Workplace Violence, Let’s Talk About This!

By Tessa Johnson, MSN, RN

Greetings nurses of North Dakota! It’s crazy to think that we will quickly be approaching the end of summer. Where did it go? As you all know we (NDNA) attended Hill day in Washington, DC in June. Be sure to read the article on Hill Day and Membership Assembly in this issue.

One of the things discussed while in Washington was workplace violence. Let’s talk about that! I believe that when we hear about workplace violence, we automatically think about patients and others that cause the violence. Ladies and gentlemen, I think we need to be honest with ourselves: do we as nurses always treat each other as we should?

Did you know that NIOSH classifies workplace violence into four basic types? Types II and III are the most common in the health care industry. Sadly enough, Type III involves a “worker-on-worker” relationship and includes “employees who attack or threaten another employee” (ANA, 2019). At this time, OSHA does not require employers to implement workplace violence prevention programs, but it provides voluntary guidelines and may cite employers for failing to provide a workplace free from recognized serious hazards. We as nurses need to step up! We need to start by reflecting on the way that we treat each other. According to Fallette 2017, “Lateral violence has been defined as ‘nurses covertly or overtly directing their dissatisfaction inward toward each other, towards themselves, and toward those less powerful than themselves,’ which can take many forms. There are several theories as to why lateral violence is so ubiquitous in nursing, including a power imbalance where nurses do not feel valued and power resides with physicians.”

We have all heard the phrase that “nurses eat their young” and I do think there is some truth to this. We must be the ones to end it. Working in an environment where lateral violence is executed is not only disappointing and stressful for nurses, but it is in violation of provision six of the American Nurses Association (ANA) Code of Ethics. This provision requires that nurses establish and maintain an ethical work environment. Nurses need to embrace that the ANA Code of Ethics applies not only to their interactions with their patients, but to all interactions they have within their professional environment.
Welcome New Members

Danielle Wilte
Lisbon
Amber Jean Blondeau
Fargo
Sandy Ann Reagan
Wahpeton
Veseda Marie Hof
Fargo
Kristen Leigh Hillebrand
Grand Forks
Michael Kierra
Bismarck
Kristen Brunelle
Bismarck
Melissa Gunn
Fargo
Katie Idalski
New Rockford
Kayla McLeod
Minot
Kara Leopold
Horace
Tracy Ellen Olson
Mayville
Alma Jean Alegres
Orapa
Tiffany Olson
Fargo
Wishak
Colton Raymond Waite
Fargo
Enrika Rain Potter
Williston

Message from the President continued from page 1

role. If rule one of the code was followed by all nurses – refining a culture of respect, dignity, and inherent worth of every person in the workplace, first and foremost our peers, nurses could operate as moral agents in their work and provide exceptional patient care (Fallette, 2017).

We as nurses, colleagues and leaders, need to make sure that we create a zero tolerance for this. We need to make sure that first, we are following the Code of Ethics and, more importantly, we are holding each other accountable. We need to make sure that we are an advocate for ourselves and the nurses that we work alongside of. I encourage all the North Dakota nurses that are reading this to think about your workplace. Is there lateral violence among nurses in your workplace? Have you done anything to help? Are you the cause? Are you the victim? Decide to change today. Make the decision to hold up your ANA code of ethics and let’s do better! Be well, we need all of you!


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 upcoming North Dakota Nurses Association are 9/4/19. 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 Vision 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.

By Gail Pederson, SPRN, HN-BC

This was the title of my vignette that was recently published in Beginnings, the American Holistic Nurses Association national publication. A recent push by the ANA for nurses to register themselves as serving on board of directors prompted this professional organization to pose the question to its members, "How does your holistic nursing philosophy influence your work on a board?" The title, first of all, recognized a very important person in my life, my mother in law, a nurse and my mentor in so many ways. Secondly, my voice is being heard in a variety of venues, as an advocate for those who may be marginalized.

When my mother in law turned 80 years old, I received a call from her. She was retiring from everything she was involved with in our hometown, Valley City, ND. This included The Open Door Center board of directors, I commented, "Great, maybe (my husband) would like to be involved;" Her reply? "No, I want you. We need infection control and we need to keep the balance of male and female on the board." A woman ahead of her time!

The Open Door Center is a non profit organization that provides services for individuals with physical and cognitive disabilities and is one of our community's largest employers. I joined the board of directors in 2004, upon her request, without hesitation. My sister in law, who has a closed head injury prompted her mom's involvement. She and my youngest son, who is cognitively disabled and would soon have future requirements are reported on.

After submitting and getting my somewhat light hearted article approved, I began to think more about the board and our responsibilities of overseeing this large organization. Budgets, audits, approval of capital expenditures, reviewing incident reports, human rights issues, policies and education are just a few of many items involved in a meeting. The never ending inspections of the multiple residences, changes for billing, safety regulations and continual changes with government funding and requirements are reported on.

Nursing and infection control are certainly a major component in maintaining the health of our individuals and the organization. Medical and non-medical plans of care are also reviewed. The dedicated nursing staff, program directors and Direct Support Personnel knows them and care personally about them. I am pleased to say that while I "sit" on the infection control committee, I mostly do just that...sit, listen and learn.

Editor's note:
The below article was inadvertently omitted from our April-May-June publication which was celebrating Nurses Week. Our apologies to Kami Lehn. Please enjoy her article in this current issue. Thank you.

Nurses Week Article

Kami Lehn

I want to wish you a Happy Nurse's Week. National Nurse's Week is a time to celebrate our dedication and positive impact each and everyone of you have made to the profession. According to the ANA there are 4 million registered nurses celebrating this year. Beginning May 6 and ending on May 12 which is Florence Nightingale's birthday. In 1993 the ANA Board of Directors dedicated May 6 - 12 as permanent dates to observe National Nurses Week in all subsequent years.

As a bedside best friend, the person murmuring calm words during crisis, the hand holder, the advocate, the pillow fluffer, the decision maker, or whatever role in your nursing career has brought you through, I want to say thank you.

Thank you for your commitment to nursing. Thank you for your kindness, your caring, and your devotion. Thank you for your empathy, your dedication, and your excellence. Thank you for the long nights, time away from your family, and your patience.

Thank you to our experienced nurses for sharing your wisdom. Thank you to our new nurses for sharing your fresh knowledge and embracing the mentor role. Thank you to our student nurses who will carry on our legacy and are the future of our profession.

The value of each of you is immeasurable. We are a team, so I thank you for being my teammate.

The Nightingale Pledge

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession海绵ently. I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and as a missionary of health I will dedicate myself to devoted service to human welfare.

NDNA 2019 Spring Conference

Deb Quiring, Evelyn Quigley, Nancy Carda, and Val Abrahamson – wonderful longtime NDNA Members - attending the Spring Conference in Grand Forks! Deb wrote an article for Nurses Week published in the Devil's Lake Journal!
Music Therapy

Appraised by:
Mel Banish, RN; Stacia Heisler, RN; Veronica Webb, RN: Mayville State University RN-to-BSN Students.

Clinical question:
What is the effect of treating patients in the palliative care setting with music therapy in conjunction with pharmaceuticals, on pain and anxiety compared to pharmaceuticals alone?

References:
Synthesis of evidence:
As nurses, we are aware that pain is difficult for patients to express and in a patient’s final journey the quality of time with family and friends is the most important. Our research by Peng, Baxter, and Lally (2019) conducted a pilot study that utilized the Edmonton Symptom Assessment Scale (ESAS) for 46 individuals to capture pre- and post-assessment levels. Administration of opioid analgesics was used pre-intervention with their standard care. Substantial reduction of pain and anxiety was found to be associated with music therapy, but in addition nausea, depression, shortness of breath, and well-being were also seen to have a significant reduction from pre- to post-intervention.

Gutgell et al. (2013) conducted a randomized control trial with the goal of determining the effectiveness of Music Therapy (MT) in a single session to reduce pain in the palliative care patient. Two hundred subjects were placed in a control group, as well as trial group. Pain was evaluated using a 0-10 scale primarily, then the Face, Legs, Activity, Cry, Consolability Scale (FLACC) and Functional Pain Scale used as secondary outcomes. Results showed a significant decrease in pain and a single MT was deemed effective.

Changing the environment for our patients with music of their choice or choice with direction by family can provide comfort to some patients. This is what we have found that MM is the use of music in a therapeutic method such as prerogative music to alter an environment by a per trained and certified with the Board of Music Therapy. We as healthcare providers attempt to promote an environment that the patient is comfortable in. Many people tend to believe that MM is one in the same, but MT is conducted by a trained therapist to assess the patient’s needs, evaluate the desired outcome, and implement the use of music in the form of therapy that leads to the overall desired outcome. Trained therapists certified by the Board of Music Therapy, utilize additional skills of assessment, planning, and implementation of therapy to process emotions and the needs of the patients; using both live music or prerecorded vibration of a drum, or cadence to facilitate therapy.

Lee (2016) in her meta-analysis evaluated 97 studies that used MT and MM. MT was found to have substantially higher benefits than MM. Lee’s evaluation determined that MT and MM both benefited the patients with decreasing pain as well as anxiety. MT allowed the therapist to assist the patient choose their preference of music, and in combination with analgesics, resulted in substantially higher levels of decreasing anxiety as well as pain. The presence of a therapist also helped the patient and process emotions that may have surfaced during the intervention.

In a qualitative review, written by Porter et al. (2017), one of the main objectives was “to illuminate individual experiences of music therapy to patients, their families, and the professionals caring for them” (p. 3) This qualitative study was performed without the goal to prove the efficacy of MT, but rather to investigate the how and why MT can be effective. Throughout the study individual experiences are shared that help to define the methods in which MT reaches palliative care patients to reduce pain and anxiety, as well as the impact for health care providers.

Implications for nursing practice: Almost every bedside nurse, if not all of them, will care for a patient in his or her final moments. Aiding in reduction of pain and anxiety can make a significant transition not only more comfortable for the patient, but also the family in attendance. If possible, the patient should have a choice in the music played that would bring him/her the most enjoyment (classical, contemporary, Christian). This information can be obtained by the patient or the family if the patient is unable to speak. Because nurses are there to support the patient and families at the end of life, this part of nursing care impacts nurses across many specialties. Having the ability to reduce pain further as well as alleviate side effects from pharmaceutical medication would allow patients increased comfort and a better quality of life in their last moments.

NOW HIRING
HMMC is seeking dedicated, caring and compassionate individuals to join our team of healthcare professionals.

Opportunities at HMMC
RN’s & LPN’s
Administrative Nurse Long Term Care
Certified Nursing Assistant

Competitive salary and benefits.
Tuition reimbursement program.

Heart of America Medical Center 830 South Main Ave.
Krugel SD 57776 719-774-4400 Apply online at www.hamc.com or email: Kailey Bonn at kbonn@hamc.com

SUCCESS (FULL) Don’t live to work. Work to live.
At Touchmark, we love the work of enriching people’s lives. We also value living life to the fullest. And that means exploring nature, music, art, learning, and all those things that bring us balance and joy. We offer our nursing team members: Paid time off to pursue adventure - A place to learn new skills Education incentives - Stable career path Schedule flexibility - Comprehensive benefits

THE (FULL) LIFE AWAITS AT TOUCHMARK! Call to learn more about living or working at Touchmark.

Touchmark on West Century
Full-Service Retirement Community
Bismarck, ND 701-573-9233 TOUCHMARK@BISMARCK.COM

A shift that does wonders for your heart
Nurses that transition to Blue Cross Blue Shield of North Dakota are often surprised at the impact they can make in an office setting. (They like the “normal” hours, too.)

How can you see your nursing skills here. BCSBND.com/careers

Tip: Use the QR Code to send this job to your phone.


Synthesis of evidence:
The first study conducted by Evans, Grunawalt, McClish, Wood, and Fries (2012) explained how bedside shift report decreased the amount of time report took and how shift report at the bedside improved nursing satisfaction overall. Nurses found that there was less distraction and they were able to incorporate the patients into their care more. Bedside shift report allows for more one-on-one time among the nurses and patients.
The second study by Ferris (2013) was in regard to a nurse implementing bedside shift report at her hospital in Tacoma, Washington. There were nurses and other staff members who were not fans of implementing this new shift report, but the nurses’ attitudes changed after BSR was implemented compared to previous times. Scores of “nurses’ attitudes towards requests, attention to special needs, nurses kept you informed, how well your pain was managed” increased from 42 to 72. Scores of “nurses’ attitudes towards requests, attention to special needs, nurses kept you informed, how well your pain was managed” increased from 42 to 72. Scores of “nurses’ attitudes towards requests, attention to special needs, nurses kept you informed, how well your pain was managed” increased from 42 to 72. Scores of “nurses’ attitudes towards requests, attention to special needs, nurses kept you informed, how well your pain was managed” increased from 42 to 72.

Evidence suggests that there is an increase in satisfaction of patients when nurses do their bedside shift report at the patient’s bedside. Research thus far has shown that shift report at the bedside has had a more positive outcome because patients are more involved, nurse’s attitudes changed for the better, the amount of time shift report takes, but most importantly it has increased patient safety. Studies are still being conducted but with the increase in satisfaction, bedside shift report will continue to be implemented and the results will continue to increase. Not all nurses are willing to implement change, but the more it is tried, the better the outcomes will be.

Implications for nursing practice:
Nurses are at the front line when it comes to patient safety; bedside shift report is an essential part of ensuring patient safety is adequate. Nurses are held accountable for the communication that occurs during bedside shift report. It is necessary to increase communications amongst nurses. It is important for each facility to develop protocols for BSR. Nurses need to be educated on the improvement of quality care, patient safety, and accountability that comes with BSR. Educating staff on BSR and how to perform it is the most essential part of the process. Patients and families should be informed on BSR during the previous shift and when their nurse is rotating. Nurses should be educated on introductions and using SBAR with BSR. The consistency with bedside shift report helps patients and families build trust with staff. When people receive BSR it is important for staff to include opportunities for the patient and family to ask questions, which also makes them a part of their own care.

A general overview of the patient can be reviewed when BSR is being completed. This can include wound sites, IV sites, solutions, and other safety measures including bed and side rails positions and clutter within the room. Research provided by the OJIN showed patient falls decreasing by 24% in the four months after BSR was implemented compared to previous. HCAHPS showed improvement. Patient satisfaction was improved with BSR based on the Press Ganey survey. Overall, earlier identification and correction of potential errors during BSR improves quality of patient care.
**Appraised by:**
- Shandel SN, Alecia Koropatnicki SN, Haley Zinke SN, & Miranda Schwab SN (NDSU School of Nursing at Sanford Health Bismarck BSN Students) Wanda Rose PhD, RN Associate Professor of Practice (Faculty)

**Clinical Question:**
In hospitalized pediatric patients in pain, does animal-assisted therapy reduce pain during procedures compared to no interventions being used?

**Sources of Evidence:**

**Synthesis of Evidence:**
Four studies were reviewed as evidence for this clinical question. Two quasi-experimental studies, and two randomized control studies.

Braun, Stanger, Narveson, and Pettingell (2009) conducted a quasi-experimental study to test the effectiveness of animal-assisted therapy to decrease pain during painful procedures in immunocompetent children ages 3-17. The study included 57 immunocompetent participants across both age groups. The intervention group was assigned to receive animal-assisted therapy (AAT) for 20 minutes with a trained AAT dog and its owner in the hospital setting. The control group was assigned to receive no AAT therapy during the same period. Results indicated that children in the intervention group showed a longer anesthesia time and lower cerebral oxygenation in comparison with the animal-assisted therapy group.

Calcaterra et al. (2015) conducted a randomized controlled trial. This study was conducted to evaluate the effects of animal-assisted therapy on the children undergoing surgery. The sample consisted of 24 children, ages 6-12 years, who were diagnosed with leukemia or brain tumours. The interventions included participation in an animal-assisted therapy (AAT) program, which consisted of three 30-minute sessions per week. Nine different instruments were used to evaluate the outcomes of the AAT program. The Brunel Mood Scale, Faces Pain Scale and Quality of Life Questionnaire were used to evaluate the effects of AAT. The results showed a significant improvement observed in the pain levels, irritation and stress of the children. The study concluded that AAT therapy provided a significant improvement in anxiety, stress and mental confusion in the children.

Silva and Osorio (2018) conducted a quasi-experimental study on children undergoing venipuncture. This study was conducted to evaluate the impact of animal-assisted therapy on children's pain and anxiety levels, irritation and stress caused by venipuncture. The control group consisted of 39 children who underwent venipuncture without the presence of a dog. The intervention group consisted of 24 children who underwent venipuncture in the presence of an AAT dog. Results indicated that children in the intervention group showed a longer anesthesia time and lower cerebral oxygenation in comparison with the control group. The study concluded that animal-assisted therapy provided a significant improvement observed in the pain levels, irritation and stress of the children. The study concluded that AAT therapy provided a significant improvement in anxiety, stress and mental confusion in the children.

The final study by Vagnoli et al. (2015) conducted a randomized controlled trial that investigated the effectiveness of animal-assisted therapy as a distraction tool for reducing children's pain and distress before, during, and after blood collection procedures. This study was performed in Florence, Italy in a hospital. They had 50 randomly selected patient's who were native born, Italian speaking, and ages 4-11 years old. The independent variable was animal-assisted therapy and the variable affected by animal-assisted therapy is pain and stress reduction. Tools for data collection included observation scale of behavioral distress, Wong-Baker scale, visual analog scale, trail anxiety inventory, and three different phases of observation of the effects of AAT on patients during procedures. The result of this study suggested that animal-assisted therapy was positive in reducing pain and anxiety levels. The study concluded that animal-assisted therapy was an effective distraction tool for reducing children's pain and distress before, during, and after blood collection procedures. The study recommended that animal-assisted therapy should be implemented in hospitals to improve the quality of care for children undergoing venipuncture.

**Conclusions:**
All four studies indicated a decrease in either pain, anxiety or stress and an improvement in physiological and psychosocial variables of children undergoing venipuncture. Implementing animal-assisted therapy could improve social and cognitive functioning during hospitalization. This would be beneficial for children who are in the hospital because they already have an increased fear with being in a strange place.

**Implications for Nursing Practice:**
Implementing animal-assisted therapy for hospitalized children could help alleviate stress, anxiety or pain in children undergoing venipuncture. Implementing animal-assisted therapy could improve social and cognitive functioning during hospitalization. This would be beneficial for children who are in the hospital because they already have an increased fear with being in a strange place.
Bundling to Prevent CLABSIs In Adult Patients in the ICU

Appraised by:
Riley Macanum SN, Seth Peltier SN, Beth Berard SN, Andrew Rosendahl-Pinks SN (NDSU School of Nursing at Sanford Health Bismarck BSN Students), Wanda Rose PhD, RN, Associate Professor of Practice (Faculty)

Clinical Question:
In adult patients on the intensive care unit (ICU) with a central line, does the use of implementing a bundle decrease the rates of central line associated bloodstream infections (CLABSIs)?

Sources of Evidence:

Synthesis of Evidence:
Four studies were reviewed for the evidence presented. Two systematic reviews; one meta-analysis; and one observational, prospective, single-center study.

The first study by Gomes da Silva and Cristina de Oliveira (2018) was an integrative review of articles that looked at the effectiveness of implementing a bundle for the prevention of CLABSI infections in the adult intensive care unit. In the studies, 19 measures that compose bundles to prevent CVC-related bloodstream infections were found in the studies. “Eleven measures were used for catheter insertion, six during maintenance and two in continuing education and feedback of the results as a global part of the process” (Gomes da Silva and Cristina de Oliveira, 2018, p.8). Overall, the review found that the implementation of bundles was shown to reduce bloodstream infections, regardless of intervention time and the measures used.

Perin, Erdmann, Higashi, Sasso (2016) conducted a systematic review of thirty-four studies concerning a decrease in CLABSI after implementing care. Twenty-six of the 34 studies showed a decrease in CLABSI after implementing care, including chlorhexidine, avoiding femoral site, and removing the catheter as soon as it is no longer necessary. Three additional articles included this care but also added educational programs addressing the use of bundles and addressing the safety. Three articles also addressed these care practices and provided simulation experiences to practice safety measures of using bundles. All of these measures, including the use of bandages, have shown significant decreases in CLABSI rates in adult populations in the intensive care unit (ICU).

Wang et al. (2018) worked together to create a systematic review from the works of 33 separate random controlled trials (RCTs). These RCTs involved 10,464 patients who were randomly chosen to receive one of four different types of central venous catheters (CVCs) for their treatment while in the hospital setting. Each treatment utilized bundles, which included five parts: hand hygiene, maximal barrier precautions, chlorhexidine skin antisepsis, optimal catheter site selection and a daily review of whether the central line was necessary for those patients (Wang et al., 2018). The different types of CVCs used in these studies included antibiotic coated catheters, chlorhexidine/silver sulfadiazine coated catheters and standard single, double or triple lumen catheters. Clinically significant findings to be derived from this systematic review showed that the use of antibiotic and silver sulfadiazine coated catheters should be implemented in the use of the current bundles. These catheters are associated with fewer incidences of central line associated bloodstream infections (CLABSI) per 1000 catheter days than standard catheters alone.

The fourth study by Wichmann et al. (2018) was an observational, prospective, single-center study. The purpose of this study was to examine the effects of introducing a checklist during the placement of central venous lines (CVL) on the rates/frequencies of central line associated blood stream infections (CLABSIs) in adult patients in the intensive care setting. The population for this study was adult patients with a CVL or temporary dialysis catheter and the sample size included 4416 CVLs that were implanted. The intervention included using a checklist during the placement of a CVL. The results conclude that using a checklist during the placement of a CVL resulted in reduced frequencies of CLABSI and catheter colonization.

Conclusions:
All four of the studies concluded the implementation of central line associated blood stream infection (CLABSI) bundles decreased the rate of CLABSIs in adult patients in the intensive care unit. Wang et al. (2018) also found that their results suggested that antimicrobial-coated catheters and chlorhexidine/silver sulfadiazine coated catheters were more effective than traditional catheters at preventing CLABSIs over the course of 1000 days stay in the hospital setting. These articles and the research attributed to them is clinically significant in how it could affect the current best practice for patient care, concerning those patients with central lines.

Implications for Nursing Practice:
The recommendation is that all health care facilities implement a CLABSI bundle when dealing with patients who have a central line. Implementation of CLABSI bundles can assist in decreasing the rates of central line infections, decrease hospital infection costs and increase patient satisfaction.

Introducing the all-new 2019 Subaru Forester:
The 2019 Subaru Forester. With standard Symmetrical All-Wheel Drive – 83 mpg! Plus, the Subaru Forester has the lowest CO2 emissions in its class for two years running, according to Kelley Blue Book.

Find Your Perfect Nursing Opportunity! Great Staff, Great Locations & Great Pay
Prairie Travelers is recruiting Traveling Healthcare Staff in Montana
North & South Dakota
• Registered Nurses (RN, LPN, CNA, Med/Surg, and ICU)
• Certified Nursing Assistants
• Certified Medical Assistants
• Certified Nurse Aides
• Full-Time and Part-Time
Prairie Traveler’s Commitment
to our Staff
• 24/7 Staff Support • Varied Work Settings
• Paid Lodging • Zero Assignment
• Travel Reimbursement  • Annual Bonus
• Excellent Wages • Health Care Benefits

APPLY TODAY 406.228.9541
Prairie Travelers Recruitment Department
130 3rd Street South, Suite 2 • Great Falls, MT 59403
For an application or more information, visit
www.prairietravelers.com
College Stress: Are Dogs the Answer?


Clinical Question: Associate Professor of Practice (Faculty) Bismarck BSN Students) Wanda Rose PhD, RN, SN (NDSU School of Nursing at Sanford Health

Page 8 The North Dakota Nurse July, August, September 2019


The study by Delgado, Toukonen, & Wheeler (2018) was a quasi-experimental study. The purpose of this study was to examine the effect of interaction with a friendly dog on the stress experienced by students using both psychological and physiologic measures. The study was based in Cleveland State University School of Nursing, Ohio. The population was college students attending the university. There was a total of 48 students that volunteered for the study. Forty-six students were in a control condition where they interacted with the dog only. Lastly, 46 participants were in a control condition where they interacted with the dog only. The study was randomized control trial. The purpose of this study was to “evaluate the efficiency of such a therapy dog program in improving the well-being of university students” (Ward-Griffin et al., 2018, p. 1). The study was based at a university in Canada. The population was college students attending this university in Canada. There were 246 participants. The pet therapy was of 90 min session and between seven and 12 therapy dogs and their handlers. The only difference between the interventions was the date it was done. The experimental group was part of the intervention a week prior to the control group. This article shows significant evidence that pet therapy is very beneficial to university students. This could impact students and the medical field by having pet therapy options available to those professions during their education and within the hospital.

The study by Graifoner, Harte, Potter, & McGuigan (2017) was a randomized control trial. The study was based at Heriot-Watt University. The population included college students attending this university. There was a control group and an intervention group. The intervention group was part of the Sheffield's Counseling Service Pet Therapy Event. The population was college students attending the University of Sheffield's Counseling Service in the UK. The population was college students attending this university for 1 week prior to the control group. This article shows significant evidence that pet therapy is very beneficial to university students. This could impact students and the medical field by having pet therapy options available to those professions during their education and within the hospital.

The study by Wood, Olsien, Thompson, Hulin, & Knowles (2018) was a quasi-experimental study. The purpose of this study was to “evaluate the efficacy of such a therapy dog program in improving the well-being of university students” (Ward-Griffin et al., 2018, p. 1). The study was based in the University of Sheffield's Counseling Service in the UK. The population was college students attending the University of Sheffield's Counseling Service Pet Therapy Event. The intervention was allowing college students to have a 15-minute therapy session with one or two guide dogs in training. There were 131 students that volunteered to participate, but only 127 students filled the questionnaire before and after the intervention. The study used the State-Trait Anxiety Inventory Questionnaire (STAI) and blood pressure measurements. Results showed there was a decrease in systolic BP by (p<0.003), diastolic BP (p=0.00), and state anxiety (p<0.001) following the pet therapy sessions.

Conclusions:

In the study by Delgado et al. (2018) they found a decrease in the psychological and physiological factors of stress. In the study by Graifoner et al. (2017) they found that in a short 20-minute interaction with a therapy dog improved student well-being, mood and decreased anxiety levels. In the study by Ward-
Appraised by: Kristin Lee SN, Mariah Porra SN, Alexa Pennick SN, Payton Schulze SN (NDSU School of Nursing at Sanford Bismarck BSN Students), Wanda Rose PhD, RN, Associate Professor of Practice (Faculty)

Clinical Question: For post-op spinal surgery patients, does the placement of Vancomycin powder inside the surgical wound prior to closure in conjunction with standard practices reduce the risk of post-op SSI’s compared with the use of standard practices alone?


Synthesis of Evidence:

Four articles were reviewed as evidence in the report. A retrospective evaluation of prospectively collected data, and a case-controlled study. The study by Okafor, Molinar, Molinari, and Mesfin (2013) added health complications for surgical complications. The control group were given only IV antibiotics and the treatment group were given Vancomycin powder in addition to intravenous antibiotics given prophylactically. These subcategories included (1) non-fusion cases, (2) instrumented posterior cases, (3) anterior – posterior cases, (4) revision thoraco-lumbar fusion cases, (5) other non-fusion cases, (6) irrigation and debridement cases. Anterior cervical cases were excluded as Vancomycin was not used in these cases. The results revealed that the use of Vancomycin decreases the rate of deep wound infections and irrigation and debridement procedures after spine surgery in comparison to a control group with standard surgical volume. Without the use of Vancomycin there were 30 cases of deep infections between 2009 and 2010 with 0 from 2012 to 2013 there were only five cases while using Vancomycin powder. Tubaki, Rajasekaran, and Shetty (2013) conducted a randomized control trial study for the Department of Orthopedics and Spine Surgery in Tamil Nadu, India. This study was conducted to assess the ability of local Vancomycin powder in preventing postoperative infections in spine surgery, when combined with standard intravenous antibiotics given prophylactically. The study included 907 patients with various spinal pathologies. The control group were given only IV antibiotics and the treatment group were given Vancomycin powder in addition to intravenous antibiotics. After a follow up period, of a minimum of 12 weeks for each participant, the data on bacterial growth was collected. Results showed there were eight infections in the control group and seven in the treatment group. In conclusion, this study surmised that there was no significant statistical differences in surgical site infections with the use of Vancomycin powder.

Conclusion:

Each of the selected studies for this review addressed the effect of Vancomycin powder on spinal surgery patients and surgical site infections. Two articles stated the use of Vancomycin powder to gather more information regarding the effectiveness of Vancomycin powder in postoperative spinal surgery patients.

Implications of Nursing Practice:

The data tells us that surgical site infections, specifically with Spinal patients, is a huge cause of morbidity and life-threatening complications. The goal is to prevent surgical site infections by treating the area prophylactically rather than providing treatment after the infection has already present. This could help between the two control groups in the study. Based on the research gathered, we concluded that there is not enough data to contraindicate the use of intrawound Vancomycin powder. We recommend further research be conducted to gather more information regarding the effectiveness of Vancomycin powder.
NDNA President Tessa Johnson, NDNA Membership Assembly Representative Tammy Buchholz, and NDNA Executive Director Sherri Miller attended the 2019 ANA Hill Day and Membership Assembly in Washington, DC June 20-22.

We were excited as activities began early Thursday morning with a breakfast briefing that provided a federal legislative overview and key talking points for nurse representatives to share with their representatives of Congress during the day’s scheduled meetings.

In addition to the briefing, various speakers addressed the group including ANA President Dr. Ernest Grant, Matthew Fitting, ANA Advocacy and Engagement Specialist, and Samuel Hewitt, ANA Senior Associate Director, Federal Government Affairs. The morning’s keynote speaker was Representative Lauren Underwood (D-IL-14), a millennial nurse in Congress! She uplifted the group with her inspiring words during her fireside chat with President Grant. When asked about what had compelled her to run for public office, Representative Underwood shared her impetus was the realization that healthcare in the U.S. was under attack. Her role as an advocate for her patients has now been transformed as an advocate for all U.S. citizens.

After the meeting, we were all transported by bus from the hotel to Capitol Hill where over 400 nurses from 48 states and the District of Columbia, Guam, and the Virgin Islands attended over 325 scheduled meetings with members of Congress. In addition, ANA nurse members unable to attend Hill Day in person delivered over 20,000 signatures to #endworkplaceviolence and over 4 million impressions via Twitter to senators and representatives. We joined our nurse colleagues on the steps of Capitol Hill for the customary group photo to commemorate the day.

Once on the Hill, our visits began with meeting Senator Kevin Cramer’s Legislative Assistant, Bree Vculek who is from Oakes, ND. The next meeting was with Senator John Hoeven and his Legislative Correspondent Ty Kennedy from Grand Forks, ND. Lastly, we met with Representative Kelly Armstrong and his Legislative Assistant Connor Crowley. While attending our meetings with senators, representatives and their staff, we had an opportunity to share our state and national priority issues related to nursing and the health and well being of all.

Our first point of discussion centered on safe staffing for nurses and patients. Although not yet formal legislation, it was important to renew our request for support on this issue. Research has shown that adding registered nurses (RNs) to unit staffing decisions can reduce the length of stay for hospital patients as well as the risk of adverse events, such as falls, injuries, infections, and bleeding. Increasing the number of RNs can yield a cost savings of nearly $3 billion – the result of more than four million avoided extra hospital stays for adverse events – and lower costs from hospital readmissions. Legislation or regulations addressing nurse staffing levels must not only consider the complexity and stability of patients, but also nurse experience, available technology, resources and unit workflow such as numbers of admission, discharges, and transfers. Addressing nurse staffing is a top priority for ANA, and as representatives of NDNA we wanted to let our members of Congress know that NDNA continues to seek support on this issue. We would like nurses to be part of staffing decisions and acknowledged that mandated nurse/patient ratios were not the answer. A collaborative effort with balanced legislation that benefits patients, nurses, and hospitals – is ideal.

Our next point of discussion was Title VIII Nursing Workforce Reauthorization Act (H.R. 728/S. 1399). We urged our members of Congress to cosponsor H.R. 728 / S. 1399, the bipartisan and bicameral Title VIII Nursing Workforce Reauthorization Act. Both pieces of legislation would reauthorize nursing workforce development programs (Title VIII of the Public Health Service Act) through FY 2024. These programs are invaluable to institutions that educate registered nurses for practice in rural and medically underserved communities. Title VIII programs bolster nursing education from entry-level preparation through graduate study. According to the Health Resources and Services Administration, between FY 2006 and FY 2012 alone these programs provided loans, scholarships, and programmatic support to over 450,000 nursing students and nurses. For five decades, these programs have helped build the supply and distribution of qualified nurses needed in all health care settings.

The major grant programs within Title VIII include Advanced Education Nursing, Workforce Diversity Grants, Nurse Education, Practice, and retention Grants, National Nurse Service Corps, Nurse Faculty Loan Programs, and Comprehensive Geriatric Education Grants.

The next point we discussed was the Workplace Violence Prevention for Health Care and Social Service Workers Act (S. 850 / H.R. 1309). This bill requires the Department of Labor to address needed protections from workplace violence in the health care and social services sectors. The legislation directs the Occupational Safety and Health Administration (OSHA) to issue a standard requiring health care and social service employers to develop...
and implement a comprehensive violence prevention plan tailored to the facility and services with the intention to prevent employees from violent incidents in the workplace. As part of the proposed legislation, employers must:

- Identify potential risks and hazards to mitigate future incidents;
- Provide training and education to employees to potential risks, workplace control measures, and reporting;
- Investigate incidents as soon as practicable;
- Meet recordkeeping requirements; and
- Prohibit acts of discrimination or retaliation against employees for reporting incidents of violence, threats, or safety concerns.

We stressed that nursing is a profession dedicated to helping others. Health care settings can be highly emotional for patients and family members, resulting in intense situations that can become dangerous. Nurses and other health care workers should have protections in place to avoid assaults and other violent acts. According to OSHA, approximately 75 percent of nearly 25,000 workplace assaults reported annually occurred in health care and social service settings (OSHA, 2015) and workers in health care settings are four times more likely to be victimized than workers in private industry (Security Industry Association and International Foundation, 2017).

We also had the opportunity to urge lawmakers to co-sponsor the bipartisan Home Health Care Planning Improvement Act (S. 296/H.R. 2150), which will allow APRNs to order home health care delivery by allowing APRNs to sign the final care plan to order home health care services. This act would protect patients and improve the efficiency of home health care services. This act would protect patients and improve the efficiency of home health care services. This act would protect patients and improve the efficiency of home health care services.

During the concluding day of the 2019 Membership Assembly, Douglas Davis - President of the National Student Nursing Association shared a powerful message, imploring “we must do better!” and Dr. Loressa Cole - ANA Enterprise CEO revealed her vision for the future, “a healthy world through the power of nursing.”

NDNA hosted the Midwest States Regional meeting which was held Friday evening. This provided an opportunity for state representatives to share updates regarding their state associations and accomplishments from the past year. Candidates running for election for several open ANA positions were invited to share information about themselves and answer questions from state representatives during the membership forum.

Saturday morning began with elections for open positions on board and committee members. Election results were shared in the afternoon. ANA Membership Assembly elected the following members to serve on the nine member board of directors: Susan Swart of ANA-Illinois was elected Treasurer; James Watson of the Texas Nurses Association was elected Director-at-Large; Marcus Henderson of the Pennsylvania State Nurses Association was elected Director-at-Large, Recent Graduate.

Elected to serve on the Nominations and Elections Committee are: Larlene Dunsmuir, DNP, FNP, ANP-C, of the Oregon Nurses Association; Laure Marimo, DNP, APRN, FNP-BC, GNP-BC, of the West Virginia Nurses Association; Sara McCumber, DNP, APRN, CNP, CNS, of the Minnesota Organization of Registered Nurses; and Gayle Peterson, RN-BC (chair-elect), of ANA Massachusetts.

In conclusion, our experience in Washington, DC was an excellent opportunity to express our nursing voices and represent our state. It was an extreme honor and privilege! We were treated with respect by our legislators and their staff who were all hospitable and provided us the opportunity to engage in meaningful and collaborative discussions.

The 2019 ANA Membership Assembly was an experience that connects North Dakota nurses to the “broader picture” and ANA’s mission “nursing advancing our profession to improve health for all.” We want to express our appreciation for the wonderful opportunity to represent NDNA.

Very respectfully,

Tammy Buchholz, MSN, RN, CNE
NDNA Membership Assembly Representative
Tessa Johnson, MSN, RN
NDNA Membership Assembly Representative
Sheri Miller, BSN, RN
NDNA President
Tammy Buchholz, MSN, RN, CNE
NDNA Membership Assembly Representative
Tessa Johnson, MSN, RN
NDNA President
Sherri Miller, BSN, RN
NDNA Executive Director
Generations of Nurses: Bridging the Gap

By Kami Lethin BSN RN

The multi-generational workforce brings a wealth of knowledge as well as workplace challenges. Technology has advanced innovation and has also created new challenges. We are all an essential part of the caring profession. My grandfather worked in the 1930s as a bedside nurse, we all have a hand in providing quality healthcare.

Acknowledging our own strengths and the strengths of the members of our team is essential in our long-term success. I encourage you to do some self-reflection. What are your strengths? What nursing prepared you for what you are doing? What nursing prepared you for what you are doing?

In nursing career, I have heard variations of the strengths of the members of our team is essential in our long-term success. I encourage you to do some self-reflection. What are your strengths? What nursing prepared you for what you are doing? What nursing prepared you for what you are doing? Do they prefer email? Finally, is there a middle ground? Do you feel valued? How do you show your gratitude? Is your communication effective? And how do you feel we can improve?

We also need to consider our bias. In my nursing career, I have heard variations of the strengths of the members of our team is essential in our long-term success. I encourage you to do some self-reflection. What are your strengths? What nursing prepared you for what you are doing? Do they prefer email? Finally, is there a middle ground? Do you feel valued? How do you show your gratitude? Is your communication effective? And how do you feel we can improve?

Acknowledging our own strengths and the strengths of the members of our team is essential in our long-term success. I encourage you to do some self-reflection. What are your strengths? What nursing prepared you for what you are doing? Do they prefer email? Finally, is there a middle ground? Do you feel valued? How do you show your gratitude? Is your communication effective? And how do you feel we can improve?

References

Four Solutions to Bridge the Generation Gap in the Workplace.
Hands Only CPR

Appraised by:
Kelsey Carlson, RN; Dayna Miranowski, RN & Vanessa Scott, RN Mayville State University RN-BSN students

Clinical Question:
In adults, how effective is hands-only CPR versus conventional CPR at preventing mortality?

Articles:


Synthesis of evidence:
Hands-only CPR or compression-only (COCPR) has been recommended by many medical professionals, especially in out-of-hospital cardiac arrest, over conventional CPR. Hands-only CPR excludes any rescue breathing throughout the process and requires continuous chest compressions to the individual. Conventional CPR in adults typically refers to the ratio of 30 chest compressions to two rescue breaths.

A study conducted in the article, “Bystander-initiated chest compression-only CPR is better than standard CPR in out-of-hospital cardiac arrest,” identified and focused on three randomized controlled trials regarding survival at hospital discharge between compression only CPR and conventional CPR on patients who suffered out-of-hospital cardiac arrests. This study recognized that interruptions of chest compressions during ventilation may have detrimental effects on survival rate. Furthermore, it acknowledged major barriers to bystanders performing CPR including lack of confidence in performing CPR correctly and reluctance to perform mouth-to-mouth. As hands-only CPR is easier to teach than traditional CPR and it removes mouth-to-mouth contact, bystanders may be more willing to perform hands-only CPR.

Another study published in Circulation consisted of patient cases from January 2005 to December 2012, in Japan, who experienced out-of-hospital cardiac arrests (OHCA) and who were resuscitated by bystanders prior to being transferred to a hospital. The study concluded that nationwide dissemination of chest compression-only CPR for lay-rescuers was associated with increased survival and favorable neurological outcome (Iwami, Kitamura, Kiyohara, & Kawamura, 2015).

Finally, a study conducted by Zhan, Yang, He, and Liu (2017) included randomized controlled trials and one cluster-RCT with a total of 26,742 participants analyzed. The study found that when CPR was performed by bystanders, more people survived until discharge from hospital after chest compression alone than they did following interrupted chest compression with pauses at a fixed ratio for rescue breathing.

Bottom line:
Research suggests that there is an increase in survival rates of adults who experience cardiac arrest in out-of-hospital situations when hands-only CPR is used in comparison to conventional CPR. Not only were survival rates increased, but hands-only CPR was also associated with more favorable neurological outcomes in out-of-hospital cardiac arrest. Additional research is always necessary for more accurate results. For example, “the influence of automated external defibrillator (AED) availability and AED use on the effect of continuous chest compression CPR needs to be examined” (Zhan, Yang, Huang, He, & Lui, 2017, p. 22).

Implications for nursing practice:
Out-of-hospital cardiac arrest is a major public health issue, claiming hundreds of thousands of lives worldwide yearly. Nurses play many roles in healthcare, but one of the most pertinent roles is that of an educator. In order to provide the best care and education possible, nurses must strive to stay current on health care topics, including CPR. Nurses are in a unique position to educate the public and may have an impact on increasing bystander-initiated CPR, thus saving lives. It is important to teach individuals to immediately call 911 and emergency personal will prompt instruction on how to perform CPR until EMS arrival.

Focused on your future.

“I continue to learn something new every day and have been able to grow not only as a nurse but as a person during my career here at Altru.”

– Allyson, RN

$10,000 - 15,000 sign-on bonus
for qualifying RN specialties

New hospital in 2022
Grand Forks, ND
Influences on Vaccination Hesitancy

Clinical Question:
What factors influence parent’s decisions regarding the refusal to immunize their children?

Sources of Evidence:


Synthesis of Evidence:
Four articles were reviewed as evidence in this report. A systematic review of meta-analysis, two correlation studies, and a cross-sectional, descriptive design. Larson, Jarrett, Eckerberger, Smith, and Paterson conducted a systematic review on understanding vaccine hesitancy around vaccinations. The review consisted of 1164 articles to be analyzed and the purpose was to inform others of the further development of SAGE model long-term global prospective systematic review of published literature. 2007–2012. Vaccine, 32(19), 2150-2159. doi:10.1016/j.vaccine.2013.06.038

The evidence indicates the essential need for education on the issue, which leads to parents’ reasoning for personal vaccination decisions. School nurses should investigate into parents’ reasoning's for personal vaccination decisions. School nurses can play a major role in the education of parents towards the importance of vaccinations. School nurses should investigate into parents’ reasoning for personal vaccination decisions.

Implications for Nursing Practice:
The evidence indicates the essential need for education to these parents. Many parents are worried about the side effects of the vaccine, believing that it can harm their child. Well-child doctor appointments, prenatal and postpartum visits, and elementary school orientations are excellent opportunities to provide vaccination education to parents. Support groups on the information or topic and in birthing classes could also be a way to help keep awareness of the importance of vaccinations. School nurses can play a major role in the education of parents towards the importance of vaccinations. School nurses should investigate into parents’ reasoning’s for personal vaccination exemptions, this could help the school nurse provide specific education to these parents regarding their concerns.
Infection Rates: Indwelling and Intermittent Catheterization

— The North Dakota Nurse —

Standardized Bedside Reporting

By: Ellen Bane SN, Katie O’Keefe SN, Heather Roy SN, Cassidy Wilhlm SN (NSDU School of Nursing at Sanford Health Bismarck SN Students) Wanda Watanabe PhD, RN, Associate Professor of Practice (Faculty)

Appraised by:

- Radtke (2013): conducted a pre-post pilot project to determine if bedside reporting would increase patient satisfaction with nursing communication. HCAP scores for nursing communication increased from 75% to 87.6%.

- Kahan and Juni (2017): conducted a qualitative study to learn the opinion of 20 Malaysian nurses regarding patient involvement in bedside handovers, and whether bedside handovers are reflective of patient-centered care (PCC). There were four main findings from the study. The nurses’ involvement in bedside reporting was superficial and lack of knowledge. The study highlighted the need for bedside reporting to increase patient autonomy.

- Synthesis of Evidence:
  - Four articles were reviewed and analyzed. These articles included randomized controlled trials, qualitative studies and quasi-experimental studies.
  - Faloon, Hampe, and Cline (2018) conducted a pre-post quasi experimental study to determine if a multifaceted education intervention and the effects of bedside shift reporting improved patient satisfaction on a stroke telemetry unit. They followed the Joint Commission National Patient Safety Goal of 2015 and showed an increase in patient communication among caregivers. The study concluded that bedside shift report should be done to support our findings.

Infection Rates: Indwelling and Intermittent Catheterization

---

Implications for nursing practice:

- Nurses should always be aware of the patient's needs, and what the doctor has ordered. The catheter should be aseptic when handling long-term catheterization. The catheter should be placed down with asepsis. Nurses should be aware of the patient's needs, and what the doctor has ordered. The catheter should be aseptic when handling long-term catheterization. The catheter should be placed down with asepsis.

---

Implications for nursing practice:

- Nurses should always be aware of the patient's needs, and what the doctor has ordered. The catheter should be aseptic when handling long-term catheterization. The catheter should be placed down with asepsis. Nurses should be aware of the patient's needs, and what the doctor has ordered. The catheter should be aseptic when handling long-term catheterization. The catheter should be placed down with asepsis.
Appraised by: Karen Benjamin, RN & Nichole Werder, RN
Mayville State University RN-to-BSN students

Clinical question:
How does the use of incentive spirometry (IS) compared to deep breathing exercises (DBE) affect the incidence of developing pulmonary complications following abdominal surgery?

Articles:


Synthesis of the evidence:
The first article we reviewed was by Al-Harbi, Nagshabandi, and ElGamal (2018) and the purpose of the study was to assess the effect of using incentive spirometry (IS) on postoperative breathing patterns among abdominal surgical patients. The control group received the hospital’s pre- and post-operative routine care. The study group received an educational session about the use of IS preoperatively. The study revealed there is no significance differences between the two groups at day three postoperatively and thereafter.

The second article we reviewed was a Cochrane Research Systematic Review of twelve studies with a total of 1834 participants. Four types of interventions were identified within the research: IS versus breathing exercises, IS versus intermittent positive pressure breathing, IS versus other chest physiotherapy, and IS versus no intervention. The conclusion drawn from this research was there is low quality evidence regarding the lack of effectiveness of IS for prevention of postoperative pulmonary complications in patients after abdominal surgery.

The third article we reviewed was a randomized control study and the purpose was to compare the efficacy of selected chest-physiotherapy and incentive-spirometry in improving cardiovascular and pulmonary functions and preventing complications in individuals who had thoracic and/or abdominal surgery. An important component of this study was the assessment and monitoring of the compliance on the use of incentive spirometer and recognizing the correct use of IS can then have a direct impact on the patient care. The study group received an educational session about the use of IS preoperatively.

The final article we reviewed was by Pattanshetty and Thapa (2015) and this study compared the effect of early mobilization program with diaphragmatic breathing exercise (DBE) versus incentive spirometry (IS) on diaphragmatic excursion and Peak Expiratory Flow Rate (PEFR) in the patients with abdominal surgery. One group for DBE and the second group for IS. Measurements: 1) Diaphragmatic excursion, 2) Peak Expiratory Flow Rate (PEFR), 3) Pain was measured, 4) Chest expansion was measured, 5) Mobility and mobility limitations were recorded. All five measurements were taken before intervention on the first day and after the intervention on the seventh day. This study witnessed compliance of DBE IS use. The study found improvement in walking distance after the intervention in both groups. The final conclusions were DBE is more effective as compared to IS in diaphragmatic excursion and PEFR post-operative abdominal surgery patients.

Bottom line:
While Incentive Spirometry remains a common intervention in all patients, the evidence presented in this review of research articles finds no statistically significant benefit when compared to deep breathing exercises in preventing the development of postoperative pulmonary complications (PPC) in abdominal surgery. There is a need to quantify this by reflecting each study was a small case study, there often was no monitoring of compliance use of the IS for several of the studies, and often the studies were coupled with early mobilization. Several studies indicated factors, of which directly related to the physiological changes which impacted the PPC; such as, type of anesthesia (general or regional), the type of incision, and the surgical technique utilized. Furthermore, co-morbidities, type of surgery and anesthesia, and if this was a first operation or a re-operation of the patient participating in the research studies also made them a vulnerable candidate for PPC after their abdominal surgery. In many studies’ conclusion suggests further research with improved study designs to be conducted.

Impaction for nursing practice:
When a patient has abdominal surgery, there is an increased risk for the development of pulmonary complications postoperatively. Educating staff about the purpose, correct use of the incentive spirometer, and providing opportunities for nursing practice for respiratory care for patients postoperatively. Group 1: Early mobilization and Incentive Spirometry (IS), Group 2: Early mobilization and chest-physiotherapy, Group 3: Early mobilization and combination of IS and chest-physiotherapy. There was no statistically significant difference in the presence of postoperative complications among the three groups.

The final article we reviewed was by Pattanshetty and Thapa (2015) and this study compared the effect of early mobilization program with diaphragmatic breathing exercise (DBE) versus incentive spirometry (IS) on diaphragmatic excursion and Peak Expiratory Flow Rate (PEFR) in the patients with abdominal surgery. One group for DBE and the second group for IS. Measurements: 1) Diaphragmatic excursion, 2) Peak Expiratory Flow Rate (PEFR), 3) Pain was measured, 4) Chest expansion was measured, 5) Mobility and mobility limitations were recorded. All five measurements were taken before intervention on the first day and after the intervention on the seventh day. This study witnessed compliance of DBE IS use. The study found improvement in walking distance after the intervention in both groups. The final conclusions were DBE is more effective as compared to IS in diaphragmatic excursion and PEFR post-operative abdominal surgery patients.

Bottom line:
While Incentive Spirometry remains a common intervention in all patients, the evidence presented in this review of research articles finds no statistically significant benefit when compared to deep breathing exercises in preventing the development of postoperative pulmonary complications (PPC) in abdominal surgery. There is a need to quantify this by reflecting each study was a small case study, there often was no monitoring of compliance use of the IS for several of the studies, and often the studies were coupled with early mobilization. Several studies indicated factors, of which directly related to the physiological changes which impacted the PPC; such as, type of anesthesia (general or regional), the type of incision, and the surgical technique utilized. Furthermore, co-morbidities, type of surgery and anesthesia, and if this was a first operation or a re-operation of the patient participating in the research studies also made them a vulnerable candidate for PPC after their abdominal surgery. In many studies’ conclusion suggests further research with improved study designs to be conducted.

Impaction for nursing practice:
When a patient has abdominal surgery, there is an increased risk for the development of pulmonary complications postoperatively. Educating staff about the purpose, correct use of the incentive spirometer, and providing opportunities for respiratory care for patients postoperatively. Group 1: Early mobilization and Incentive Spirometry (IS), Group 2: Early mobilization and chest-physiotherapy, Group 3: Early mobilization and combination of IS and chest-physiotherapy. There was no statistically significant difference in the presence of postoperative complications among the three groups.

The final article we reviewed was by Pattanshetty and Thapa (2015) and this study compared the effect of early mobilization program with diaphragmatic breathing exercise (DBE) versus incentive spirometry (IS) on diaphragmatic excursion and Peak Expiratory Flow Rate (PEFR) in the patients with abdominal surgery. One group for DBE and the second group for IS. Measurements: 1) Diaphragmatic excursion, 2) Peak Expiratory Flow Rate (PEFR), 3) Pain was measured, 4) Chest expansion was measured, 5) Mobility and mobility limitations were recorded. All five measurements were taken before intervention on the first day and after the intervention on the seventh day. This study witnessed compliance of DBE IS use. The study found improvement in walking distance after the intervention in both groups. The final conclusions were DBE is more effective as compared to IS in diaphragmatic excursion and PEFR post-operative abdominal surgery patients.
Influenza Vaccine vs. No Vaccine for Over 65 Patients: Risk for Pneumonia Comparison

Appraised by:
Michaela Lund, RN, Brittany Thordal, RN and Heather Carl, RN- Mayville State University RN-to-BSN students

Clinical question:
For patients 65 years and older, how does the use of an influenza vaccine compared to not receiving the vaccine influence the risk of developing pneumonia during flu season?

Articles:

Synthesis of evidence:
The first study we reviewed by Demicheli, et al. looked at the effectiveness of vaccines against influenza in the elderly. The study determined older adults receiving the influenza vaccine may experience less influenza over a single season, from 6% to 2.4%, meaning that in 30 people would need to be vaccinated with inactivated influenza vaccines to avoid one case of influenza. Older adults also probably experience less influenza-like illness (ILI) from 6% to 3.5%, meaning that 42 people would need to be vaccinated to prevent one case of ILI. The amount of information on pneumonia and mortality was limited. Data were insufficient to be certain about the effect of vaccines on mortality. No cases of pneumonia occurred in one study that reported this outcome, and no data on hospitalizations were reported (Demicheli, et al., 2018).

The second study we reviewed was to investigate the factors associated with influenza vaccination coverage in hospitalized patients aged equal to or greater than 65 years, hospitalized due to causes unrelated to influenza in Spain. A bivariate analysis was made to compare vaccinated and unvaccinated patients considering the sociodemographic variables and risk medical conditions. Due to access to health care per region, the multilevel regression model was used to estimate crude and adjusted odds ratio. Covariates were introduced into the model using a backward stepwise procedure with the influenza vaccination coverage in elderly hospitalized patients in Spain (58.0%) is clearly lower than the 75% target proposed by the World Health Assembly for people aged ≥65 years. No association was found between sex and influenza vaccination coverage. A US study found that 88% of persons vaccinated against influenza had received the pneumococcal vaccine. In this study, the figure was 54.5% (Demicheli, et al., 2018).

The study by Kondo, et. al was also reviewed by our team and the purpose of this hospital-based, matched case control study was to investigate the potential influence of recent pneumococcal and influenza vaccination on pneumonia in those 65 and older. Older adults who received the influenza vaccine showed a 9% relative decrease of risk for pneumonia compared to unvaccinated elderly (Kondo, et al., 2015).

The fourth and final study was conducted using a randomized placebo controlled clinical trial. Researchers examined the potential sources of bias in observational studies of influenza, including comparing unvaccinated patients with influenza in one study that reported this outcome, and we discuss available evidence regarding the efficacy and effectiveness of licensed influenza vaccine (Truccchi, Pagano, Orsi, De Florentiis, & Ansaldi, 2015).

Bottom line:
Evidence suggests that most influenza vaccines confer relative protection against naturally acquired infection also in the elderly, who are at increased risk for influenza and complications due to influenza infection. The use of influenza vaccines is recommended worldwide from several years and cost-effectiveness issues must be properly re-assessed in times of economic recession (Trucchi, et al., 2015).

Older adults receiving the influenza vaccine may have a lower risk of influenza (from 6% to 2.4%), and probably have a lower risk of influenza-like illness compared with those who do not receive a vaccination over the course of a single influenza season (from 6% to 3.5%) (Demicheli, et al., 2018).

Although, the data that we have collected shows that there is a decreased risk of pneumonia when an individual 65 and older receives the vaccine, additional research is needed.

Implications for nursing practice:
Influenza infection is associated with considerable yearly morbidity and subjects aged ≥ 65 years are among those at highest risk of serious outcomes. Annual influenza vaccination, that is considered the most effective strategy to prevent influenza by the World Health Organization, is recommended for elderly in many developed countries (Kondo, et al., 2018). Since this is the most effective strategy to prevent influenza, nurses should be advocates for the elderly.

Influenza is a potentially serious disease that can lead to hospitalization and sometimes even death. Every flu season is different, and influenza infection can affect people differently, but millions of people get the flu every year, hundreds of thousands of people are hospitalized and tens of thousands of people die from flu-related causes every year. An annual seasonal flu vaccine is the best way to help protect against flu. Vaccination can help prevent many benefits including reducing the risk of flu illnesses, hospitalizations and even the risk of flu related death in children. With this information, nurses can be prepared for influenza season and offer the influenza vaccine to the people who are admitted to the hospital or in the clinic.

Studies show that a yearly flu vaccine can help prevent pneumonia in those 65 and older. It is our job as nurses to make sure information is available to the public on the benefits of the yearly flu shot.
Clinical question: In post-operative patients, is handwashing more effective than alcohol-based hand rub in decreasing the rate of hospital acquired infections?


Synthesis of Evidence: This synthesis comprises four studies relating to evidence that support the above research question.

The first study was conducted by Harverstick, S., Goodrich, C., Freeman, R., James, S., Kullar, R., & Ahrens, M. (2017), and its focus was to determine if increased access to hand hygiene products and patient education could improve patients’ hand hygiene and reduce the transmission of hospital acquired infections. Emphasis was to see if there was a decline in rates of infection with methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant enterococci (VRE), and Clostridium difficile. According to this project, VRE infections decreased by 70% in a 19-month period after the intervention. The contrary, C difficile infections increased 31% in a 19-month period after the intervention.

The second study was conducted by the National Center for Biotechnology Information (NCBI) (2009), which included 10 participants who hands were infected with Clostridium difficile (C. Difficile). The study experimented with many variations of hand washing including soap and water using warm water versus cold water, alcohol-based hand rub, hand wipes, and also using no method to attempt to remove bacteria. The C Difficile from their hands. Both the entire surface of the hand, as well as only the palms were contaminated to see if that also made a difference in the results. The method that had the best results in removing C. Difficile was using warm water and hand soap.

The third study was also conducted by the National Center for Biotechnology Information (NCBI) (2017), and focused on comparing waterless hand rub (alcohol based chlorhexidine gluconate solution) versus a traditional hand scrub with soap and water in means of preventing surgical site infections. With a sample size of 14 patients who underwent orthopedic surgery, a post-operative comparison was done and screenings were performed postoperatively for surgical site infection. In conclusion, the waterless hand rub is a cost-effective, time efficient and effective alternative to the traditional hand scrub in a surgical setting to prevent surgical site infections.

The fourth study conducted by Tanner, (2017), focuses on surgical hand antisepsis on all the studies we reviewed, no one method; and to determine the effects of surgical hand antisepsis on the numbers of colony-forming units on the hands of the surgical team. The authors compared different types of hand antisepsis before surgery. The two most common forms of hand antisepsis involve aqueous scrubs and alcohol rubs. This study concluded that although both methods were not 100% effective in decreasing surgical infections, washing hands with soap and water when hands are visibly soiled is the most effective way of preventing surgical site infections.

Bottom line: Hand hygiene is vital in preventing infection in patients. Both hand washing with soap and water and alcohol-based sanitizer will kill pathogens that can harm patients. However, hand washing with soap and water is more effective in preventing hospital acquired infections for hospitalized patients (Tanner, 2016). Alcohol-based hand rubs are not as affective in removing Clostridium difficile spores from the surface of the skin, placing patients at an increased risk of infection (NCBI, 2009). From the study conducted by Tanner, (2016), there was uncertainty about the optimal method of hand antisepsis for minimizing surgical site infection but one thing that remains clear is that adherence to proper hand washing is important in reducing the transmission of all types of infections in hospitalized patients. Thus, further research is needed in this area to explore more answers to the above PICO question.

Implications for nursing practice: Hand hygiene and infection control is one of the most important aspects in nursing care. In delivering quality care, healthcare professionals must minimize the chances of transmitting infections to the patients by ensuring proper hand hygiene. From the study conducted by Tanner, (2016), there was uncertainty about the optimal method of hand antisepsis for minimizing surgical site infection but one thing that remains clear is that adherence to proper hand washing is important in reducing the transmission of infections to our patients. This study sought to find out the best way we can prevent infections. This is very important in nursing because one of our top priority as healthcare professionals who come in contact with patients on a daily basis is to make sure that we break the chain of infection and keep our patients safe. As nurses our knowledge from this study will help us reinforce hand hygiene and compliance in our various places of work to decrease infections rates and reduce hospitalization. Nurses are real models and stand the chance of making a difference by providing safe care through hand hygiene practices. They should be an example for others to follow. Together we can break the chain of infection.
Before you make decisions about nurse-patient assignments, you need as much information as possible about your patients. Were they admitted to the hospital, transferred from another facility, in the emergency department, or postanesthesia care unit? Other important clues to your patients’ current condition are their vital signs, lab results, psychological status, and confirmation of orders. Fluid balance, medications, nutrition, respiratory status, and vital signs are critical information you need before you can make assignments.

Common patient decision factors

Demographics
- Age
- Ethnicity
- Gender
- Language

Safety measures
- Airway
- Contact precautions
- Dermatologic precautions
- Fall precautions
- Restraints
- Surveillance

Common patient decision factors

Acuity
- Level of complaint
- Code status
- Cognitive status
- Comorbidities
- Condition
- Diagnosis
- History
- Lab results
- Procedures
- Type of surgery
- Vital signs

Safeguard support
- End-of-life care
- IV therapy
- Pain
- Physical therapy
- Respiratory care
- Wound care

Psychosocial support
- Emotional support
- Family support
- Intellectual needs

Adjust the assignments

You just made the assignments, so why do you need to adjust them? The nurse-patient assignment list is a living, breathing document. It involves people who are constantly changing—Their conditions improve and deteriorate, they’re admitted and discharged, and their nursing needs can change in an instant. The assignment process requires constant evaluation and reevaluation of information and priorities. And that’s why the assignments are usually written in pencil and can be changed on any erase board.

As the charge nurse, you must communicate with patients and staff throughout the shift and make necessary adjustments. Your goal is to ensure patients receive the best care possible: How that’s accomplished can change from minute to minute.

Evaluate success

What's the best way to evaluate the success of your nurse-patient assignments? Think about your priorities and goals. Did all the patients receive safe, quality care? Did you maintain continuity of care? Did the new nurse get the best orientation experience? Were the assignments fair? Measure success based on patient and nurse outcomes.

What you need to know

Choose your process

Your nurse-patient assignment process may be different. Assign nurses to patients based on your unit’s geography, the number of patients, and patient ratio. Most nurses use one of three assignment processes.

Area assignment

This process involves assigning nurses and patients to a particular area, such as triage in the ED or beds 1 and 2 in the PACU, and then patients are assigned to each area throughout the shift.

Direct assignment

The second option is to assign each nurse directly to one or two specific patients (direct process). A unit nurse is assigned to an area, such as triage in the ED or beds 1 and 2 in the PACU, and then patients are assigned to that nurse.

Group assignment

This process involves assigning nurses to groups and then assigning the nurse to a group. Bigger units have larger teams and need to rotate nurses. A unit nurse is assigned to an area, such as triage in the ED or beds 1 and 2 in the PACU, and then patients are assigned to a group throughout the shift.

Reprinted from American Nurse Today Successful assignments require attention to the needs of both nurses and patients. YOUR MANAGER wants you to learn how to make assignments that work. What’s the secret? When did you become a senior nurse on your first floor? Did you spend the first year learning how to make nurse-patient assignments? What’s already? When you do a critical analysis of your current practice, you’ll find that the process of making nurse-patient assignments is challenging, but with your mentor’s help, you’ll move from novice to competent in no time.

Gather your supplies (knowledge)

Before completing any nursing task, you need to gather your supplies. In this case, you’re gathering your knowledge of the unit, the nurses, and the patients. (See What you need to know.) Some of this information you already know, and some you’ll need to gather. But make sure you have everything you need before you begin making assignments. Managers need to be aware of serious nurses and may jeopardize patient and staff safety.

Find a mentor

Most nurses learn to make nurse-patient assignments from a colleague. Consider asking if you can observe your charge nurse make assignments. Ask questions about what factors are taken into consideration for each assignment. Nurses who make assignments are aware of their importance and are serious in their efforts to provide the best possible care for their patients when making them. By asking questions, you’ll better understand how priorities are set and the thousands of pieces of information that a nurse-patient assignment is challenging, but with your mentor’s help, you’ll move from novice to competent in no time.

Set priorities for the shift

The purpose of nurse-patient assignments is to provide the best and safest care to patients. It’s also the opportunity for nurses to consider and prioritize. This is where making assignments gets difficult. You’ll need to consider the number of new patients, new-patient orientation and education, patient requests and satisfaction, staff well-being, fairness, equal distribution of the workload, nurse development, and workload completion.

Make the assignments

Grab your writing instrument and pencil in that first nurse’s name. This first match should satisfy your highest priority. For example, if nurse and any other returning nurses are assigned to the patients they had on their previous shift. It’s not always possible to assign nurses to the highest-than-average-acuity, you just assigned your first priority. After you’ve satisfied your highest priority, move to your next highest priority and match nurses with unscheduled patients and areas. If you’re staffing 12-hour shifts, try to balance your workload and assign nurses who can work in rooms at opposite ends of the unit. If you work in a labor and delivery unit, you can assign one nurse to triage area (area process), while another nurse is assigned to one or two specific patients (direct process). Area nurse characteristics direct your process for making assignments. Your process will remain the same unless your unit’s geography or patient characteristics (length of stay, nurse-patient ratio) change.
Diabetes Self-Management Education & Support (DSMES) Delivers Results

➢ Improves A1C levels
➢ Reduces hospitalizations, complications and health care costs

Refer to an accredited/recognized DSMES program today!
➢ Qualified educators
➢ Goal oriented discussion tailored to patient needs
➢ Team based care for optimal results
➢ Covered by most health insurance plans

4 Times to Refer
• At diagnosis
• Annual assessment
• When complicating factors occur
• When transitions in care occur

Find a complete list of North Dakota’s DSMES programs at www.diabetesnd.org

Questions? Email jlpastir@nd.gov

NORTH DAKOTA DEPARTMENT OF HEALTH

STOP OPIOID OVERDOSE

20 DEATHS IN 2013
68 DEATHS IN 2017

Overdose deaths in North Dakota increased from 20 deaths in 2013 to 68 deaths in 2017.
CDC/NCHS, National Vital Statistics System, Mortality

YOUR ROLE IN PREVENTING OPIOID OVERDOSE

You can prevent opioid overdose by assessing patient pain and need for pharmacologic pain relief and by helping patients understand the risks and benefits of pain treatment.

STRATEGIES TO PREVENT OVERDOSE DEATHS

1. Utilize the Prescription Drug Monitoring Program (PDMP) to assist in treatment planning.
2. Educate patients about the risks and benefits of pain treatment options, including those that do not involve pain medication.
3. Recommend effective treatment strategies (including Medication Assisted Treatment) to individuals with opioid use disorder.

NORTH DAKOTA BE LEGENDARY

BE BEHAVIORAL HEALTH HUMAN SERVICES

behavioralhealth.nd.gov/stopoverdose

ADVANCE YOUR NURSING CAREER

Choose from educational options that fit your needs.
• With locations in Fargo and Bismarck, North Dakota, the NDSU School of Nursing offers small class sizes, experienced faculty and an excellent value.
• An RN to BSN blended online part-time program provides flexibility to transform your professional practice
• Pre-licensure BSN program — Bismarck and Fargo
• LPN to BSN blended online program
• Doctor of Nursing Practice (BSN to DNP)/Family Nurse Practitioner program — Bismarck and Fargo

NDSU offers programs to part- and full-time students, working professionals and those seeking online educational opportunities.

nds.edu/nursing

BECOME A BUPRENORPHINE PRESCRIBER


NORTH DAKOTA STATE UNIVERSITY