The North Dakota Nurse

NDNA
NORTH DAKOTA NURSES ASSOCIATION

NORTH DAKOTA NURSES ASSOCIATION

THE OFFICIAL PUBLICATION OF THE NORTH DAKOTA NURSES ASSOCIATION
Sent to all North Dakota Nurses courtesy of the North Dakota Nurses Association (NDNA). Receiving this newsletter does not mean that you are a member of NDNA. To join please go to www.ndna.org and click on "Join."
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Vol. 85 • Number 4 **November, December 2016, January 2017**

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Raise It for health north dakota

YES 4 KIDS! YES 4 VETERANS! YES 4 HEALTH! YES ON MEASURE 4!

PROFILE UPDATE

Don't wait! Update your MyANA profile today!

President's Message

Culture of Safety: It starts with you!

Roberta Young

Roberta Young MSN, RN, President NDNA

ANA continues to define different facets of culture of safety while nursing is called to lead this work. NDNA will be embarking on a revised Advocacy Platform this month as the North Dakota Legislative Session gets into full swing. Several points will directly tie to enhance culture of safety such as attention to workplace violence and increasing numbers of behavioral health care providers. Development of this platform took collaboration, studying of the issues, prioritizing causes, and leadership.

Leadership from the middle is one of the monthly topics on Culture of Safety promoted by ANA in August. (http://nursingworld.org/CultureofSafety-August) I feel that there is an important message for all of us in this discussion because it explores the myths of leadership. To enhance and solidify a culture of safety we all need to step into leadership.

One of the first prevailing myths of leadership is that it is left to the formal roles of management. Nothing could be further from the truth. Nurses in all types of practice, in all types of settings need to be able to communicate effectively, take charge of situations as needed, adapt to change while keeping values and ethics genuine. This is leadership in action; nurses need to continually develop and sharpen their skills. In this way, we can continually improve patient care. As nurses, we are the most consistent presence; our actions and missed actions are keys to safety. I'm confident that you can reflect on a time that you spoke up regarding a concern when others did not. Or ever observed a colleague take a deep breath, speak up, and bring calm, common sense, and a way forward into a complex situation. I remember a time early in my career as an adult ICU RN, we were caring for a man in extreme respiratory distress with an unknown cause. He was suffering from air hunger, and several well intended providers from many specialties were discussing the priority etiology. I was very frustrated, not in the best frame of mind to "lead" from, but spoke up and said, "so does it matter right now why, can we just get him more comfortable and before we have a full blown respiratory arrest?" You don't wait for formal leadership in times like this… a nurse needs to step up to do the right thing.

A tip, if you find yourself thinking, this is not my role, or my place to speak up; think again. It might be the perfect time to speak up.

Leadership skills are not all "soft" skills as many believe. To be effective, yes there is much value in continual learning about people, teams, and communication. Effective messaging is very important, but often it is the unpolished, still quiet voice that speaks up that is most powerful. I feel two of the most powerful leadership learning tools are self-reflection and a very good confidant to give you honest feedback. Learning comes from being humbled. This is certainly not pleasant in the moment but so powerful for growth and wisdom.

A third myth about leadership is that people are born leaders. Not true. Leadership is a whole box of critical thinking skills and tools that can be learned, practiced and improved. We all have the ability as we care for patients and our team members, plus we have the ethical obligation to be brave and stretch those skills.

One path forward is to look under the "Practice" tab at Nursingworld.org and click on 2016 Culture of Safety. There are several webinars to participate in and links for useful, leadership stretching, articles. Nurses Rock in making a safe culture being leaders. ANA membership can provide more education and learning opportunities for you. If you not currently a member of NDNA, I want you to take that step. We need leaders like you!!

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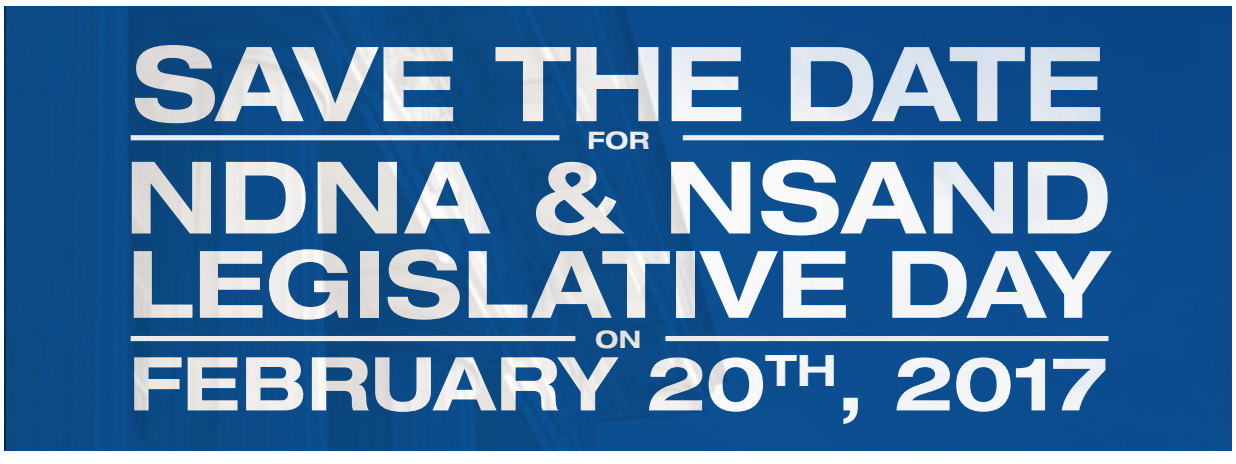

NDNA 2016 Culture of Safety Conference & Annual Meeting

Pat Hill speaking at the NDNA 2016: Culture of Safety Conference

THANK YOU to the 80 plus attendees for participating in the NDNA 2016 Culture of Safety Conference on October 7th! We had a successful conference and very diverse group of speakers including Pat Hill, RN, and Melissa Hanson MSN, RN from the North Dakota Board of Nursing, Jesse Breidenbach, PharmD & Kristin Roers MS, RN, CPPS from Sanford in Fargo, Jacki Bleess, PMHNP-BC, MSN, APRN from Prairie St. Johns and Midwest Mental Health Clinic in Fargo, Dr. David Saxon, West Region Medical Director in Dickinson, Jerry Stein from the Bismarck Police Department and a very moving & inspirational story from Jackie Binstock. We THANK ALL OF YOU for speaking and providing our attendees with such great and current information! Also a huge THANK YOU to our sponsors: Arthur L. Davis Publishing Agency in Iowa, Country House Memory Care and Kensington Evergreen Dickinson, CHI Dickinson, Sanford Health Dickinson, IRET Properties, Dakota Travel Nurse, and Trinity Health in Minot.

On Saturday, October 8th members of NDNA held their Annual Meeting. Reports from current board members, installation of new board members and of course bylaws changes were on the agenda! Committees met and discussed membership, communications, education, advocacy and finance. Thank you members of NDNA for ALL of your input and time given to NDNA. After the Annual Meeting the NDNA board met for a collaborative meeting with the Nursing Student Association of North Dakota. The two boards are planning a Legislative Day on February 20th at the Capitol in Bismarck. We look forward to seeing you all there! SAVE THE DATE!

One of several Committee Meetings of the North Dakota Nurses Association

Welcome New Members

Brittny Riemer
Theresa Langenstein
Erika Fazardo
Ariel Mack
Debra Emo
Tracy Bina
Payton Borud
Kaitlyn Lundstrom
Lindsey Markel
Danica Kochis-Belleque
Joseph Vetter
Alyssa Blumler
Nicole Podliska
Mary Schiel
Katie Johnson
Carly Hanson
Collette Christoffers

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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.

Congratulations to our New Board Members

Employer – Sanford Health, Occ MED, Dickinson

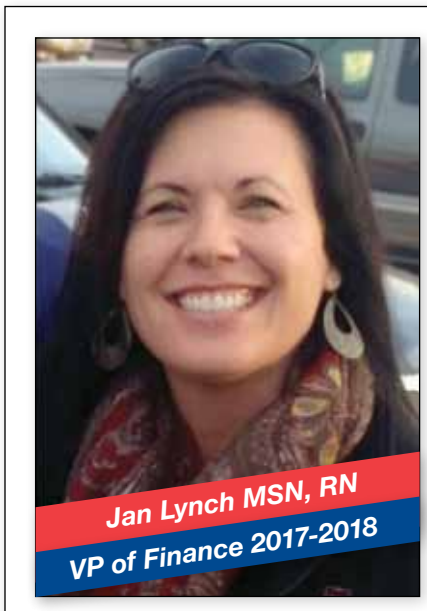
I have a genuine passion for nursing and nursing practice in the state of ND. I have been the VP of membership for NDNA during this last year. During my term as VP of Membership so far, I feel that I have the ability to do more, and give more time to the nurses in the state. Being part of the board has shown me the selfless time, effort and dedication it takes to be a board member and I want to help the board and the nurses in the state be the best they can be.

Employer – Sanford Health, Fargo

My desire to serve comes from wanting to be a part of the discussion when it comes to change. I firmly believe we all need to take an active role when it comes to the decision making process for things we feel strongly about. As NDNA works with government to create a healthcare system that works for everyone, our voices as nurses are imperative. As a student nurse, I was involved on the Curriculum, Admissions/ Progression, and Assessment/ Evaluation Committees. I was also a peer selected representative on our Student Council. As a member of the Nursing Student Association (NSA), I served as Vice President and I chaired both the Apparel and the Heart of the Herd Committees. Through my involvement in NSA, I was also awarded Student Nurse of the Year, the Student Leadership Award, multiple local scholarships, and the National Council of State Boards of Nursing Scholarship. I am also involved in the military and have been involved in all the leadership training that is a part of that. I was awarded a Medal of Honor as the top graduate from my Advanced Individual Training course and promoted to a Non-Commissioned Officer after 2 years of service.

Employer – Manager at Altru Health System, Grand Forks

I am a motivating, people oriented, collaborative nurse manager with over 20 years of leadership experience in the fast-paced, inpatient world of health care. Results orientated leader with focus on patient, family, physician, and staff relationships, evidence-based care, quality management, customer satisfaction, productivity and financial performance. Greatest strengths: team-building focused on mission, vision, and values of the organization; facilitating professional growth and development with coaching; strong communication skills; and financial strategic planning.



Employer – United Tribes Technical College, Bismarck

Greetings! I have been a nurse since 1995, first as an LPN, then an RN in 1997. I graduated with a Masters in Nursing with an Education Specialization in 2008. In my 20+ years of Nursing experience, I have worked in a plethora of practice areas. My primary acute focus was OB for 11 years. After leaving the hospital, I worked in long term care, long-term acute care, research (contract research company), school nursing and finally academia. I have always been interested in the challenges that face our profession and now that my children are older there is no better time for me to be involved.

Professor on the Prairie

How to embrace being a professional nurse.

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

80 % of success is showing up. ~Woody Allen

"Showing up" is not the act of punching in . . . it is the action of bringing the best "you" to work. The "you" that remembers that it is a privilege to be a witness in your patient's life at an intimate time – even their best friends might not have this privilege.

Trish Strom

Don't wait for leaders; do it alone, person-to-person. ~Mother Teresa

If we wait for the formal leaders to direct all positive change, we are setting them up for failure. It is recognizing as professional nurses our responsibility to provide leadership in the areas we know best ~ the unit where we practice professional nursing, the communities we live in as professional nurses, etc.

Integrity is honesty carried through the fibres of the being and the whole mind, into thought as well as action so that the person is complete in honesty. That kind of integrity I put above all else as an essential to leadership. ~Pearl S. Buck

Mind, body and spirit . . . the building blocks of holistic nursing. Also the building blocks of professional nursing. Honesty in words, thought, and action brings congruence, we are exhibiting integrity. Example: if we, as professional nurses, understand that a healing environment includes the nurse as a person, yet show up to work grumpy, complaining, and unavailable to others (patients/families/peers), we are not showing integrity. Are there ways to keep on track? First ask yourself what you really want – then act in a way that will get you what you want. Also, think about what your values are related to professional nursing – then act in a way that speaks those values to others.

As soon as I saw you, I knew an adventure was going to happen. ~Winnie the Pooh

Greet each new day, each new patient, and each new employee with the wide-eyed excitement of children preparing for an adventure! We have the ability (personally and professionally) to influence outcomes. Think about how we as a profession could start a revolutionary change in our work cultures!

When you talk, you are only repeating what you already know. But if you listen you may learn something new. ~Dalai Lama

Teachers and lessons are everywhere. Yet I find that sometimes in my need to get things checked off, knowledge passed on, and assignments completed, I talk, walk and listen too fast. Chances are, those days I have missed out on something pretty important and awesome – be it from my patient, my staff, my students—I'm sorry I missed it. Try and practice listening with intention every day.

I make 50 cents for showing up - and the other 50 cents is based on my performance. ~Steve Jobs

This can be applied to one's self, but it is also a perfect way to describe the Pay for Performance environment that healthcare lives in now. It's important to remember how you act, your performance affects the health of your patient and the health of your work place (both in measurable and non-measurable ways). In short – do the work, and do it well. Many are counting on us.

If you judge people you have no time to love them. ~Mother Teresa

Enough said.

Last but not least:

Piglet noticed that even though he had a very small heart, it could hold a rather large amount of gratitude. ~A.A. Milne

There are many things to be thankful for, but in relationship to my professional nursing career, I have a list. Thank you for my health. Thank you for the intelligence to do the important and sacred work of professional nursing. Thank you to the patients I have cared for, for trusting me to advocate on your behalf and to perform my work with excellence. Thank you to my students for teaching me grace and forgiveness every day, and for laughing at my jokes. Thank you to the staff I served for being shining examples of what excellence looks like. Thank you to my friends in nursing for sharing the same sick sense of humor that I have, for understanding that sometimes giving of one's self is hard, and for reminding me of why I do it – either by your words or actions. Thanks.

Member Spotlight

Jacki Bleess Toppen, PMHNP-BC
Featuring Lori Hahn MSN, RN

"The servant-leader is servant first. It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead." Robert Greenleaf.

For this member spotlight, we are getting to know more about Lori Hahn. Lori is in the heart of Boomtown, USA. In the midst of the 'fastest growing little town' in the western part of the state, she is managing to maintain her focus on patient safety and quality outcomes while finding creative ways to navigate the widespread workforce issues across the state. I had the opportunity to visit with Lori to learn more about her background and experience and how she has managed to become the successful nurse that she is today. Lori has been with NDNA for over 30 years and we are blessed to have a nurse like her on our team.

Lori Hahn MSN, RN

Tell us a little bit about your nursing career

I began my nursing career working as a nursing aide in a long term care facility in Devils Lake, ND. After graduating from UND with a BSN in 1984, I began working as an Emergency Room Nurse at Mercy Medical Center, Williston ND (now CHI St. Alexius Health Williston). For the next ten years I worked between ICU and ER, while teaching Advanced Cardiac Life Support to physician/nursing staff and rhythm interpretation/ defibrillation to the Williston Ambulance Service. In 1995, I transitioned to working as the Patient Care Coordinator and then Manager for the hemodialysis unit (a satellite unit of St. Alexius Medical Center) where I worked for 15 years. In 2010, I became the Quality Manger/CRO at Mercy Medical Center. In 2012, I secured the position of Chief Nursing Officer/Risk Manager; in the fall of 2015 the position transitioned to Vice President of Patient Care Services/Risk Manager.

When did you know you wanted to become a nurse?

I knew I wanted to become a nurse as a little girl; I loved playing with my little plastic medical kit. I also was known to find injured animals and try nursing them back to health (baby rabbits, ducks, mourning dove….). I had an aunt and an uncle who suffered CVA's with hemiparesis: I often stayed with and helped care for them.

Where was your first job?

My first job was selling concessions at the Lake Region Drive-Inn, in Devils Lake, ND.

What do you feel is the most rewarding thing about your profession?

I am humbled by the opportunity to touch people's lives in ways no other profession can; we as nurses are invited to sacred places in our patient's lives and as leaders our team member's lives. I love listening to their stories, working with them to find solutions to challenges, and the tears and hugs we share along the way. Nursing is one of the unique professions where you are afforded the opportunity to be a true servant leader.

How long have you been an NDNA member?

I joined NDNA in 1984.

How have you seen the NDNA change over the years since you have been a member?

Through the use of technology, NDNA is able to offer resources to all members; educational, employment resources, and advocacy. NDNA works collaboratively with other entities to find solutions for today's health care issues: i.e. mental health care shortages.

How have you been able to manage the workforce shortage in your organization?

We have been very creative in working through staffing challenges, particularly during the height of oil activity in our region. With day care shortages, many of our nursing staff had to decrease to part time or as needed only; we offer a variety of employment opportunities with and without benefits. Recognizing the need to have experienced staff, we worked with international companies to secure experienced long term contract staff. We then began working with our local nursing college (Williston State College) on strategies for improving the student's experience and recruiting new-graduates. In addition, we developed tier wages; allowing opportunities for nurses to advance if they chose to. Finally, we developed a Nurse Practice Council, where front line nursing staff provide input into their practice and work environment; our goal is to work towards Pathways to Excellence Designation.

What guidance would you give to a new nurse joining the profession?

I believe the best advice would be to join the nursing profession only if you truly love to serve others. Search for employers whose mission, vision, and values are in-line with your own personal values. Maintain a strong support system of family and friends and plan for opportunities for rest and relaxation ("fill your cup") in order to avoid burn-out and continue to serve others.

What has been the biggest change you've seen working in the Western part of the state?

We have definitely seen growth and diversification in population and business. There are many young families moving to our area; our deliveries have more than doubled in the last 4 years. We work with people from all over the world and have the opportunity to learn from them and also must be able to provide resources to meet their needs. We have developed evidenced based strategies for caring for patients with higher acuity than we had seen in the past (trauma and medical).

What do you think sets you apart from other nurses?

That is a difficult question! I am a servant leader; I love what I do and see my work as a privilege not a job.

What do you consider the most rewarding thing about the nursing profession today?

We have access to so much more information than we did in the past; it is far easier to keep up on evidenced based practice and measure outcomes to insure we are providing high quality care and meeting our patient's expectations.

What factors do you think contribute the most to employee satisfaction?

I believe employees need proper orientation, individual feedback, and opportunity to provide input into work processes and their work environment.

What do you like to do in your free time?

I like to spend time at the lake with family; boating and fishing in the summer. In the winter, I love family visits and cheering for the Minnesota Vikings!

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

I would like to lead the nursing leadership team through the Pathways to Excellence Designation process, become a more active member in the NDNA/ANA, and hopefully be a wonderful grandparent some day.

YES 4 KIDS! YES 4 VETERANS! YES 4 HEALTH! YES ON MEASURE 4!

Raise IT for health north dakota

Measure 4

Measure 4 is health initiative to raise North Dakota's shamefully low cigarette and tobacco taxes from $0.44/pack to $2.20/pack. Raising tobacco taxes are a proven way to prevent kids from ever starting, encourage current tobacco users to quit, reduce health care costs, and fund important health and veterans' services in the state of North Dakota.

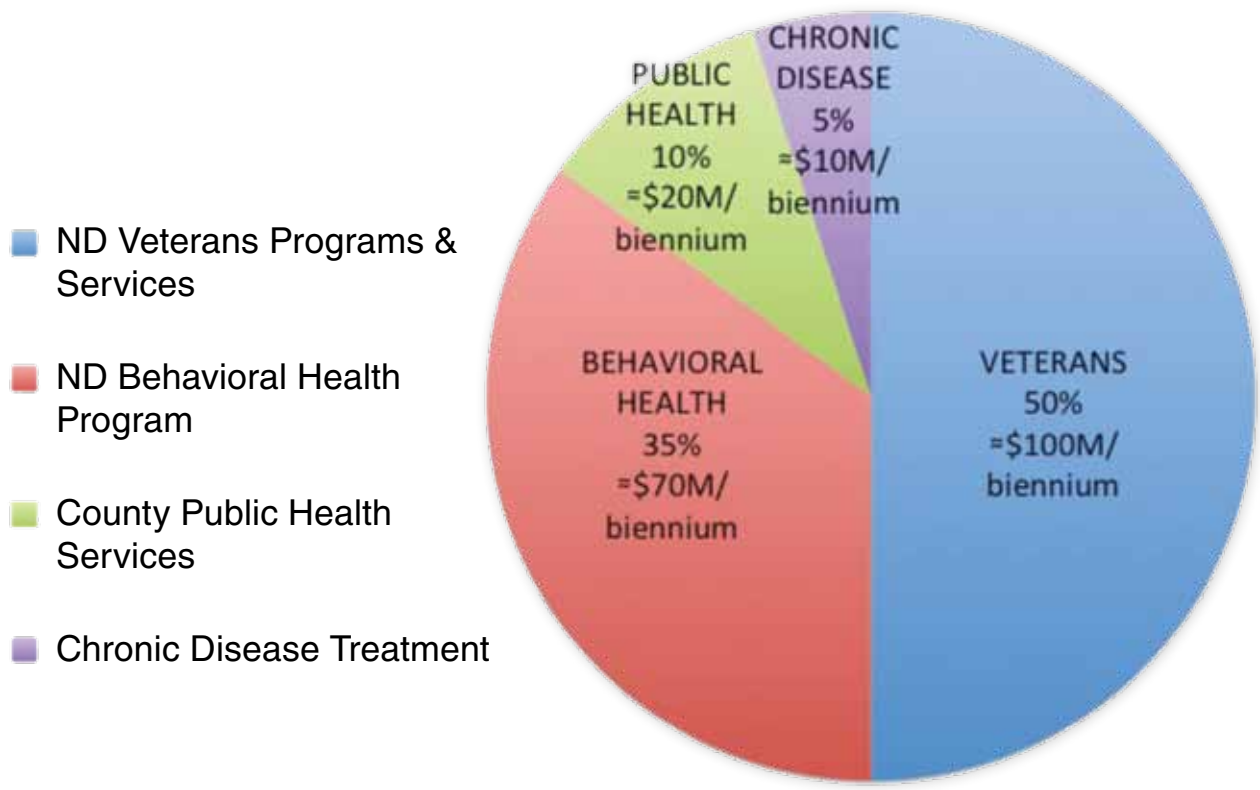
The measure is supported by more than 30 ND organizations, including the ND Veterans Coordinating Council, ALA, AARP ND and the ND Nurses' Association, among many others.

Benefits of Measure 4

Measure 4 has many wide-reaching benefits for the people of North Dakota:

- Measure 4 is estimated to decrease youth initiation rates by 20% and prevent 5,800 ND youth under 18 from ever starting.
- Measure 4 is estimated to lead to 6,600 current adult smokers quitting, and North Dakota already provides free services to help.
- Measure 4 would provide and protect funding for our state's veterans, crucial health care services and programs, and North Dakotans with mental health and addiction disorders, and chronic disease.
- Measure 4 would save an estimated $246.57 million in long-term health care costs from reductions in adult and youth tobacco use.

Tobacco Tax Measure NEW Revenue Allocations Estimated $200 Million/Biennium



Where does the funding go?

Fifty percent of new revenue will go to the Veterans Tobacco Tax Trust Fund to support a strategic plan for veterans' services and programs.

The other 50% will go to the Community Health Trust Fund to support the Behavioral Health Comprehensive Plan, essential local health unit services, and Department of Health support from chronic disease.

Quick facts about Measure 4

- Measure 4 was initiated by North Dakotans. Sponsoring committee members include medical/mental health/addiction recovery professionals, veterans, legislators and concerned parents.
- North Dakota tobacco tax currently ranks 47th in the nation for cigarette taxes, ranking below many tobacco-producing states.
- Measure 4 will reduce youth tobacco use.
- Measure 4 will help motivate tobacco users to quit.
- Measure 4 will save lives.
- Measure 4 will help reduce health care costs.
- Measure 4 will provide important program funding for veterans services, behavioral health, public health and chronic disease.

About the opposition

Measure 4's opposition is an in-state surrogate for Big Tobacco. Already, Altria and R.J. Reynolds have poured more than $1,000,000 into our state to try to defeat Measure 4 by spreading misinformation about the measure's intent.

Measure 4 will save lives while funding essential programs in our state. YES 4 KIDS! YES 4 VETERANS! YES 4 HEALTH! YES ON MEASURE 4!

Knowledge and Confidence Levels of Senior-Level Nursing Students in the Care and Treatment of Individuals with Parkinson's Disease

Jennifer Bailey DeJong, PhD, FNP-BC, IBCLC, CNE, Associate Professor of Nursing Concordia College, Independent Study Advisor for Kayla Doebbeling, Abigail Haugen, Nick Leen, and Cassie Scherer, Bachelor of Arts Nursing Students, Concordia College Nursing Department, Moorhead, Minnesota

Introduction:

Parkinson's disease (PD) is a chronic and progressive neurodegenerative disorder whose incidence is expected to double by the year 2030. According to the Parkinson's Disease Foundation (PDF), nearly one million people in the US are living with PD, which is more than the combined number of people diagnosed with multiple sclerosis, muscular dystrophy and Lou Gehrig's disease. One study ranked North Dakota first, South Dakota second, and Minnesota third in the nation in prevalence of Parkinson's disease (National Parkinson's Foundation of Minnesota). Despite the prevalence of Parkinson's disease in the region, many nursing students graduate before they are afforded the opportunity to deliver hands-on care during supervised clinical rotations to patients living with PD. Similarly, nurse educators struggle to find the resources and time to teach an ever-expanding curriculum, leaving students unprepared to effectively meet the quality and safety needs of these clients. In light of a growing number of people developing Parkinson's and the shortage of healthcare providers specializing in the disease, it is even more pressing that nursing students be prepared to care for patients with PD.

Purpose:

The purpose of this study was to assess senior-level nursing students' knowledge and confidence in caring for individuals with Parkinson's disease (IWPD) using a pre-test/post-test study design. The research was conducted by four senior-level undergraduate nursing students who were taking part in an independent study, guided and assisted by their faculty advisor in nursing, and a statistician. The students were referred to the HeartSprings Parkinson's Disease Support Group of North Dakota, and the Struthers Parkinson's Center (Park Nicollet Methodist Hospital) where Dr. DeJong was one of approximately 180 nurses to date who has participated in the Edmund J. Safra Visiting Nurse Faculty Program for Parkinson's Education (EJSVNF) since its inception in 2009. The EJS-VNF program is a 40-hour accredited "train the trainer" program which improves nursing care in PD by training faculty leaders across the United States so they can, in turn, educate nursing students.

Methods:

A literature review was conducted by the independent study group and reviewed by Dr. DeJong for accuracy. The literature review was focused on the pathophysiology of Parkinson's disease, clinical manifestations, pharmacological treatment, and non-pharmacological treatment of Parkinson's disease and how these topics related to nursing interventions for patient-centered care. Overwhelmingly, there was a lack of research found in regards to undergraduate nursing students' education about Parkinson's disease. To enhance their understanding and make connections with patients with PD, the students were required to attend one support group session through HeartSprings of North Dakota. The information gleaned from the literature review and through the support group meeting was used to create a 20-question true/false survey about the care of individuals with Parkinson's disease, as well as, a seven-item Likert-based survey about students' perceived confidence levels in caring for individuals with Parkinson's disease. The confidence survey used a four-point Likert scale.

Prior to implementation, the 1-hour educational session PowerPoint that was prepared by the students, as well as the survey, was reviewed for content validity and reliability by two healthcare team members of the Struthers Parkinson's Center. Items were adapted as recommended to reduce confusion and enhance readability. An expedited IRB proposal was approved by the college.

At the beginning of a senior-level spring semester adult health course, students (n=25) were given the option of partaking in the research project. Informed consents were provided and signed. Students were advised that no risk or benefit to them would be gained by their participation, nor would there be any disadvantage to not participating in the study.

The pre-test was administered followed by an hour-long educational session about Parkinson's disease and the care of individuals with PD by the student investigators. Following the educational session, the post-test was immediately administered. Students were asked to provide a unique identifier on both surveys to link and compare pre- and post-test findings. No student names were documented on any surveys, and students were assured that their confidentiality and anonymity would be maintained. Surveys were kept in a locked office not accessible to other students. The results were analyzed using Statistical Package for the Social Sciences (SPSS) data software. Statistical significance was set at $p<.05$.

Results:

After the senior-level undergraduate nursing students participated in an hour-long Parkinson's educational session (n=25), they had increased post-test scores (M=3.88, SD=2.42) compared to the pre-test scores, $t(25)=8.01$, $p<.001$.

Furthermore, after the senior-level undergraduate nursing students participated in an hour-long Parkinson's educational session, they rated their perceived confidence levels in caring for individuals with Parkinson's Disease as higher (M=5.32, SD=2.48) compared to the perceived confidence levels prior to the intervention, $t(25)=10.73$, $p<.001$.

The score on the pre-test was not significantly correlated to the students' levels of perceived confidence prior to the educational session, $r(25)= -.27$, $p= .19$.

Question 4 stated "Do you believe you have had sufficient Parkinson's-specific educational opportunities through the Concordia College Nursing program up to this point in the curriculum in order to provide care to individuals with Parkinson's Disease (IWPD)?" Students were given the options of yes and no. There was not a statistically significant relationship between students who responded "yes" to question 4 and the Pre-knowledge score (M=19.25, SD=1.50) $t(4)= .61$, $p= .39$. However, there was a statistically significant relationship between students who responded "yes" to question 4 and the pre-confidence score (M=19.75, SD= .96) $t(4)= 2.25$, $p = .02$.

Interpretation:

The increased post-test score reflected an increase in knowledge regarding Parkinson's disease following the educational session. The perceived confidence level of students also increased following the hour-long educational session regarding the care of patients with Parkinson's disease. Interestingly, students who perceived themselves as more confident on the Likert scale questionnaire were <u>not</u> more knowledgeable about Parkinson's disease prior to the educational session. In addition, students who believed they had sufficient knowledge regarding Parkinson's disease (according to question four) did <u>not</u> have increased knowledge regarding Parkinson's disease but did have more confidence.

Discussion:

The educational session was effective in increasing the knowledge of students regarding Parkinson's disease, as well as, students' perceived confidence levels in caring for patients with Parkinson's disease. The students scored an average of 3.88 points higher on the post-test than on the pre-test. The perceived confidence levels increased from a mean of 17.16 on the pre-confidence response to 22.48 on the post-confidence response out of a possible 28 points (28 representing the maximum confidence level). When comparing pre-knowledge levels with pre-confidence levels of students, there was no significant correlation, but when differentiated with question four there was a significant negative correlation between having said "Yes" to question four and having a higher pre-knowledge score. This suggests that students who had a higher perceived confidence level may actually have less knowledge regarding Parkinson's disease than their peers who reported a lower perceived confidence level. This may represent a false confidence in their preparedness to care for individuals with Parkinson's disease without the knowledge base to justify it.

Limitations of the Study:

One limitation of the study is that one survey question needed to be eliminated from the analysis secondary to imprecise information presented during the educational session. As a result, the knowledge measurement was potentially less representative of the students' knowledge regarding that particular topic.

Knowledge and Confidence Levels of Senior-Level Nursing Students in the Care and Treatment of Individuals with Parkinson's Disease continued on page 8

Knowledge and Confidence Levels of Senior-Level Nursing Students in the Care and Treatment of Individuals with Parkinson's Disease continued from page 7

Recommendations for Future Research:

Recommendations for future research, include: a) using a larger population of nursing students, b) comparing junior-level nursing students' knowledge before their first clinical course with senior-level students' knowledge after their final clinical course, and, finally, c) dividing the class and only providing the educational session to a randomized control group, in order to validate that the educational session was indeed the source of the improvement in post-knowledge scores and not just by chance. Finally, utilizing an interdisciplinary case study approach has also been integrated into the students' curriculum for social work, nursing, dietetics, and long-term care administration at our institution, and further research on the effectiveness of this method on students' overall learning about the care and treatment of patients with PD is warranted.

Conclusion:

Despite the prevalence of Parkinson's disease in the region, many nursing students graduate before they are given the opportunity to provide hands-on care during supervised clinical rotations to patients living with PD. A one-hour educational session provided by students and a faculty advisor, who is an alumnus of the 2013 EJS-VNF program, who undertook a comprehensive literature review and attended a support group for patients with PD can be an effective means to increase undergraduate nursing students' knowledge and confidence levels in providing care consistent with the recommendations and practice guidelines of leading authorities, including The Parkinson's Disease Foundation and the Edmund J. Safra Visiting Nurse Faculty Program for Parkinson's Education (EJS-VNF).

More About the Edmund J. Safra Foundation and the Visiting Nurse Faculty Program for Parkinson's Education:

The Edmond J. Safra Foundation supports hundreds of projects related to science and medicine, education, religion, culture and humanitarian relief in over 40 countries. The Foundation has provided significant funding for Parkinson's disease research and patient care at dozens of hospitals and institutes in places as varied as Natal (Brazil), Toronto, New York, Grenoble, Paris, London, and Jerusalem. For more information, visit www.edmondjsafra.org.

Established by the Edmond J. Safra Foundation in 2009, The Edmond J. Safra Visiting Nurse Faculty Program offers faculty members from undergraduate nursing programs a 40-hour curriculum that includes academic instruction, hands-on experience with people with Parkinson's disease, independent study, and mentorship from nurse specialists at nationally recognized movement disorder centers. More than 180 nurse faculty have completed the program, returning to their classrooms better able to train the next generation. All alumni are expected to complete a project to benefit nursing education or patient care in Parkinson's disease.

Many of the program's alumni have gone on to become local leaders in Parkinson's disease care, with some developing into national leaders who are changing nursing education. Since 2014, the program has been housed at the Parkinson's Disease Foundation as part of PDF's commitment to training health care professionals. To learn about the program and to apply to upcoming trainings, please visit http://www.pdf.org/visitingnurse14.

Upcoming trainings are in: Baltimore, MD (June 2016), Minneapolis, MN (June 2016), San Francisco, CA (July 2016), Boston, MA (August 2016), Phoenix, AZ (October 2016), New York, NY (November 2016), and Philadelphia, PA (November 2016).

Resources for Nurses

The Edmond J. Safra Foundation at www.edmondjsafra.org

The HeartSprings Community Healing Center at www.heartspringscenter.com

The Midwest Parkinson's Organization at www.midwestparkinsons.org

The National Institute of Neurological Disorders and Stroke at www.ninds.nih.gov/disorders/parkinsons_disease/parkinsons_disease.htm

The Parkinson Foundation at www.Parkinson.org

The Parkinson Foundation of Minnesota at www.parkinsonmn.org

Parkinson's Disease Across the Lifespan: A Roadmap for Nurses at event.netbriefings.com/event/parkinson/Archives/nurses/register.cgi

Anti-Platelet Medication after Stent Placement

Appraised by:
Tia Sumption, RN Mayville State University, RN-BSN student
Amber Rauschendorfer, RN Mayville State University, RN-BSN student

Clinical Question:

Does taking an anti-platelet medication prevent cardiac complications after stent placement?

Articles:

Kwok, C., Rao, S., Myint, P., Keavney, B., Nolan, J., Ludman, P., . . . Mamas, M. (2014). Major bleeding after percutaneous coronary intervention and risk of subsequent mortality: A systemic review and meta-analysis. *Open Heart*, 1-12.

Poorhosseini, H.R., Hosseini, S.K, Davarpasand, T., Lotfi Tokaldany, M., Salarifar, M., Kassaian, S.E., & … Amirzadegan, A.R. (2012). Effectiveness of two-year versus one-year use of dual antiplatelet therapy in reducing the risk of very late stent thrombosis after drug eluting stent implantation. *Journal of Tehran University Heart Center*, *7*(2), 47-52.

Reza Khosravi, A., Pourmoghadeas, M., Ostovan, M., Kiani Mehr, G., Gharipour, M., Zakeri, H., & … Sarrafzadegan. N. (2011). The impact of generic form of Clopidogrel on cardiovascular events in patients with coronary artery stent: Results of the OPCES study. *Journal of Research in Medical Sciences*, *16*(5), 640-650

Tada, T., Natsuaki, M., Morimoto, T., Furukawa, Y., Nakagawa, Y., Byrne, R., . . . Inada, T. (2012). Duration of dual antiplatelet therapy and long-term clinical outcome after coronary drug-eluting stent implantation. *Circ Cardiovasc Interv*, 381-391.

Synthesis of Evidence:

We gathered data from research articles surrounding the topic of stents and antiplatelet therapy. One of the studies that we found from Khosravi et al. discussed "the impact of using generic clopidogrel after a coronary artery stent for 12 months after the patient received a bare metal stent" (2011 p. 640). The study found that the patient was less likely to develop a Major Acute Cardiovascular Event (MACE). The risks include bleeding, MI, and mortality (Kwok, et al). This is a very important finding as the cost of the generic clopidogrel is about 80% cheaper than the trade name. This could possibly help increase compliance with this patient type taking the medicine routinely. A second study that we utilized was from the *Journal of Tehran*, *University Heart Center*, written by Poorhosseini et al. that studied the effectiveness of two-year versus one-year use of dual antiplatelet therapy in reducing the risk of very late stent thrombosis after drug eluting stent. This study looked at the benefit of increasing the clopidogrel to 24 months to see if it had any greater significance on the results of complications found in regards to the cardiac complications. This study concluded that there was no greater benefit of taking dual antiplatelet therapy after 12 months. Another study also claims that 12 months should be the standard of care, yet also includes this will likely change as the research expands (Tada, et al, 2012). This will also be cost effective for most patients who find it hard to afford these medications.

Bottom Line:

Using dual antiplatelet (either Generic or Brand name) therapy for 12 months after percutaneous coronary intervention (PCI) proves to be effective against major acute cardiac events. This continues to be the standard of practice for most providers. Research is still being done to study whether or not the long term benefits of the antiplatelet therapy outweigh the risks. Many of the risk factors involved with antiplatelet therapy are increased in patients with underlying chronic diseases. Each provider is to carefully weigh these factors and increased risks against the benefits of the clopidogrel use. Further studies will be conducted and will continue to evolve as the research guides.

Implications for Nursing Practice:

Nursing can use this information to educate their patients on the importance of medication compliance and the consequences of not following medication orders. Nurses can also use this information to guide further research to increase knowledge base on future antiplatelet therapies and post stent treatments.

High-Dose versus Standard-Dose Influenza Vaccine

Appraised by: Heather Bergeron, RN, Mayville State University RN-to-BSN student Kathryn Mosher, RN, Mayville State University RN-to-BSN student Andrea Rall, RN, Mayville State University RN-to-BSN student

Clinical question:

In patients 65 years and older, how does the use of high-dose influenza vaccine, in comparison with standard-dose influenza vaccine, differ in protecting the patient from developing influenza?

Articles:

DiazGranados, C.A., Dunning, A.J., Kimmel, M., Kirby, D., Treanor, J., Collins, A., &… Pollak, R. (2014). Efficacy of high-dose versus standard-dose influenza vaccine in older adults. *The New England Journal of Medicine*, *371*, 635-645. doi:10.1056/nejmoa1315727

Falsey, A. R., Treanor, J. J., Tornieporth, N., Capellan, J., & Gorse, G. J. (2009). Randomized, double-blind, controlled phase 3 trial comparing the immunogenicity of high-dose and standard-dose influenza vaccine in adults 65 years of age and older. *The Journal of Infectious Diseases* (200), 172-180. http://dx.doi.org/10.1086/599790

Fry, A. M., Kim, I. K., Reed, C., Thompson, M., Chaves, S. S., Finelli, L., & Bresee, J. (2014). Modeling the effect of different vaccine effectiveness estimates on the number of vaccine-prevented influenza-associated hospitalizations in older adults. *Clinical Infectious Diseases*, *59*(3), 406-409. doi:10.1093/cid/ciu328

Parodi, V., de Florentiis, D., Martini, M., & Ansaldi, F. (2011). Inactivated influenza vaccines recent progress and implications for the elderly. *Drugs & Aging*, *28*(2), 93-106.

Moro, P. L., Arana, J., Cano, M., Menschik, D., Yue, X., Lewis, P., & ... Broder, K. (2012). Postlicensure safety surveillance for high-dose trivalent inactivated influenza vaccine in the vaccine adverse event reporting system, 1 July 2010–31 December 2010. *Clinical Infectious Diseases*, *54*(11), 1608-1614.

Synthesis of evidence:

Adults 65 years of age and older are at increased risk, in comparison with younger adults, to influenza infection and complications related to influenza infection (DiazGranados et al., 2014). Morbidity and mortality have not declined, even with an increased rate of immunization (Falsey et al., 2009). Immunization is currently the best prevention against contracting influenza. Adults 65 years of age and older have a decreased antibody response to standard-dose influenza vaccine in comparison with younger adults (DiazGranados et al., 2014). To combat this problem, a high-dose influenza vaccine was developed to elicit a better immune response in adults 65 years and older. High-dose influenza vaccine contains four times as much hemagglutinin as standard-dose vaccine, and was designed this way to elicit a better immune response in older adults (DiazGranados et al., 2014). Protection elicited for elderly adults from the high-dose influenza vaccine is estimated to be at 62%, which is a level of protection similar to that seen in younger adults with standard-dose influenza vaccine (DiazGranados, et al., 2014).

With team collaboration, a PICO question was developed to help determine the difference in protection between high-dose influenza vaccine and standard-dose vaccine for adults age 65 and older. Critical appraisal of research was conducted to answer the following PICO question: In patients 65 years and older, how does the use of high-dose influenza vaccine, in comparison with standard-dose influenza vaccine, differ in protecting the patient from developing influenza? A total of 17 research articles were critically reviewed. We chose 5 articles that supported our question with the highest quality and strongest evidence. Review of the articles revealed the following key points:

- Influenza causes a substantial amount of illnesses, hospitalizations, and deaths each year (Fry, Kim, Reed, Thompson, Chaves, Finelli, & Bresee, 2014).
- Persons whom are 65 or older experience a decreased antibody response and protection from vaccines in comparison to that of a younger adult (DiazGranados et al., 2014).
- Multiple factors affect the older adults seroconversion, including chronic illnesses, years of medication use, and nutritional issues (Falsey et at., 2009).
- High-dose influenza vaccine contains four times as much hemagglutinin as standard-dose vaccine, and was designed this way to elicit a better immune response in older adults (DiazGranados et al., 2014).
- One study concluded that adults 65 and older should receive a vaccine that has two high doses of antigen to reach an acceptable antibody response (Parodi, 2011).
- The high-dose vaccine helps to defend against both A and B strains of influenza (Falsey et al., 2009).

Bottom Line:

High-dose influenza vaccine is clearly more effective than standard-dose influenza vaccine in decreasing the risk of contracting influenza in adults 65 years and older as evidenced in the critical appraisal of the literature. Evidence also supports a decrease in the complications associated with influenza infection related to the reduced severity of the influenza disease, even when the vaccine effectiveness is low (Fry, Kim, Reed, Thompson, Chaves, Finelli, & Bresee, 2014). The adverse effects of the high-dose vaccine are only slightly more than the standard-dose vaccine and there was no permanent ailment of people who received the high-dose vaccine (Moro et al., 2012).

Implications for nursing practice:

As nurses, it is important to be aware that adults 65 and older have a decreased antibody response to standard-dose influenza vaccine and there is a high-dose influenza vaccine available which is more effective for this age group in preventing influenza. Educating patients this age group on the availability of the high-dose vaccine and the increased efficacy can result in increased immunization rates. This could decrease influenza related complications and hospitalizations, with the potential to decrease morbidity and mortality related to influenza.

Probiotic and C-Difficile Infection

Appraised by: Bonnie Overby, RN, Mayville State University RN-to-BSN student; Jessica Kloster, RN, Mayville State University RN-to-BSN student; Rachel Ramsay, RN, Mayville State University RN-to-BSN student

Clinical question:

In adults receiving antibiotic therapy, does the use of probiotic (compared to not using a probiotic) affect the incidence of C-diff infection?

Articles:

Johnston, B.C., Ma, S., Goldenberg, J.Z., Thorlund, K., Vandvik, P.O., Loeb, M., & Guyatt, G.H. (2012). Probiotics for the prevention of clostridium difficile-associated diarrhea. *Annals of Internal Medicine*, *157*(12), 878-888.

Mergenhagen, K., Wojciechowski, A., & Paladino, J. (2014). A review of the economics of treating clostridium difficile Infection. *Pharmacoeconomics*, 32(7), 639-650. doi:10.1007/s40273-014-0161-y

Plaza-Diaz, J., Gomez-Llorente, C., Campaña-Martin, L., Matencio, E., Ortuño, I., Martínez-Silla, R., & ... Fontana, L. (2013). Safety and immunomodulatory effects of three probiotic strains isolated from the feces of breast-fed infants in healthy adults: Setoprob Study. P*los ONE*, *8*(10), 1. doi:10.1371/journal.pone.0078111

Suardi, E., Crippa, F., & Monforte, A. d. (2013). Probiotics in the prevention of antibiotic-associated diarrhea in adults. *International Journal of Probiotics & Prebiotics*, *8*(1), 41- 44.

Synthesis of evidence:

Clostridium difficile infection (*C-diff*) is increasing the burden on healthcare with its adverse events from antibiotic use. Antibiotics strongly associated with *C-diff* include clindamycin, third generation cephalosporins and fluroquinolones. Probiotics are microorganisms believed to counter-act disturbances caused by antibiotics and reduce the risk of colonization by pathogenic bacteria. *C-diff* symptoms include multiple, foul-smelling loose stools with stomach cramping and can lead to toxic mega-colon, colectomy and even death (Mergenhagen, Wojciechowski, & Paladino, 2014). Because of this increasing health care burden, research was conducted to answer the PICO question, in adults receiving antibiotic therapy, does the use of a probiotic (compared to not using a probiotic) affect the incidence of *C-diff* infection.

A total of 17 articles were critically appraised to help support the evaluation and answer the PICO question. The articles included in this abstract were narrowed down according to their strength in evidence and research quality. Review of the literature revealed the following key points:

- The systematic review and meta-analysis by Johnston, et al. (2012) found that there was moderate evidence that there was a large risk reduction in incidence of *C-diff* when using probiotics.
- A literature review by Mergenhagen, et al. (2014) found conflicting evidence with different trials. Due to the lack of conclusive efficacy evidence and potential side effects to certain populations, the use of probiotics to reduce the risk of *C-diff* was not recommended.
- The study done by Plaza et al. (2013) found that three certain strains of probiotics were safe to use with varying degrees of immune effects. Though the actual effect on *C-diff* infected individuals was not studied, discontinuation of a certain strain of probiotic resulted in an increase of *C-diff* in the feces of healthy subjects.
- The meta-analysis done by Suardi, Crippa & Monforte, (2013) concluded that although probiotic use is generally safe, research is lacking for support of beneficial evidence towards the reduction of incidence of *C-diff* associated diarrhea.

Bottom line:

Current research shows probiotics are safe to use in healthy adults. Additionally, research has shown potential for the therapeutic use of probiotics in preventing *C-diff* and its associated diarrhea. However, gaps in research studies include dosing, scheduling, strain of probiotic and inconsistencies in the manufacturing of probiotics. These gaps lead to a need for further research to be done in determining if probiotics are, indeed, effective in reducing the incidence of *C-diff* infection and its associated diarrhea.

Implications for nursing practice: As health care professionals, it is important to be aware that the use of broad-spectrum antibiotics may lead to *C-diff* infection and to recognize signs and symptoms of *C-diff* quickly for prompt treatment. Efforts should be made to prevent *C-diff* by encouraging only the necessary use of antibiotics. Utilizing infection control measures including proper handwashing technique will limit the spread of *C-diff*. Education should be provided to the patient on recognizing and reporting signs and symptoms of *C-diff*. The nurse can also provide education to patients receiving antibiotics suggesting probiotics in the form of nutrition, such as yogurt, as potentially preventing *C-diff* or in alleviating its associated diarrhea.

Vitamin D and Multiple Sclerosis

Appraised by: Cheri Baldwin, RN, Lauryn Christensen, RN, & Brittney Lommel, RN Mayville State University RN-to-BSN students

Clinical question:

Does taking a vitamin D supplement decrease the risk of multiple sclerosis (MS) in adults in the northern half of the United States compared to those who don't take a vitamin D supplement?

Articles:

Ascherio, A., Munger, K., & Luneman, J. (2012). The initiation and prevention of multiple sclerosis. *Nature Reviews. Neurology*, *8*(11), 602-611. doi: 10.1038/nmeurol.2012.198.

Mokry, L. E., Ross, S., Ahmad, O. S., Forgetta, V., Smith, G. D., Leong, A, & Richards, J. B. (2015). Vitamin D and risk of multiple sclerosis: A mendelian randomization study. *PLoS Medicine*, *12*(8), e1001866. http://doi.org/10.1371/journal.pmed.1001866

Vojinovic, S., Savić, D., Lukić, S., Savić, L., & Vojinović, J. (2015). Disease relapses in multiple sclerosis can be influenced by air pollution and climate seasonal conditions. Vojnosanitetski Pregled: *Military Medical & Pharmaceutical Journal of Serbia*, *72*(1), 44-49. doi:10.2298/VSP140121030V.

Synthesis of Evidence:

Multiple sclerosis (MS) is a debilitating neurological autoimmune disease that presents early in life with a mean onset of 28-31 years of age. This disease has no cure. The following PICO question was developed within team collaboration: Does taking a vitamin D supplement decrease the risk of multiple sclerosis in the northern half of the United States compared to those who don't take vitamin D supplements? Research has shown that those living in areas of high altitudes which results in lower sunlight are at risk for developing MS. What if taking a vitamin D supplement along with sunlight could help reduce the risk of this disease, and prevent relapsing of MS in patients? Several research studies were critically reviewed by our team to see if vitamin D plays a role in preventing MS. We narrowed our research down to 3 articles that rated high in both evidence and quality. Review of the literature revealed the following key points:

- In a genomic study n=33,996 four singe nucleotide polymorphisms (SNP) were associated with 25-hydroxyvitamin D level from sunlight. All four SNP's lay in or near genes strongly implicate in separate mechanisms influencing 25OHD. Next, a study was conducted to describe the effects of genetically lowered 25OHD on the odds of MS in the International Multiple Sclerosis Genetic Consortium Study, genetically lowered 25OHD. Alleles (variant form of a gene) were weighted by their relative effect of 25OHD levels by using sensitivity analysis. The conclusion was a genetically lowered 25OHD levels is strongly associated with increased susceptibility to MS (Mokry, Ross, Ahmad, Forgetta, Smith, Leong, & Richards, 2015).
- In the study conducted by Ascherio, Munger & Lunemeann (2012) a correlation between MS and the duration and intensity of ultraviolet (UV) rays was determined. Also, high latitudes which leads to lack of sunlight during most of the year limits vitamin D synthesis. Ascherio, Munger, and Luneman (2012) suggested populations living in northern United States and other high latitude areas should add vitamin D supplementation to their diets to help reduce the risk of MS.
- Vojinovic, Savić, Lukić, Savić, & Vojinović (2015) looked at environmental factors (sun light and air pollution) and the correlation in relapses of MS. Data was gathered over the course of 5 years, utilizing specialized agencies in meteorology and the Environmental Protection Agency. The months of the year were clustered into groups associated with the appropriate vitamin D level according to the seasons; low (January–April), high (July– October) and medium (May, June, November, December). This was then compared with the participants within the study to see if there was a relapse in MS. The conclusions indicated that there was a significant increase in relapses of MS during the low vitamin D months and a decrease in relapses of MS during the high vitamin D months (Vojinovic, Savić, Lukić, Savić, & Vojinović, 2015).

Bottom Line:

Living in the northern United States puts individuals at higher risk for multiple sclerosis as evidenced by our research appraisal. The identified research studies gave information that showed with the decrease in UV rays in the northern climates, individuals are unable to synthesize vitamin D. Individuals can supplement vitamin D in various forms to help lower their risk and possibly prevent multiple sclerosis. It is important that nurses understand the effects vitamin D can have on patients to aid them in prevention and treatment of MS. We must educate on compliance in taking this supplement to help reduce the risk of the debilitating neurological immune disease.

Implications for Nursing Practice:

Nurses may care for patients who have multiple sclerosis or work in an area where MS is a risk factor for the population. It is important for nurses to be educated on risk factors for MS and the relation of MS relapse in relation to Vitamin D. Nurses should have an awareness that vitamin D levels could be low in patients with or without MS. Nurses should advocate for patients with MS to ensure Vitamin D levels are monitored, and discuss the use of a vitamin D supplement with the interdisciplinary team. Nurses should also provide education on the studies performed that support the use of supplementing with vitamin D, vitamin D enriched foods, fish/cod liver oil and the need for obtaining the proper UV rays from sunlight to help decrease the risk factors for this debilitating, neurological autoimmune disorder.

Is Early Therapy/Ambulation Beneficial in Reducing DVT's Following Hip Replacement?

Appraised by: Molly Anderson RN, Stephanie Fugleberg RN and Randi McCausland RN (Mayville State University RN-to-BSN students)

Clinical question:

In adults following hip replacement is early therapy/ambulation compared to bedrest beneficial in reducing post-op DVTs?

Articles:

1. Parvizi, J., Azzam, K., & Rothman, R. (2008). Deep venous thrombosis prophylaxis for total joint arthroplasty: American Academy of Orthopedic Surgeons guidelines. *Journal of Arthroplasty*, *23*(7), 2-5.
2. Stewart, S. P. (2012). Joint replacement and rapid mobilization: A clinical perspective on rapid arthroplasty mobilization protocol. *Orthopedic Nursing*, *31*(4), 224-23.
3. Chiung-Jui Su, D., Yuan, K., Weng, S., Hong, R., Wu, M., Wu, H., & Chou, W. (2015). Can early rehabilitation after total hip arthroplasty reduce its major complications and medical expenses? Report from a nationally representative cohort. *Biomed Research International*, 20151-7.
4. Autar, R., Buyukyilmaz, F., Sendir, M., & Yazgan, I. Y. (2015). Risk level analysis for deep vein thrombosis (DVT): A study of Turkish patients undergoing major orthopedic surgery. *Journal of Vascular Nursing*, *33*(3), 100-105.
5. Kalisch, B. J., Lee, S. & Dabney, B. W. (2014). Outcomes of inpatient mobilization: A Literature review. *Journal of Clinical Nursing*, *23*(11/12), 1486-1501.

Synthesis of evidence:

Numerous studies have examined prevention methods for post-op deep vein thrombosis (DVT's) these include, surgical technique, pain management, mechanical and pharmacological prophylaxis and early mobilization.

The American Academy of Orthopedic Surgeons developed a set of guidelines for DVT prevention.[1] Patients should be mobilized as soon after surgery as possible, considering safety and pain, the goal being the first postoperative day.[1] Patients should be taught simple exercises including dorsiflexion and plantarflexion and done in sets of 10 to 20 during wakeful hours.[1]

Rapid Arthroplasty Mobilization Protocol (RAMP) is multi-modal technique trialed over 9 years on Total hip arthroplasty (THA) & total knee arthroplasty (TKA) patients in one Australian hospital.[2] This trial found ambulation alone is not adequate prophylaxis. A mobilization study included 195 post-TKA patients that were divided into two groups.[2] The early mobilization group walked within 24 hours following surgery. The control group walked the second postoperative day. "Incidence of DVT fell from 27.6% in the control group to 1.0% in the early mobilization group"[2] (p. 228).

A review of patients who had undergone THA from 1998 to 2010 were identified and compared in two groups: early rehabilitation and delayed rehabilitation.[3] Following TKA the use of early rehabilitation is associated a major reduction of DVT.[3] Mechanical prophylaxis includes rehabilitation, simple leg lifts, elevating the foot off the bed, isotonic and isometric exercises, and active and passive ankle motion.[3]

A group of 102 patients were studied to determine the levels of risk, the risk factors, and their odds ratio for postoperative DVT's following major orthopedic surgery.[4] DVT is affected by preexisting factors including orthopedic procedures, the presence of infection, and mobility level, age and sex.[4] Risk factors identified to be knowingly responsible for the occurrence of DVT were prolonged operation (>2 hours), prolonged immobility (≥72 hours), and high body mass index (BMI).[4]

Bottom line:

Evidence supports the benefit of early therapy/ambulation in adult postoperative hip replacement patients. Although no evidence supports the reduction of DVT's in postoperative patients related to early therapy/ambulation alone, reduction includes the study of early therapy/ambulation, though the main focus of the research is combined with the use of anti-coagulation, compression and reduction of risk factors. Research recommends further evaluation of interventions to reduce postoperative DVT's.

Implication for nursing practice: Total hip arthroscopy is a common procedure. According to the Center for Disease Control and Prevention (2010), roughly 332,000 hip replacement procedures took place in the year 2010. Each procedure putting patients at risk for DVT. Nurses play an important role in DVT prevention. This begins preoperatively with assessment of DVT risk and education of the benefits of early mobilization postoperatively. Pain assessment postoperatively is a key role of the nurse as pain management is vital in allowing patients participation in early rehabilitation. Studies have found that "ambulation of patients was identified as the most frequently missed element of inpatient nursing care, missed 76.1-88.7% of the time"[5] (p.1486). Given the known benefit of ambulation in DVT reduction, it is essential that ambulation not be overlooked in nursing care.

Ethical Component of Unused Frozen Embryo

Appraised by:
Andrea Solberg, RN Mayville State University RN-to-BSN student and Samantha Brekke, RN Mayville State University RN-to-BSN student

Clinical question:

What are the ethical components couples face when deciding the disposition of unused frozen embryos?

Articles:

Jin, X., Wang, G., Liu, S., Liu, M., Zhang, J., & Shi, Y. (2013). Patients' attitudes towards the surplus frozen embryos in China. *Biomed Research International*, 934567-934567 1p. doi:2013/934567

Paul, M. S., Berger, R., Blyth, E., & Frith, L. (2010). Relinquishing frozen embryos for conception by infertile couples. *Families, Systems, & Health*, *28*(3), 258-273. doi:10.1037/a0020002

Samorinha, C., Pereira, M., Machado, H., Figueiredo, B., & Silva, S. (2014). Factors associated with the donation and non-donation of embryos for research: A systemic review. *Human Reproduction Update*, *20*(5), 641-655. doi:10.1093/humupd/dmu026

Takahashi, S., Fujita, M., Fujimoto, A., Fujiwara, T., Yano, T., Tsutsumi, O., & ... Akabayashi, A. (2012). The decision-making process for the fate of frozen embryos by Japanese infertile women: A qualitative study. *BMC Medical Ethics*, *13*(1). doi:10.1186/1472-6939-13-9

Synthesis of evidence:

Science has progressed over the years to the point in which an egg has the potential to be fertilized by sperm in a laboratory setting, implanted back into the female, and pregnancy is achieved, if the process is successful. Although this advanced reproductive technology has brought great joy to many unfertile couples, several ethical implications arise when couples are left with the decision of what to do with their unused embryos. It has been estimated that there are roughly 400,000 frozen embryos in the United States alone (Paul, Berger, Blyth, & Frith, 2010).

Statistics such as this raise question to the complex and controversial process couples face when deciding the fate of their unused embryos. Following thorough research performed through partnership with my colleague, we implemented a PICO question to better understand the complex decision-making process and ethical dilemmas involved with the disposition of unused embryos following advanced reproductive treatments. The research accomplished helped comprehension of the following question: What are the ethical components couples face when deciding the disposition of unused frozen embryos? A total of twelve research articles were carefully critiqued. The search was cautiously condensed down to four quality research articles that served as strong relevance to our PICO question. The following key points were highlighted following review of the literature:

- Participants that described embryos as parental responsibility, a sense of ownership, and human life felt strongly about the embryo being protected at all costs. Participants that classified embryos before implantation as biologic tissue were more open to the idea of donating embryos for research purposes.
- Life circumstances, including clinic storage fees, the mother's health and emotional status, the age of current children, and sudden maternal or child health issues changing the family building process influenced couple's decisions about embryo disposition.
- A strong correlation exists between low-quality embryos, and the acceptance of embryo disposal by the embryo holders. The length of embryo storage, particularly greater than five years, influenced a couple's decision to discard embryos.
- Couples willing to donate embryos for research purposes reported strong feelings toward the positive benefits science, research, and medicine provide for the health care industry. Couples declining the donation of embryos for research found the risks, lack of information in regards to research projects and motives, and the conceptualization of embryos in terms of human life outweighed the benefits.

Bottom line:

Through a combination of research articles, we learned that many different outlooks on embryo disposition exist, and couples have to carefully consider the advantages and disadvantages of their personal decisions. Research on this topic needs continuous support in order to properly navigate the emotional and logistical complexities involved with the decisions of embryo disposition for future generations.

Implications for nursing practice:

As nurses we need to be aware of the ethical components couples face when they are choosing the disposition of their unused embryos. Couples face many different factors that influence their decision. It is our job to help them through this process by providing education in a compassionate manner regardless of how long the embryos have been frozen.

Timing of Administration of Chemical Prophylaxis in Orthopedic Surgical Patients

Appraised by: Kayley Peterson, RN, Mayville State University RN-to-BSN student and Kristen Young, RN, Mayville State University RN-to-BSN student

Clinical Question:

In adult preoperative orthopedic patients, does the administration of a blood thinner reduce the risk of blood clots postoperatively when compared to adult orthopedic patients who did not receive a preoperative blood thinner?

Articles:

Ahsin, S., Bashir, E. A., Faiz, S. A., Tahir, J., & Ijaz, A. (2014). Estimation and comparison of intra operative bloodloss in patients with and without venous thromboembolism prophylaxis. *Pakistan Armed Forces Medical Journal*, *64*(1), 71-74. Retrieved from: http://web.b.ebscohost.com/ehost/detail/detail?vid=126&sid=5e385047-ea14-47a8-b545-b1b37850c89b%40sessionmgr102&hid=110&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=a9h&AN=98269829

Dar, T., Wani, K., Ashraf, M., Malik, A., Ahmad, S., Gojwari, T., & Iqbal, A. (2012). Low molecular weight heparin in prophylaxis of deep vein thrombosis in Asian general surgical patients: A Kashmir experience. *Indian Journal of Critical Care Medicine 16*(2), 71-74. doi: 10.4103/0972-5229.99107.

Donath, L., Lützner, J., Werth, S., Kuhlisch, E., Hartmann, A., Günther, K., Weiss, N., & Beyer-Westendorf, J. (2012). Efficacy and safety of venous thromboembolism prophylaxis with fondaparinux or low molecular weight heparin in a large cohort of consecutive patients undergoing major orthopaedic surgery – findings from the ORTHO-TEP registry. *British Journal of Clinical Pharmacology 74*(6), 947-958. doi: 10.1111/j.1365-2125.2012.04302.x.

Perka, C. (2011) Preoperative versus postoperative initiation of thromboprophylaxis following major orthopedic surgery: safety and efficacy of postoperative administration supported by recent trials of new oral anticoagulants. *Thrombosis Journal*, *9*(1), 17-23. Retrieved from: http://web.b.ebscohost.com/ehost/detail/detail?vid=62&sid=5e385047-ea14-47a8-b545b1b37850c89b%40sessionmgr102&hid=110&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=a9h&AN=70213688

Synthesis of evidence:

Preventing blood clots in post operative orthopedic patients remains a high concern for health care professionals. Venous stasis due to of lack of activity and constriction of the limb due to casting or splints all contribute to an occlusion of blood flow. Postoperative blood clots are a significant reason for hospital readmissions and death. By reviewing several articles about the administration of preoperative anticoagulants versus postoperative anticoagulant administration, the research has shown very consistent information. The following articles highlight some of the main points of the research.

The purpose of the study from Ahsin, Bashir, Faiz, Tahir, and Ijaz (2014) was to show the effects of a preoperative anticoagulant on blood loss during surgery of mastectomy patients. The study was done on fifty female patients randomly divided into two groups of twenty-five patients. One group received pre operative anticoagulants and the other did not. They were all mastectomy patients and the surgeon and operating room staff were all the same. They did not know which patients received the anticoagulant and which didn't. The conclusion of this study was that pre operative anticoagulants did not have a significant difference on blood loss during surgery. (Ahsin, Bashir, Faiz, Tahir, and Ijaz, 2014)

Dar et al. (2012) was a blinded- prospective study over two and a half years was conducted on 215 high risk patients. 104 of the patients were in a prophylactic group, 108 were in a group without prophylaxis. Clearly defined results as follows; "the incidence of DVT was found to be 7.40% without prophylaxis, as compared with 0% in the study group" (Dar et al., 2015). Enoxaprin and nadroparin were the prophylactic drugs of choice and were administered one to two hours prior to the induction of anesthesia (Dar et al., 2012).

Donath et al. (2012) had investigated other trials and meta-analyses on LWMHs and fondaparinux and felt the populations in the studies may be affected by selection bias. So they utilized two large unselected cohorts of patients getting the two drugs at their facility to study. This included 3,896 patients who had underwent major orthoscopic procedures in a three year span. Symptomatic VTE was noted in 4.1% of patients who were given the LWMH and in 5.6% of the patients receiving fondaparinux (Donath et al., 2012). It is noted that at the LWMHs were started the night prior to surgery and the fondaparinux the evening after surgery and LWMHs had less rates of symptomatic VTE (Donath et al., 2012).

Perka (2011) reviewed three trials in an attempt to discover if pre operative anticoagulants are more effective than post operative anticoagulants in orthopedic patients. The trials consisted of patients receiving different types of anticoagulant medication. Some of these were preoperatively administered and some post operatively administered. Rates of DVT's and increased bleeding were reported. However, there was not a control group in any of the studies. This article suggests that based off of these studies, pre operative prophylaxis is not necessary (Perka, 2011).

Bottom line:

The majority of the research found for this PICO question states that a combination of mechanical interventions, an anticoagulant, and early ambulation are enough to prevent VTE's when initiated postoperatively. A preoperative anticoagulant doesn't necessarily harm or hinder the patient, as the research has indicated that there isn't always a significant increase in the amount of blood loss depending on the pharmacological agent chosen. Some articles mention the use of prophylaxis prior to surgery, although not specifically in a persuasive manner. It is mentioned that there are benefits to early VTE prevention. More evidenced based studies are needed to assist in determination of true benefit of chemical prophylaxis prior to orthopedic surgeries.

Implications for nursing practice:

It is important for nurses to be aware of signs and symptoms of VTE's and which patients are more at risk than others. Nurses should also recognize when their patients need to be on chemical prophylaxis and educate their patients on why the medication is so important. Helping to inform patients on VTE risk factors and medication administration and purpose can help prevent many complications for the orthopedic postoperative patient.

Surgical Site Infections after Delivery

Appraised by
Lisa Johnson, RN, Mayville State University, RN-to-BSN student
Megan Gathman, RN- Mayville State University RN-to-BSN student
Stephanie Davenport, RN, Mayville State University, RN-to-BSN student

Clinical question

In women during the postpartum period, does a vaginal delivery (as opposed to a cesarean delivery) decrease the risk of surgical site infections after delivery?

Articles

Amer-Alshiek, J., Alshiek, T., Almog, B., Lessing, J., Satel, A., Many, A., & Levin, I. (2013). Can we reduce the surgical site infection rate in cesarean sections using a chlorhexidine-based antisepsis protocol? *Journal Of Maternal-Fetal & Neonatal Medicine*, *26*(17), 1749-1752. doi:10.3109/14767058.2013.798291

Gong, S., Guo, H., Zhou, H., Chen, L., & Yu, Y. (2012). Morbidity and risk factors for surgical site infection following cesarean section in Guangdong Province, China. *Journal Of Obstetrics & Gynaecology Research*, *38*(3), 509-515. doi:10.1111/j.1447-0756.2011.01746.x

Gregson, H. (2011). Reducing surgical site infection following caesarean section. *Nursing Standard*, *25*(50), 35-40.

Kamel, A., & Khaled, M. (2014). Episiotomy and obstetric perineal wound dehiscence: Beyond soreness. *Journal Of Obstetrics & Gynecology*, *34*(3), 215-217. doi:10.3109/01443615.2013.866080

Thornburg, L., Linder, M., Durie, D., Walker, B., Pressman, E., & Glantz, J. (2012). Risk factors for wound complications in morbidly obese women undergoing primary cesarean delivery. *Journal Of Maternal-Fetal & Neonatal Medicine*, *25*(9), 1544-1548. doi:10.3109/14767058.2011.653422

Synthesis of evidence

We developed a PICO question based off of our knowledge, personal interests, and nursing professions. Our team evaluated 15 articles for evidence related to our PICO question, and chose five high-quality articles to synthesis information for our conclusion.

Prevention techniques of surgical site infections may include the use of prophylactic preoperative IV antibiotics administered within a set amount of time prior to incision, preoperative skin preparation using chlorhexidine gluconate wipes, avoiding hair removal from the surgical site if possible, and the use of chlorhexidine with alcohol base preoperative surgical skin prep rather than previously used povidone-iodine skin prep solutions (Amer-Alshiek, 2013).

Contributing factors that could likely increase the risk of developing a surgical site infection include obesity, American Society of Anesthesiologists preoperative assessment score, emergency surgery, lack of prophylactic antibiotics, pre-existing infections, prolonged labor, premature rupture of membranes, vaginal examinations, the presence of meconium, primary indication for surgery, certain types of anesthesia, prolonged operative time, lack of surgical experience and blood loss (Gong et al., 2012). Most research studies that were reviewed in order to come to a conclusion for our PICO question, clearly stated that there is a great need for additional research specialized to surgical site infections relating to cesarean sections.

The common theme throughout our research is an emphasis on the importance of using aseptic technique whether that be on perineal trauma repairs, episiotomies, or cesarean section surgical sites. Other common themes stress the importance of prevention techniques, interventions and proper post wound cares. Though infection rates can occur either post vaginal delivery, or post cesarean delivery, many research articles place emphasize on surgical site infections post cesarean delivery. Associated with surgical site infections post cesarean delivery, many articles highlight cost factors contributed from this infection risk. Such things as prolonged hospital stays, readmissions, frequent emergency department visits, additional corrective surgical procedures, medication and treatment regimens, and the psychological effects on a mother's wellbeing and newborn bonding experience play a toll on those mothers' whom are already in a fragile state of mind. During the postpartum period of time, the nursing goals for the patient center on the bonding experience with her newborn, feeling educated and confident to care for her newborn, and heal post-delivery. Infections in this period can disrupt this patient's ability to meet these goals which can affect her physically, psychologically and emotionally. Women who develop post-cesarean section surgical site infections who plan to breastfeed, are at risk of discontinuing to breastfeed due to the burden on their body from the infection.

Bottom line

Surgical site infections can, and do happen post-delivery. Having a cesarean section can increase the risk of these infections. Many predisposing factors may play a role in reasons for the increase of these infections such as, obesity, gestational diabetes, hypertension, pre-eclampsia, and pre-term labor (Thornburg et al., 2012).

Using proper aseptic technique including isopropyl alcohol to remove all ultrasound gel, and a chlorhexidine gluconate surgical scrub prior to surgical incision has proven to decrease post-delivery surgical site infection rates (Gregson, 2011). While our research did indicate more infections were seen with postpartum cesarean section incisions, more research is needed to validate these findings, and identify the best interventions to help prevent infections.

Implications for nursing

Nurses are instrumental in assisting patients with postpartum surgical site care. The following are items that nurses should consider when caring for patients with postpartum surgical sites:

1. Checking patient allergies against the medication orders pre-operatively, including the antibiotic ordered and the surgical site scrub preparation.
2. Monitoring vitals closely during the recovery and postpartum period.
3. Monitoring the surgical site while the patient is inpatient, and noting wound approximation, any redness, warm/hot areas, and drainage from the site.
4. In the case that the patient has an atypical wound dressing, such as a negative pressure wound vac, it is important for nursing to understand and follow the orders carefully on how to manage that system.
5. Providing education to the patient about monitoring for signs of infection after discharge including if and when to contact a provider.
6. Provide education to the patient about proper wound care and lifting restrictions.

American Nurses Association

Nursing Coalition Praises Commission on Care Recommendations to Improve Veterans' Healthcare

APRNs, RNs looking forward to being part of solution to improve access to timely care.

WASHINGTON, D.C. – Advanced practice registered nurses (APRNs) and other registered nurses (RNs) in the Veterans Health Administration (VHA) stand ready to be part of the solution to improve veterans' access to timely, quality healthcare by working to their full practice authority as recommended by the Commission on Care in a report to the White House on July 5, said Juan Quintana, DNP, MHS, CRNA, president of the American Association of Nurse Anesthetists (AANA).

The commission, established as part of the Veterans Access, Choice, and Accountability Act of 2014, was charged with examining veterans' access to VHA healthcare and determining how best to deliver healthcare to veterans during the next 20 years. The 308-page report was the culmination of an exhaustive 10-month assessment by the commission.

Speaking on behalf of a Nursing Coalition which endorses direct access to APRNs including Certified Nurse Practitioners (CNP), Certified Registered Nurse Anesthetists (CRNA), Certified Nurse Midwives (CNM), and Clinical Nurse Specialists (CNS), Quintana said that allowing all VA APRNs to practice to the full scope of their education and abilities without physician supervision would improve veterans' access to essential healthcare by reducing long wait times for appointments and services.

The commission's recommendation supports a Veterans Administration (VA) proposed rule to grant direct access to VA APRNs that was published in the Federal Register on May 25; comments on the rule are being accepted by the VA until July 25. With less than two weeks to go, more than 62,000 comments have been received from veterans, healthcare professionals, and the general public, mostly in favor of the rule.

"The evidence cannot be denied," said Quintana. "The commission's final report adds more data to the growing stack of evidence highlighting the need to allow all APRNs to have full practice authority as a major step toward increasing veterans' access to quality healthcare."

During its examination of veterans' access to healthcare and how to best deliver healthcare services over the next two decades, the commission reviewed the results of the independent assessment of the VHA that was ordered by Congress in 2015; met with a broad range of stakeholders, including veterans and leaders of Veterans Service Organizations; made site visits to VHA facilities; and exchanged ideas with VA leaders and employees, members of Congress, and healthcare experts. Ten APRN and nursing groups provided an outline for the commission on the role and recommendations of APRNs to improve VHA healthcare delivery.

"The American Organization of Nursing Executives (AONE) applauds the Commission on Care for its support of full practice authority for advanced practice registered nurses in the VHA," said Maureen Swick, RN, MSN, PhD, NEA-BC, AONE chief executive officer/American Hospital Association senior vice president, Nursing. "APRNs are a vital link to ensuring quality care is readily accessible for America's veterans."

"The clinical evidence and informed recommendations that patient care is improved by direct access to APRNs continue to grow," said Cindy Cooke, DNP, FNP-C, FAANP, president of the American Association of Nurse Practitioners (AANP). "Veterans, the AANP, other APRN groups, the VA, and now an independent congressional commission on the VHA all agree that the VA's highly-qualified APRNs, including 4,800 nurse practitioners who provide a wide range of healthcare services, are the right solution to ensuring veterans have access to timely, quality healthcare."

American Nurses Association (ANA) Chief Executive Officer Marla Weston, PhD, RN, FAAN, who previously served in the VHA as program director in the Office of Nursing Services and then as deputy chief officer in the VA Workforce Management and Consulting Office, praised the commission's recommendations on clinical operations.

"The commission's recommendation that clinical operations should be enhanced through more effective use of health professionals – particularly optimizing use of advanced practice registered nurses – along with improved data collection and management, is right on target," said Weston. "The commission's recommendation is consistent with the recommendations of the National Academy of Sciences to remove scope-of-practice barriers and allow the VA to fully utilize the skills of its APRNs to the full extent of their education, training, and certification."

The American Association of Colleges of Nursing (AACN) commended the commission for recognizing that the way in which APRN students are educated must align with how they practice to achieve the best patient outcomes. "The Commission on Care should be applauded for its steadfast work to advance recommendations based on the evidence," said Juliann Sebastian, PhD, RN, FAAN, chair of the AACN Board of Directors. "For our nation's Veterans to receive the care they need, when they need it, we must look to the decades of data that show APRNs excel in providing high quality care when practice barriers are removed."

The VA's proposed policy to allow direct access to APRNs in order to improve veterans' access to timely healthcare is supported by veterans groups such as AMVETS, Paralyzed Veterans of America, Military Officers Association of America, and Air Force Sergeants Association; AARP (whose membership includes 3.7 million veteran households); numerous healthcare professional organizations; and more than 80 Democratic and Republican members of Congress.

Comments on the proposed rule can be submitted at www.regulations.gov/document?D=VA-2016-VHA-0011-0001.

Coalition Members

For more information about the coalition members, visit:
American Association of Colleges of Nursing (www.aacn.nche.edu)
American Association of Nurse Anesthetists (www.aana.com)
American Association of Nurse Practitioners (www.aanp.org)
American Nurses Association (www.nursingworld.org)
American Organization of Nurse Executives (www.aone.org)

American Nurses Association Launches Enhanced Career Center Powered by YourMembership

Silver Spring, MD — The American Nurses Association (ANA) is pleased to announce the launch of an enhanced version of the ANA Career Center. The newly redesigned site is powered by YourMembership — the leading provider of career center and job board services.

In addition to listing thousands of nursing jobs, the ANA Career Center will also provide:

- Anonymous resume posting so applicants can control who views their information
- Recruitment options for employers and access to ANA's exclusive Job Flash, Smart Brief and Career Brief emails
- Integration of job content to engage with ANA's Twitter, Facebook and LinkedIn communities, and convenient access to webinars, continuing education courses and conferences
- Advertising opportunities for employers
- Mobile-friendly interface to access YourMembership's network of nearly 2,500 career centers
- Alerts so applicants receive timely updates on jobs that match their goals and interests

"The ANA Career Center serves the nursing profession by providing our members with value-added opportunities for professional development and career growth," said Donna Grande, ANA's VP of Products and Services. "Our members are committed to the highest standards of integrity and training and are exceptionally appealing to employers." Grande added, "Powered by YourMembership's technology, ANA's Career Center will connect nurses with health care organizations seeking their sought-after skills and expertise."

"The American Nurses Association is a world-class organization whose members are an integral part of the country's healthcare industry," said Tristan Jordan, YourMembership's SVP and GM of Revenue Solutions. "The ANA Career Center is an innovative gateway that matches the right employers with the right nursing talent to help keep healthcare organizations well-staffed and nursing professionals' careers moving along a path that meets their goals."

To jump start your nursing career, please visit the ANA Career Center.

American Nurses Association

Making Care Transitions Safer: The Pivotal Role of Nurses

By Jeffrey Brady M.D., M.P.H., Rear Admiral, U.S. Public Health Service, and Director, AHRQ Center for Quality Improvement and Patient Safety, and Richard Ricciardi, Ph.D., N.P., AHRQ Senior Nursing Advisor

In support of ANA's continued efforts to help nurses create a Culture of Safety in all health care settings, the Agency for Healthcare Research and Quality (AHRQ) has published "Making Care Transitions Safer –The Pivotal Role of Nurses." In the blog post, Jeffrey Brady MD, MPH, and Richard Ricciardi, PhD, NP, write that "Nurses are typically the first to ask about or notice changes in a patient's health condition, such as mental status, medication routine, or vital signs, when a patient is transferred to a different hospital unit or care setting. It's no surprise then that nursing's largest membership organization, the American Nurses Association (ANA), has identified transitions of care as a key component of its 2016 Culture of Safety campaign..."

Jeffrey Brady M.D., M.P.H.

Richard Ricciardi, Ph.D., N.P.

As front-line practitioners, nurses are highly attuned to the fact that patients' needs can be very different depending on their setting of care. This insight gives nurses a unique role in making care transitions safer, a longstanding goal of AHRQ, along with our local and Federal patient safety counterparts, and one where nurses play a pivotal role.

Care transitions occur when a patient is transferred to a different setting or level of care. They can occur when the patient moves to a different unit within the hospital, when a patient moves to a rehabilitation or skilled nursing facility, or when a patient is discharged back home. Among older patients or those with complex conditions, our research shows that care transitions can be associated with adverse events, poorer outcomes, and higher overall costs, if not managed well. They can also lead to an increase in potentially preventable hospital readmissions.

Nurses are typically the first to ask about or notice changes in a patient's health condition, such as mental status, medication routine, or vital signs, when a patient is transferred to a different hospital unit or care setting. It's no surprise then that nursing's largest membership organization, the American Nurses Association (ANA), has identified transitions of care as a key component of its 2016 Culture of Safety campaign. At AHRQ, we support this priority and nurses' efforts to make transitions safer, both at the local level and through Federal efforts.

One such effort is the Partnership for Patients' (PfP) Community-based Care Transitions Program that was launched in 2012. The goal was to improve care when Medicare patients move from hospitals to home or to other settings, such as nursing homes. Of the sites that participated in the project, those that successfully lowered hospital readmissions implemented nurses or coaches and offered at least two support services for older patients, according to a 2014 program evaluation report.

Some of the hospitals participating in PfP efforts have used AHRQ's Re-Engineered Discharge Toolkit (RED) to successfully reduce readmissions and improve care transitions. For example, the San Francisco-based Dignity Health system cut its 30-day Medicare readmission rate at its Bakersfield Memorial Hospital by more than half within months by incorporating elements of the toolkit, according to a recent AHRQ case study. Another RED supporter, Euclid Hospital, a Cleveland Clinic facility in Euclid, Ohio, introduced the toolkit to local nursing homes, which saw readmissions for heart failure patients drop from 21 to 5 percent after 6 months.

The RED Toolkit describes a process in which nurses or health coaches lead efforts to oversee the discharge process. Before patients leave the hospital, the nurse makes sure they understand information such as their diagnosis, medications, and how to care for themselves when they get home. Nurses also ensure that patients' followup appointments are arranged, so posthospital tests or test results don't fall through the cracks.

Care transitions between units within a facility can also be problematic, especially when teamwork breaks down. AHRQ's TeamSTEPPS® is a curriculum that promotes a culture of safety by improving communications and teamwork skills among nurses and others on health care teams. Developed originally for use in hospitals, the curriculum has been adapted to apply these safety-enhancing skills to other care settings, such as medical offices and long-term care settings.

Promoting safe and effective care across the many settings where patients receive care is a complex challenge—one that can be addressed only with the input and leadership of nurses. We're making good progress, especially in the hospital setting, but more work remains. Working together with nurses and other front line clinicians, AHRQ will continue to develop tools and resources to ensure that all patients receive the safest care possible, no matter where it is delivered.

American Nurses Association and Elsevier Announce New Care Coordination Education Program

Setting the Stage for the Future of Care Coordination

SILVER SPRING, MD — The American Nurses Association (ANA), the premier organization representing the interests of the nation's 3.6 million registered nurses, and Elsevier, a world-leading provider of scientific, technical and medical information products and services, today announced a new collaboration to set the stage for the future of care coordination with a new eLearning product.

"ANA is pleased to partner with Elsevier to extend our reach and provide distinct educational products to empower nurses and other healthcare professionals," said Terri Gaffney, PhD, MPA, RN, Vice President, Product Development, ANA.

With the healthcare system in transition, ANA is on a mission to improve care coordination by educating nurses to assume roles that will transform the nurse-consumer relationship. ANA's work in this area includes publications such as *Care Coordination: The Game Changer - How Nursing Is Revolutionizing Quality Care*, position statements that recognize and encourage funding for nurses' essential role in patient care coordination, and additional online resources that focus on care coordination.

ANA and Elsevier have developed an eLearning product that advances the nursing profession through ongoing continuing education. *Care Coordination: What Nurses Need to Know* is currently available to registered nurses working in health care organizations.

"Elsevier is honored to work with ANA to continue to bring high-quality, respected and credible products to the market," said Cindy Tryniszewski, MSN, RN, Vice President, Clinical Content, Elsevier Clinical Solutions. "As a nursing professional and longtime advocate for continuing education for nurses, I am confident that this eLearning product will meet the current and future needs for nurses who must advance the profession in an ever-changing workplace."