Collaborative interprofessional education with the incorporation of simulation utilization will facilitate the meeting of the benchmark expectations of the provision of safe, competent, coordinated, quality patient care with enhanced outcome.

Deborah J. Schwytzer, DNP, RN-BC, CEN

Displaying Your Credentials

If you have achieved increasingly higher levels of academic degrees, it is not necessary to list all of those credentials. Typically, the highest degree is the one listed – Mary White, PhD, RN, or Sam Green, EdD, RN. However, if you have different types of degrees, you may choose to list them. For example, if Marion Martin has a baccalaureate degree in nursing and a master’s in business administration, she may choose to list her credentials as MBA, BSN, RN. When listing a combination of nursing and non-nursing degrees, the non-nursing degree is listed first.

When do you use which credentials? It depends on the purpose. In clinical practice settings, typically only the licensure designation is used – Jonathan Jacobson, RN, or Becky Thompson, CNP. Because you need to know and follow the policy and procedure for proper use of your credentials on patient medical records and other facility-specific documents. When writing articles for publication or using your credentials for a presentation, all of your credentials should be provided, in the order listed above.

Use your credentials with pride! They mean something to you, to other healthcare providers, and to the public. Standardizing the way credentials are displayed helps people understand our education, expertise, and professionalism.


Pam Dickerson, PhD, RN-BC, FAAN
Director of Continuing Education
Montana Nurses Association
Simulation is a hot topic in the healthcare field today, especially nursing. Nursing programs have integrated simulation into curriculums across the globe. Yet, simulation is not a new tool. Recorded in the 17th century, as a tool to teach midwives difficult and complex deliveries. Simulation is used in basic life support and advanced cardiac life support training. Some of the first manikins that nursing students practiced on were adult clothing filled with straw simulating a patient, until Mrs. Chase, the first nursing manikin, was created.

Games, case scenarios, dissection, role playing are all forms of simulation. So why does simulation feel like it’s a new concept or technology? According to Webster, simulation is defined as, “something that is made to look, feel, or behave like it’s a new concept or technology?” Games, case scenarios, dissection, role playing are all forms of simulation. So why does simulation feel like it’s a new concept or technology? According to Webster, simulation is defined as, “something that is made to look, feel, or behave like it’s a new concept or technology?”

Simulation building and design takes skills and knowledge. Educators that are unfamiliar should set the stage, time frame, and any pre-work that may need to be provided to the learner. These foundational concepts will guide the overall design of the simulation scenario. As the simulation is built, adding components such as Moulage (sensory enhancements) can make the simulation more realistic, enhancing the memorable experience for the nurse. Before the simulation is finished, have a qualified peer complete a practice test through the simulation to ensure that there are no creases of confusion or pitfalls through the simulation. Remember that for the first few simulation that the educator designs, start off with small and short simulations to avoid getting overwhelmed. As the educator gets more experience with the simulation designing and planning, the complexity can increase.

Another part simulation design is the debriefing and evaluation time. The debriefing is where most of the learning occurs. Debriefing can be formal questions to the learners, have them answer or it can be a guided conversation. This is when the educator is able to evaluate if the learners reached the desired outcome. If the learners did not reach the desired outcome through the simulation, it is the duty of the educator to pull the pieces together so the learners can meet the original goal. It is a common practice that the debriefing time should be twice as long as the simulation time. In an hour time period, the simulation is actually 15-20 minutes, leaving 40 minutes for debriefing and evaluation time. However, if the educator is more familiar with the simulation technology by practicing the same material over and over again, thus saving time in the long run.

Simulation may sound like a new trend in education, but it has been a part of learning for years. Educators should embrace the opportunities to enhance the education experience of the nurses by integrating simulation. The hardest part is taking the first step. Simulation is an underutilized resource that has the potential to make priceless impacts.

Guest article by Christina Stillwell, MSN, RN, CCRN, CDP.
The Ohio Nurses Association was able to attend the State Science Fair at The Ohio State University and award 3 awards in the spring! Katherine Murphy took first place! She will use her award towards her nursing degree at Defiance College. Meghan Kessinger and Isha Sawhney both received Honorable Mentions. This summer, ONA’s Tools for the Future event, presented by the ONA Retired Nurses Forum, was a huge hit! We sold out months in advance. The reviews are in and the learner loved the event! “Best ONA event ever!” Everyone is ready to see what next year holds! During the event Tools for the Future, ONA was able to raise funds for the ONF through raffles. A special thanks to the following for your kind donations: Author David Publishing, American Federation of Teachers (AFT), and American Heart Association. Please look at all of our upcoming events in this issue of the “Ohio Nurse” as well as www.ohnurses.org/events.
Political Action Visits – A New Generation of Nurses Connecting with Legislators

In 1996, the American Association of Colleges of Nursing published *The Essentials of Master’s Education for Advanced Practice Nursing*. This document outlined core curriculum content for master’s education in nursing. The first core element was Research, Health Policy, Organization, and Financing of Health Care came in at number two. Since the publication of this document, and a subsequent revision that renamed the subject to Health Policy and Advocacy, most graduate nursing schools have added a health policy course. In these courses, graduate nursing students are socialized to be advocates for their patients and for the profession.

I have taught this course for the past decade, most recently at the Ohio State University. I am convinced that exposure to this content will result in nurse leaders who will influence the way scarce resources are allocated and impact the regulation of health care. Based on student feedback, I believe that this education is making a difference.

One of my course assignments is a political action visit, which requires students to visit a legislator, educate them about a nursing issue, and share opinions regarding current legislation. The following paragraphs are excerpts from students’ experience in getting to make their voices heard.

Cassie Bradford shares these comments, “I developed a real interest in the political side of nursing. I could honestly see myself being a part of some sort of advocacy. It might be working with HB 170! This bill would prohibit employers from taking actions against employees who refuse the annual mandatory influenza vaccination. Sometimes, all it takes is a quick meeting to educate [legislators] on an issue that they previously didn’t know about for changes to start happening! Our legislators and peers only know what they know. I understand this now and why it is so important to have the nurse’s voice in policy-making.”

Zach Scott visited Ohio House Representative Margaret Ruhl to discuss HB 216. This bill is known as the advanced practice nurse (APRN) modernization act that promotes independent practice. Zach commented, “As the co-sponsor, Representative Ruhl understands the fiscal and regional implications HB 216 would have for Ohio. She had a couple of questions regarding the difference between physicians and APRNs, and whether or not other physicians would be in support of this particular bill. She hopes this will become law and that [physicians] will come around to the issue. I enjoyed the appointment considerably and felt that Representative Ruhl understood our issue.”

Rachel Childs also discussed APRN issues with Ohio Senator Charleta Tavares. “We discussed the opposing arguments on behalf of physician lobby groups. The Senator identified a need for increased legislator education and strategic advocacy efforts. She had questions regarding the difference between physicians and APRNs, and whether or not other physicians would be in support of this particular bill. Senator Tavares advised that effective advocacy efforts should include a personal story that draws the legislator in, along with evidence in order to increase legitimacy surrounding the issue.”

Rachel summarized her experience, “Education is key. Nurses need to be aware of the issues they’re advocating for as well as the opposing arguments. Advocacy does not occur in a bubble. Legislators consider the implications of a specific bill against the backdrop of a wider, complex environment relating to their party, leadership goals, election funding, and political climate of their district. This visit was an incredible stepping-stone in beginning to develop advocacy skills. I will use this experience to advocate throughout my time in graduate school and beyond.”

We are educating a new generation of nurse leaders who will take their place at the political table and make their voices heard. Engaging in a conversation and educating legislators provides a context for future political involvement. Stepping onto the marble floor of the Ohio Statehouse is the first daunting step in developing advocacy skills and confidence in the legislative arena.

Peggy Halter, PhD, BSN, MSN

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developing a nursing IQ—Part II: the expertise of nursing process

this independent study was developed by: Barbara g. walton, MS, RN

Objective: enhance the ability to interpret the various levels of the cognitive domain and apply this understanding of the level to patient care situations as a critical thinking tool. 1.95 contact hours will be awarded for successful completion of this independent study.

the authors and planning committee members have declared no conflict of interest. this information is provided for educational purposes only. for legal questions, please consult appropriate legal counsel. for medical questions or personal health questions, please consult an appropriate health care professional.

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study

In this independent study, we will be looking at nursing process and exploring what a great critical thinking tool it really is. Now I know a lot of individuals groan when they think of nursing process, but it truly is a wonderful problem solving tool that leads us from a basic level of thinking and practice to higher levels of cognition and expert practice. In other words, it takes us into critical thinking. Nursing process leads us from a novice level of thinking to an expert level. first, we will look at some of the theory and review nursing process. we will then apply this information to a variety of cases and a case study to illustrate the theory we have discussed.

Levels of Thinking: Benjamin Bloom

Benjamin Bloom was an American educational psychologist who lived from 1913 to 1999. bloom organized educational learning into three domains. the domains are cognitive, psychomotor and affective. Each domain is further organized into levels of complexity, and bloom arranged the levels from the simplest, or a lower level, to the more complex, or a higher level of thinking. Bloom organized it this way so that it provides a framework for the formulation of objectives. when one completes a continuing education activity, there are always behavioral objectives. refer to the objectives at the beginning of this module. The objectives reflect the use of Bloom’s taxonomy. if you are trying to make a decision as to whether or not to participate in a continuing education activity, read the course objectives printed on the brochure. The objectives will give you an idea as to the complexity of the offering. if the objectives are very simplistic, the program may contain basic information. if the objectives reflect a more complex level, the program is more likely to be advanced. because critical thinking originates in the cognitive domain, we will focus the bulk of the discussion on the cognitive domain. however, i will briefly mention the psychomotor and affective domains below.

The psychomotor domain deals with our abilities to learn, utilize and adapt physical skills. Learning to ride a bicycle or to administer an intramuscular injection are psychomotor skills. How quickly someone is able to learn a psychomotor skill will be dependent on the complexity of the skill and the experience and physical health of the learner. Think for a moment about the psychomotor skills as well. Perhaps the purchasing of one’s co-workers. Just as with the psychomotor domain, the affective domain levels begin with an easy or simple level and progress to a more complex level of thinking and behavior. Think about when you were young and you may have hit your younger sibling out of frustration because he took your toy. your parents told you “It’s not nice to hit. We do not hit people.” That statement reflects receiving. In other words, you received the belief that hitting was not nice. Receiving and valuing might be reflected by the fact that you no longer hit your sibling, but when he or she did irritate you, you stuck your tongue out at him or her instead.

Organizing and characterizing are reflected by the fact that you no longer hit anyone and it is an option for dealing with frustration that does not even cross your mind. The cognitive domain deals with our abilities to learn, process and utilize information in a meaningful way. Within this domain we learn new information and generally quickly assimilate that new information. We learn by reading, listening, and experiencing new information. Memorizing all the bones of the body in anatomy class is in the cognitive domain. When we read the newspaper and learn new information or give consideration to an opinion—that is the cognitive domain. When we complete an independent study, such as this, we are learning within the cognitive domain. While clearly there are a lot of psychomotor skills and affective traits in nursing, there is a lot of nursing that takes place in the affective domain.

Look at the levels in the psychomotor domain. do you see how the levels reflect a simple, easy level and progress to a very highly skilled, functioning level? now think back to the first urinary catheter you inserted. or for many of you, in the absence of a rectal tube, have used a foley catheter with a 3-4 balloon? i also remember first inserting a foley catheter under the patient’s nose to stop a terrible nosebleed. the foley balloons were inflated to achieve a tamponade effect and stop the bleed. if you’ve ever used an item for another purpose or had to devise another means to achieve an outcome with a patient, you have articulated psychomotor skills. think for a moment about your own practice.

What procedures do you have to adapt to fit various patient scenarios? just think about all the ways we have of getting someone out of bed. an important aspect of articulation is that it is key procedural steps remain intact. For example, regardless of what orifice the catheter is to be inserted into, a key step would be to check the integrity of the balloon before it is inserted. It would also be important to inflate the balloon after it is inserted versus prior to insertion. just as it is key to deflate the balloon prior to removing the catheter from the patient! the affective domain deals with our abilities to learn and integrate attitudes, feelings and behaviors. Sometimes we integrate these together into a skill. for example, formulating a nursing care plan is a cognitive level, but being able to implement that plan is a nursing process. Nursing process leads us from a novice level to a more complex level of thinking or a higher level. the general rule of thumb is that it may take as much as six months, with diligent practice, to learn a new attitude, belief or habit. how many of you have made New Year’s resolutions? Perhaps you chose to exercise four times per week as your resolution. How much time has it taken you to adhere to that resolution? If you are successful at exercising four times per week for six months, you will have developed a habit for exercise. you will likely be more successful in adopting this as a lifestyle choice versus the person who gave up after exercising for two weeks. now think about the lifestyle changes that we ask patients to make. We expect them to change the way they eat, stop smoking, begin an exercise program, lose weight and manage their stress—all in one day! effectively we can learn this information about healthy lifestyles, but these are all habit changes and are generally not accomplished in one day. It may take six months, or more in the case of some individuals. The levels within the affective domain are receiving, responding, valuing, organizing, and characterizing. here are some examples of objectives regarding developing rapport with co-workers.

<table>
<thead>
<tr>
<th>Affective Domain</th>
<th>Taxonomy Sample</th>
<th>Behavioral Objective Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving</td>
<td>Points to Select Choices</td>
<td>Points to three positive characteristics of one’s co-workers.</td>
</tr>
<tr>
<td>Responding</td>
<td>Practices Conforms Shows interest in</td>
<td>Shows interest in learning a skill from a co-worker.</td>
</tr>
<tr>
<td>Valuing</td>
<td>Accepts Integrates Influences</td>
<td>Shares knowledge and/or skills with a co-worker in return.</td>
</tr>
<tr>
<td>Organizing</td>
<td>Adheres Complete</td>
<td>Is consistent in practicing the newly acquired skill and consulting with the co-worker.</td>
</tr>
<tr>
<td>Characterizing</td>
<td>Integrates Influences Solves</td>
<td>Integrates the newly acquired skill, learned from a co-worker, and collegiate attitude into everyday practice.</td>
</tr>
</tbody>
</table>

Psychomotor Level | Taxonomy Sample | Behavioral Objective Example |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Imitation</td>
<td>Follows the example of</td>
<td>Mimics the steps of Foley catheter insertion.</td>
</tr>
<tr>
<td>Manipulation</td>
<td>Carries out the procedure</td>
<td>Follows the procedure for Foley catheter insertion while maintaining the sterile field.</td>
</tr>
<tr>
<td>Precision</td>
<td>Demonstrates skills using</td>
<td>Demonstrates skill in inserting a Foley catheter.</td>
</tr>
<tr>
<td>Articulation</td>
<td>Carries out Is skillful in using</td>
<td>Is skillful in using Foley catheters in various settings and applications.</td>
</tr>
<tr>
<td>Naturalization</td>
<td>Is competent in using Skillfully uses</td>
<td>Is competent in inserting Foley catheters in a variety of patients.</td>
</tr>
</tbody>
</table>
I have the five rights?” recite the steps and the rationale for the steps as we do successfully administer the medications and we are diligent about following the procedure, comprehension give us. The trunk of the tree our thinking, which is what knowledge acquisition we come to understand concepts and ideas; that together smaller pieces of information to form bigger together, they form larger roots. Just as we pull join a health club or purchase a home exercise bike. difficult or impossible for him to undertake a home because he has arthritis in his knees, making it recognizing Mr. Chopin has difficulty exercising for the “whole picture,” or a more global view of indwelling catheter. I think of synthesis as a higher...
situations and uses maxims to guide practice. Maxims add nuance to situations and our practice. The advanced beginner begins to recognize problems and may recognize cyanosis as a problem and try to correct it. A proficient nurse, even though she recognizes cyanosis as unfavorable, recognizes that some patients, such as Mr. Mozart who has advanced emphysema, may never be totally devoid of cyanosis. So while cyanosis is not generally acceptable to the advanced beginner, it may still be acceptable to the proficient nurse with other patients may be acceptable. While this may be very confusing to an advanced beginner or a competent nurse, it makes total sense to the proficient nurse. Proficient nurses are able to perceive the meaning of situations as they apply to the long-term goals or outcome for individual patients.

The Expert Nurse: The expert nurse no longer relies on analytic principles such as rules, guidelines, and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions. I do not mean to say this nurse is a loose cannon. She still uses and practices according to rules, guidelines and maxims to connect her understanding of a clinical situation to appropriate nursing actions.

...
Let’s say Ms. Bartok is a relatively healthy individual, who is hospitalized for knee surgery following many years of skiing, playing basketball, and generally leading a vigorous lifestyle. The patient suddenly suffered a cardiopulmonary arrest would be an unexpected and undesirable outcome. Again because of your diligence and skill, Ms. Bartok is successfully resuscitated. However, this is not the end of the further assessment as to why she sustained a cardiopulmonary arrest. Ms. Bartok is worked up and found to have a cardiomyopathy associated with atrial fibrillation, which led to her suffering a small myocardial infarction when a blood clot passed into her left anterior descending artery, and resulted in the cardiopulmonary arrest.

To summarize nursing process:

Assessment

• Diagnose is problem recognition.
• Planning is what you intend to do about the problem.
• Intervening is what you did do.
• Evaluating is deciding if you were effective in obtaining the desired outcome.

Putting it all together: Bloom, Bennet & Nursing Process:

We’ve covered a lot of groundwork. Now we will pull all of this together. Think back to our discussion of levels of nursing expertise and the cognitive levels of thought. Don’t novice and beginner nurses think only about knowledge acquisition? While key thinking skills for the competent nurse are comprehension and application? Isn’t diagnosing or recognizing a problem the same as comprehension? In other words the nurse comprehends the significance of the data collected in regard to the patient and understands or comprehends there is a problem. As we approach synthesis and evaluation, these represent the highest levels of cognition, and the highest level of nursing process is evaluation. Proficient and expert nurses routinely think at these levels, reflecting expert care. Consider the table below.

<table>
<thead>
<tr>
<th>Nursing Process Level</th>
<th>Bloom’s Cognitive Domain Level</th>
<th>Benner’s Nursing Expertise Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess</td>
<td>Knowledge Acquisition</td>
<td>Novice to Competent</td>
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<td>Diagnose</td>
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<td>Plan</td>
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<td>Evaluate</td>
<td>Synthesis &amp; Evaluation</td>
<td>Proficient and Expert</td>
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Each level within a domain relates to the levels within the other domains. The assessment of nursing process is data collection. This is similar to Bloom’s knowledge acquisition. Through assessing a patient, we acquire knowledge about a particular patient problem as well as readily identify the outcomes of our practice. Some nurses refer to this as the “art” of nursing. Novice and proficient nurses master these skills at this level. For example, a patient is suffering from dyspnea. The competent to proficient nurse recognizes the dyspnea and plans to select/identify the problem. Let’s see why at this level the nurse is critically thinking.

Evaluation is the same as Bloom’s cognitive level of evaluation. This is the highest level of cognitive processing. At this level the nurse is thinking in terms of outcomes, pulling together many pieces of information not only in regards to the patient but also from experiences as well. They recognize problems, perhaps before they even develop. Let’s say Sharon is a postanesthesia unit nurse with many years of experience. Sharon is taking care of John, a sixty-six year old who has awakens suddenly from abdominal surgery, but then drifts back to sleep. Before he is fully awake and even able to talk to him, he is experiencing pain. She says he doesn’t want him waking up experiencing pain, so to prevent the patient from experiencing pain, she medicates him. When asked why she did this, Sharon is able to tell the less experienced nurse that when she sees a patient such as Mr. Litz awaken suddenly as he did, she intervention that he is attempting to experience pain. To keep the pain at bay and before the full effect of anesthesia wears off, Sharon medicates him in order to prevent this from happening. She says she doesn’t want him waking up experiencing pain, as that pain may become uncontrollable and make continued intervention ineffective. This depicts the thinking of an expert nurse. At this level the nurse often cannot even tell how she knows what she knows. She is working on an intuitive level. The expert nurse is constantly evaluating.

Case Study

In order to consider this case study, we will look for evidence of nursing process, cognitive level and identify what level of nursing expertise is demonstrated by the nurses. This is an actual case
that I reviewed in my role as a medical-legal nurse consultant.

The Case of the Blue Arm

Ms. Hadyn is a 26-year-old with a history of lupus and Raynaud’s phenomenon. She was admitted for treatment of a right neck abscess. Tylenol, Percocet 5, and Demerol and Vistaril were ordered on admission to treat mild, moderate and severe neck pain. She was also receiving IV antibiotics and Konyne (clotting factors). Ms. Hadyn was admitted to the care of R.V., a RN of medical-surgical nursing experience. The following are nursing process notes.

10 AM Percocet 5, 2 tabs given. IV remained from left arm. -B. Smith RN

2:45 AM MS 5 mg IV for Left arm pain

3 PM Tylenol grain X was given for complaints of pain in Left arm—J. Jones, RN

4 PM The IV that was in the right forearm was dry. IV was readministered in the left arm. -S. Jones RN

8 PM Patient complained of tingling of Left hand and fingers. She complained of swelling. -M. Smith RN

10 PM Complains of pain in left hand and arm, IV patent. Straight swelling of the entire arm, cool to touch and firm, slightly discolored. Pulse present.

10:30 PM Dr. Blue was called. “3” of Nitropaste was rubbed onto Left arm. Percocet 5, 2 tabs given for pain. IV removed from left arm.-B. Smith RN

12:45 AM Continues to complain of arm pain. Arm continues to be cool, circulatory status of arm is unchanged since 4 PM. -D. Davis, RN

3 AM Percocet 5, 2 tabs given for Left arm pain

4 AM Left arm and hand continues to be swollen, elevated on pillow.—J. Brown

8 AM Arm edematous, the hand is highly swollen. Finger joints are highly swollen and spongy looking. Skin, cool, skin dusky, unable to palpate radial pulse due to edema.

10 AM Crying complaining of much pain in left arm and hand. Demerol and Vistaril IM given.

11:30 AM Some relief noted, but the arm pain is not completely gone.

12 PM Dr. Blue is in to see patient

2 PM Morphine Sulfate 5 mg IV is given for complaints of severe pain. Left arm is the same. Patient is sent to the venous lab for a doppler study of the left arm.

4 PM Left arm continues. Patient states she has major edema in left arm. She is in pain. She is in the purple/blue in color, cool to touch.—D. Davis, RN

6:45 PM MS 5 mg IV for Left arm pain

8 PM MS 5 mg IV for Left arm pain

8:15 PM MS 5 mg IV for Right arm pain

8:45 PM MS 5 mg IV for Left arm pain

9:15 PM Demerol 2 mg IV for severe pain to Left arm. Patient crying. -M. Moore, RN

The doppler study completed at 2 PM revealed a large thrombus formation in the left subclavian vein, that was determined to be caused by the administration of Konyne (clotting factors). Ms. Hadyn was subsequently transferred to another hospital, where, in spite of efforts to save the arm, her left arm was eventually amputated at the shoulder. As it turned out, Ms. Hadyn did not have any type of bleeding disorder.

Discussion of the Case of the Blue Arm

Before proceeding, take a few moments to analyze this case study for yourself. Take a piece of paper and answer the following questions.

1. What are two main problems Ms. Hadyn is experiencing?
2. In regard to the first problem you identified:
   • What components of nursing process do you identify in the case study?
   • What level(s) of thinking are demonstrated?
   • What components of nursing expertise are demonstrated?
3. In regard to the second problem you identified:
   • What components of nursing process do you identify in the case study?
   • What level(s) of thinking are demonstrated?
   • What level(s) of nursing expertise are demonstrated?

Analysis of this case study:

The answer is no. So again, nursing process is evaluated in this case. There are no components of the nursing process from the nurses that are evaluated to identify the desired outcome of left arm pain. The nurse did not evaluate the effectiveness of the Percocet. At 10 AM, Ms. Hadyn is noted to be crying and complaining of much left arm pain. At this point, the nurse interdisciplinary team should have stopped and fully evaluated the pain as described. This nurse did assess diagnosis, plan and intervene regarding the pain. However, at 11:30 AM, after receiving the Demerol and Vistaril, Ms. Hadyn continues to complain of pain. Therefore, the nurse is not achieving the desired outcome of the pain medication and identify the fact she is not obtaining the desired outcome of pain relief.

With all these nurses, they are assessing, diagnosing, planning and intervening regarding the patient’s pain. The piece of nursing process that is evaluated is whether the nurses are obtaining the desired outcome. The nurses are reaching a competent level in attempting to manage the patient’s pain, but they are not evaluating the effectiveness of the nursing intervention. Therefore, the nurse remained in pain. However, the bigger issue is that all these nurses are not recognizing the problem that it is left arm pain, when one would expect the patient to be experiencing right neck pain. Therefore they are failing to diagnose this problem and they stop nursing process here, putting them all in the beginner level of practice (and the other nurses for that matter). The nurse is failing to recognize that the escalating level of pain, that not even Demerol and Vistaril are effective in treating. Had they asked, “Is this patient getting better or getting worse?” would have then identified the desired outcome she was attempting to achieve from the Nitropaste.

Let’s look at the circulation problem.

At 8 PM Ms. Hadyn complains of tingling in the left hand and fingers. The nurse collects this information and determines the patient is experiencing circulatory insufficiency. The IV remained patent without apparent problems. However this did nurse comprehend the significance of the complaint of tingling in the left hand? The nurse in this case has failed to recognize the complaint of tingling in the left hand as a new problem. Furthermore, they are all failing to recognize the complaint of left arm pain as a new problem and they stop nursing process here. Therefore the nurse has failed to recognize the left arm pain as a new problem and they stop nursing process here. If this nurse had known why she was using the Nitropaste, she would have then identified the desired outcome she was attempting to achieve from the Nitropaste.

If this nurse had known why she was using the Nitropaste and what outcome to look for, perhaps she would have realized she did not achieve the desired outcome from the Nitropaste and the nurse would have then identified the problem as a problem and contacted the physician again. However, this nurse does not comprehend or understand the use of the Nitropaste. She knows she is using the Nitropaste (knowledge acquisition, following the rule of following the doctor’s orders), but she too is demonstrating a beginner level of practice. She fails short of competence because she is not applying what she knows and further does not know why she is to administer the Nitropaste. It is absolutely critical that nurses understand why
things are done for patients, as it tells us the desired outcome.

At 12:45 AM the left arm is noted as continuing to be dusky in color and is swollen. This nurse collects this data (assesses). However, does she comprehend the significance of this information? The answer is no. If she comprehended or diagnosed a problem, she hopefully would have planned and intervened on behalf of the patient. Further, this nurse was aware of the fact Nitropaste had been applied at 10:30 PM, yet the arm remains compromised. Again, this is not the desired outcome from the Nitropaste application. This nurse also admitted to not knowing why the Nitropaste was applied. By admitting they don’t know the why of what they are doing, these nurses are admitting they do not understand application and therefore do not demonstrate even a competent level of practice.

The nurses continue in this mode of thinking throughout the remainder of the case study. At 8 AM for example, again we see data collected regarding the arm and hand; however, the diagnosis of a problem and subsequent plan, intervention and evaluation is missing. Had any of these nurses asked themselves the question: “Is this patient getting better or getting worse?” would they have recognized a problem and taken further action? What do you think? Is this patient getting better or worse?

Obviously this patient is getting worse. Given the situation, shouldn’t the nurses have minimally contacted the physician or made sure a physician saw the patient? The unfortunate fact in this case is that even when the physician did see the patient, while a doppler study was ordered, revealing a large thrombus in the left subclavian vein, it wasn’t until later that night the patient was transferred to another hospital. At that point, even having performed fasciotomies on the left hand and arm, it was not enough to save the arm. Furthermore the physician had ordered Konyne, which again is a preparation containing enough to save the arm. Furthermore the physician had ordered Konyne, which again is a preparation containing enough to save the arm. Furthermore the physician had ordered Konyne, which again is a preparation containing enough to save the arm. Furthermore the physician had ordered Konyne, which again is a preparation containing enough to save the arm. 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3. Fill out the registration form and return original or copies of the registration form, post test, evaluation and payment (if applicable) to: Ohio Nurses Association, 4000 East Main Street, Columbus, OH 43213.

References

References will be sent upon request.

Questions

Contact Sandy Swearingen (614-448-1030, sswearingen@ohnurses.org), or Joseph Hauser, MSN, RN, Director, Continuing Education (614-448-1027, jhauser@ohnurses.org).

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So why would an average nurse blog for other nurses, on a topic that ‘other nurses’ have also studied thoroughly, become the trusted experts on, and have actually become, themselves?

Hard to say.

Is it because ‘Health’ is simply a cool topic? Yeah, maybe. Nothing wrong with living a long, happy life, full of nutritious food, restful sleep, vigorous exercise, meaningful work, heartfelt relationships, intellectual stimulation, and everything else that encompasses good health.

Is it because when the ONA call came out for someone to accept this challenge, my email inbox became sprinkled with variations of, “You ought to try this,” from friends, work colleagues, and district association board members?

Is it because of the ANA Code of Ethics – Provision 5?

“The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.”

Yes. As professionals, we’re bound. You’ve got to admit, healthy nurses are important for the effective practice of nursing and the health of the general population. And this is one way to contribute.

On the ANA Healthy Nurse, Healthy Nation website, (highly recommended – check it out) ANA defines a healthy nurse as one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing. A healthy nurse lives life to the fullest capacity, across the wellness/illness continuum. Healthy nurses are strong, role models, advocates, and educators, personally, for their families, their communities and work environments, and ultimately for their patients.

Wow! That says a lot. Perhaps the reason that I am blogging, though, is that I am that ‘average’ nurse. Just like you, I’ve read and studied plenty about promoting health, safety, and integrity, maintain competence, and continue personal and professional growth. I’ve learned the right behaviors and understand why nurses’ families, communities, and patients should exercise, maintain healthy weights, clear their minds, rest, sleep, and eat nutritious food. However, do I consistently follow all the recommended behaviors myself? No way. Always a huge struggle! Always competing interests. . . . and always a new resolve to do better. Perhaps that’s the best and most realistic approach I can bring to a blog about healthy nurses. And the best and most realistic way to truly be a Healthy Nurse is to practice those health behaviors that are most satisfying. At least to start with.

I am Lucinda. I’ve been a nurse for over 30 years, and work full-time in professional development at a major medical center in Cleveland. The best way to channel my own inner ‘Healthy Nurse’ is to follow the healthy behavior one of those people who will not drive a car when bicycle transportation will suffice. This is especially true for getting to work, and taking other short trips. Bicycling has to be a Healthy Nurse Behavior. Pedaling burns calories. It reduces carbon emissions and use of fossil fuels. There is little that is more invigorating than wind whooshing across my face (the faster the better). Whoops. Maybe not too fast. Unbridled speed, together with reckless abandon is a sure recipe for accidents and falls. Broken bones. Definitely no longer healthy. Back to that balance and synergy concept from the ANA definition. Slow down. Be safe. Enjoy.

A Healthy Nurse blog has to be about more than just bicycling, however. It has to include other Healthy behaviors of interest to more nurses.

So what would be of interest? I’d appreciate any and all suggestions. To start off, I played a little game – sort of like those mental tricks designed to stimulate/preserve brain health. I listed ‘Healthy Nurse’ words alphabetically. Take a look. Add to the list. And let us know which topics are of greatest interest. We’ll start with those. Just like the best way to become a ‘Healthy Nurse’ is to start practicing the most satisfying health behaviors, the best way to start a Healthy Nurse Blog is to write about the most satisfying topics.

Lucinda Cave MSN RN BC

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**Healthy Nurse Alphabet**

- A – Adequate Sleep, Aging, Antioxidants, Aromatherapy
- B – Back Health, BMI, Brain Health, Breastfeeding
- C – Clean Air
- D – Diet, Disaster preparedness
- E – Emotions, Energy, Environment, Ethics, Eye Care, Exercise
- F – Fitness, Flossing
- G – Gardening, Going Green
- H – Healthy Nurses (Of Course!)
- I – Immunizations, Integrative Modalities
- J – Joy
- K – Kindness
- L – Laughter
- M – Meditation, Memory
- N – Nature, Nutrition
- O – Orthopedic Health (Had to move this one down from ‘bone health’)
- P – Peace
- Q – Quality Care, Quitting Smoking
- R – Reiki, Relaxation, Rest, Running
- S – Safety, Sitting Reduction, Skin Care, Spiritual Health, Stress Management
- T – Training Effect
- U – Urgent Care
- V – Vegetables, Violence Reduction, Vitamins
- W – Waist Circumference, Water, Weight Management, Work Environment
- X – X-Ray (Radiation) Exposure
- Y – Yoga
- Z – Zumba

(All right. Some of these are stretches, but you get the picture.)

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**Ohio Nurse**

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