Ohio Nurse

The Official Publication of the Ohio Nurses Foundation for Nursing

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Advocacy: For Our Patients, Ourselves, and Our Profession

Welcome to the second issue of the *Ohio Nurse!* The Ohio Nurses Foundation has received numerous calls and emails from nurses all over the state expressing their excitement and enthusiasm about this new publication. You are receiving it because you are a nurse licensed in Ohio or a member of an organization that is involved in nursing education or nursing care. The Ohio Nurses Foundation is committed to this publication as a way to communicate with you, enhance your professional development, and keep you updated on things that are happening in the world of nursing. The result of your receiving this information is that you will have a better way to advocate for your patients, yourself, and the profession of nursing.

To advocate means to support or to speak on behalf of. Advocacy is part of our role as nurses. We support and promote patient safety and quality of care, we consider our own needs for growth and learning so we can remain competent, and we have the opportunity to enhance nursing by positively supporting things that advance the profession. Think about the ways you do each of those things.

Ohio nursing law and rules speak to the advocacy role of the nurse in many ways. We have defined scopes of practice for RNs and LPNs to identify the strategies we employ to provide care for our patients. We have a statement in Ohio Board of Nursing rule that addresses maintaining patient safety through our competence. Nurses are expected to keep learning, to update ways things are done as new evidence for practice becomes available, and to use critical thinking to determine what nursing actions are appropriate for a patient at any given time, based on our nursing judgment.

Another rule addresses the process for carrying out prescribed treatments or medication administration plans. The nurse is expected to follow the prescribed plan of care unless he/she believes that the prescription is inaccurate, not properly authorized, not current or valid, harmful or potentially harmful, or contraindicated by other documented information. Advocating for patients means knowing both the patient and the proposed treatment regimen and using nursing judgment to make sure patient safety will be maintained when the medication or treatment is administered.

Ohio Board of Nursing rules also relate to behaviors that promote an emphasis on advocating for the patient–the nurse is not to violate professional boundaries or take advantage of a patient in any way. The nurse is expected to provide privacy and dignity and to treat each patient with respect. As we do these things, we are advocating for the rights of our patients to have safe care.

The Code of Ethics for nurses from the American Nurses Association speaks of advocacy in several ways as well. The Code states that the primary commitment of the nurse is to the patient. This means that we are respectful of the uniqueness of each patient. It also means that we collaborate with other nurses, as well as with colleagues from other healthcare disciplines, as we work together to provide comprehensive care.

On a broader level, the Code of Ethics states that nurses participate in establishing, maintaining, and improving healthcare environments and conditions of employment and that we advocate for the advancement of nursing. This may mean being involved in process improvement activities at your place of employment, sharing "best practices" information with your colleagues, or speaking with your legislator about a pending bill that would affect nursing practice.

How do you serve as an advocate for your patients, for yourself, and for nursing? Several upcoming opportunities will give you tools you need to be an effective advocate. First, patient care is enhanced when your knowledge base is expanded. The continuing education opportunities presented in this issue enable you to learn new things, or perhaps to validate your current knowledge.

Second, there is information in this issue for the upcoming Nurses Day at the Statehouse. Collaboratively sponsored by ONA and numerous other nursing organizations, this premier event gives nurses the ability to become knowledgeable about how the political process affects nursing, and vice versa. Participants in this annual event are always excited about the empowering effect of nurses who work together and speak up together to advocate for nursing.

Third, national nurses' week will be happening during the first week in May. Take time now to stop and think about how you can use that special opportunity to be an advocate. Maybe it involves considering your role in patient care. Maybe you can think of a way you can use nurses' week to thank your colleagues for the work that they do and recognize them for jobs well done. Perhaps it's an opportunity to increase your own involvement through organizational initiatives or active participation in a professional association.

Thank you for being a nurse. Thank you for caring, and for being involved. Thank you for being an advocate.

Pamela S. Dickerson, PhD, RN-BC
Chair, Ohio Nurses Foundation Provider Council

President's Message

Thank you for reading the second edition of the *Ohio Nurse*. The response to the first edition exceeded our wildest expectations, and we hope you find this issue just as useful. If you have ideas of what you would like to see in future issues or would like information on contributing an article, please contact me either via email at gharsheymeade@ohnurses.org or send a note to our office at 4000 East Main Street, Columbus, Ohio 43213.

Sincerely,

Gingy Harshey-Meade RN—President & CEO, Ohio Nurses Foundation

The *Ohio Nurse* is now available online at www.ohnurses.org. Click on "Foundation" to read current and previous issues.

No Lift is a Safe Lift–Protecting Nurses From Musculoskeletal Injuries

by Glenna Baker, RN, Capital University

Musculoskeletal injuries (MSIs) are occurring at epidemic proportions in the profession of nursing. Nurses are at high risk for sustaining this type of injury resulting in physical and emotional pain. Financial costs are in the millions of dollars for treatment of MSIs. This article defines some facts and myths along with a personal experience of an MSI. Through legislative efforts encouraged by nursing associations programs are being introduced at the state and federal levels. The Ohio Bureau of Workers' Compensation (BWC) is offering a preventative no-interest loan program to acute and extended care facilities (ECF). The goal of this article is to describe MSIs and their impact on the nurse shortage. Finally, strategies for prevention and implications for nursing to help eliminate this devastating dilemma are offered.

The Injury

An MSI can occur at any time. MSIs are generally cumulative in nature and happen as a result of repetitive strain. The symptoms associated with MSI can range from mild to debilitating. The risk factors include repetitious, forceful, or prolonged exertion with frequent or heavy lifting. Other contributing factors involve pushing, pulling, and carrying of heavy objects while in awkward posture or continuous exposure to vibrating motions. The consideration of the time, frequency and level of exposure is necessary in evaluating MSI. (NIOSH, 1997)

Facts related to MSIs

Estimates show that 12% of nurses leave the profession annually due to back injuries and 52% complain of chronic back pain. These figures compound the already critical nurse shortage. Let us review some additional facts underlying this epidemic:

- The US Bureau of Labor Statistics ranked registered nurses 6th in a list of at risk occupations for strains and sprains.
- The US Bureau of Labor Statistics estimates that incidences of MSI involving lost work days are 181.6 per 10,000 full-time workers in ECF and 90.1 per 10,000 full-time workers in hospital settings.
- In an 8-hour shift the cumulative weight lifted by a nurse is equal to 1.8 tons per day.
- Nursing is 2nd after industrial work for physical workload intensity.
- 80% of injuries are not reported by nurses. This means that only 1 out of 3 nurses file reports, which is reflective of a pervasive "grin and bear it" attitude with respect to MSIs.
- An aging workforce (average age of today's nurse is 45.2 years nationally and even older in Ohio–47 years) and an increasingly heavier population is exacerbating the injuries. (Nelson, 2003)

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No Lift is a Safe Lift . . .

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Myths

Several misconceptions are associated with MSIs:

- *Education on lifting techniques and proper body mechanics are effective in reducing injury.* These techniques have been taught for years and by themselves are not effective in reducing the number of MSIs according to injury statistics.
- *MSI is restricted to lifting.* Other high-risk tasks include bending and twisting as well as transferring lateral patients on a horizontal plane.
- *Nurses require screening before hiring to assess their level of risk.* With the current rate of injury, recruitment will be difficult.
- *The use of back belts helps to prevent injury.* Studies have proven no effectiveness of this device. Injury levels do not change with their use.
- *Mechanical lifts are not affordable.* The cost of equipment is far less than the cost of work related injuries.
- *Nursing staff will stop lifting with a no-lift policy.* Policies have failed due to the occlusion of the technologic components. (Nelson, Fragala and Menzel, 2003) (Gatty, 2004)

On November 1, 2004 while working in an emergency department (ED) I sustained a severe MSI. My injury occurred while monitoring a critically ill patient in x-ray while wearing an oversized lead apron. This apron was the only equipment available to protect me from radiation exposure. In an instant my life changed.

The patient was being transferred to the ED cart from the x-ray table with the assistance of four other staff members. The patient grabbed for her esophageal tube. With a twisting motion I reached for her arm to prevent removal of the tube, which would have been catastrophic for her. Immediately, I felt a burning sensation down my right leg and pain in my lower back. Within hours, I experienced numbness in my right leg. The realization that this injury was severe became apparent.

The very next day I reported to work and discussed my injury with the appropriate personnel. Subsequently, I became a patient in the ED. My thought process was an innate fear that my career might come to an abrupt end. A magnetic resonance image (MRI) revealed bulging disc, L5-S1 with nerve impingement. I was sent to a neurosurgeon who started a regimen of physical therapy and epidural steroid injections.

This injury affected all aspects of my life. The treatment was not successful as the pain and numbness persisted. I was assigned light duty and my career was in jeopardy.

I consented to discectomy of the L5-S1 disc. The numbness and tingling of my right leg was alleviated. However, four days post- operatively I suffered a spinal fluid leak. The leak caused excruciating headaches in any position other than supine. I was admitted back to the hospital on strict bed rest in trendelenberg position for three days. After 36 hours I was to be released if the headache was gone with ambulation. Spontaneously, I coughed and the headache returned immediately. I notified my nurse who spoke with the resident on duty. The resident discharged me in spite of the headache.

I felt like my head was going to explode all over the car. The headache was worse than before. I returned to the ED and was back at square one in trendelenberg position. My frustration, fear and anger towards this injury was exacerbated The next day, it was decided that surgical repair of the leak was indicated. After nine weeks of recovery and therapy, I was released back to work without restriction.

This MSI and the two spinal surgeries have created permanent disability. I have lost flexibility and experience pain on a daily basis. Prior to the MSI, I was active in aerobic activity three times a week. My belief in alternative pain management methods such as meditation, breathing, hot baths, and sheer stubbornness and grit have been my salvation. I have become very protective of my back. I am continuing my education to prepare to leave 15 years of bedside nursing. I feel that this is necessary to maintain the physical ability that I have left after my MSI. I am a statistic contributing to the shortage of experienced bedside nurses.

Recently, I have been experiencing some renewed symptoms with numbness and tingling in my left leg and worsening pain in my lower back. I am beginning to work through the mounds of paperwork required of an injured worker. This is a long and tedious endeavor. The emotional and physical rollercoaster continues.

Legislative and Association Efforts

Historically, nurses have not taken a proactive role in the prevention of MSIs. With the rising number of injuries and the cost of workers' compensation at $1.7 billion annually, legislatures and nursing associations are developing strategies. (Goldsmith, 2001) Several states have already introduced and some have implemented relevant legislation.

Texas was the first state to pass House Bill 1525 in May of 2005. This bill ensures that hospitals and nursing homes adopt and implement policies that identify, assess, and develop plans to control the risk of injury to nurses and patients. It also puts procedures in place for nurses to refuse to perform or be involved with patient handling that they believe in good faith will expose a patient or nurse to an unacceptable risk. (Hudson, 2006)

In 2004 the American Nurses Association (ANA) announced its program *"Handle with Care"*. This ambitious initiative aims to prevent career-ending MSIs among nurses. The program includes the following recommended steps:

1. Create an ergonomics committee. Establish, implement, and monitor a comprehensive ergonomics program.
2. Analyze the data, conduct a walk-through, and survey employees. Review illness and injury logs, incident reports and other reporting systems. Examine and explore any apparent injury patterns and trends.
3. Assess patient-dependency levels. Consider patients' needs and abilities regarding equipment use.
4. Assess risky patient-handling tasks. Perform an ergonomics hazard assessment based on information and data.
5. Develop and adopt a safe patient-handling policy. Institute a no-lift policy that discourages manual lifting and promotes use of appropriate equipment.
6. Research, evaluate, and select a pilot project. Include frontline health care workers in every step of pilot projects.
7. Provide comprehensive and interactive training for staff. Train staff on policies regarding equipment and devices before implementing them.
8. Encourage reporting of back injuries, strains, and other musculoskeletal injuries. Create a blame free environment for reporting work-related injuries or illnesses.
9. Track patient and worker injuries and evaluate the program. Continue to gather and analyze data; update the program with the latest policies, best practices, and most the advanced technology. (ANA, 2004)

ANA is taking the right steps toward creating a safe environment for nurses and patients. Schools of nursing are following suit by incorporating ergonomics and lift equipment into their curriculums. These efforts will allow students to bring expertise into their practices.

Nursing professionals must also step up and protect themselves. We must avoid injury at all cost as the current shortage may increase work demands, thereby placing nurses at greater risk for this type of injury. We must incorporate safe practices into our daily routines and become active in our places of employment with the implementation of no-lift policies and no-lift equipment. It is our professional obligation to promote the health and welfare of our patients, colleagues and selves.

Ohio Bureau of Workers' Compensation (BWC)

The Ohio Nurses Association (ONA) has been working with the Ohio General Assembly to enact legislation that provides incentives to facilities for the purchase and installation of lift assist devices and equipment. In Ohio, under the auspices of the BWC, a plan of action is in place. Its plan, *A Long-Term Program*, provides no-interest loans for the purchase of lift equipment. It is intended to help Ohio's extended care facilities (ECFs) and acute care facilities to reduce the frequency and severity of workplace MSIs.

The *Long-Term Program* is available to any state-funded or self-insured ECF or hospital as defined by Ohio law. The loans will fund lift assist equipment and ergonomic training for employees with the implementation of no-lift policies. The institutions must be current on all workers' compensation assessments and premiums. The program provides interest reimbursement every six months for a loan not to exceed five years. The loan amount cannot exceed $100,000, and the interest rate cannot be greater than 2.5 percent of the prime.

The process includes:

1. Completion of an application available on the BWC website (www.ohiobwc.com)
2. Meeting with a BWC ergonomic specialist.
3. Receipt of a verification signature from the ergonomic specialist.
4. Mailing the signed completed application to the BWC.

Participating institutions can receive guidance in the development of their no-lift policies from a BWC ergonomic specialist. The BWC requests that successful case studies be forwarded to the department to validate the benefits of the program to other employers. More information on the program can be found on the BWC website. (BWC, 2007)

Evidence-Based Practice

Research has proven that several factors must be evaluated to promote improvement of MSIs. A study reported in the *Journal of Advanced Nursing* involved a questionnaire distributed in 2005. The survey included 23 orthopedic and 24 intensive care nurses. Questions included: history of MSI; workload; problems; solutions; and psychophysical measures of exertion.

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OHIO NURSE

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If you need additional information or have questions, please contact Shannon Richmond, Director of Communication at (614) 448-1029.

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Member of the American Nurses Association

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Street Address | City, State and Zip | County

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(____) Work Phone | (____) Work Fax | Work Email

Employer | US Citizen? (__)Yes (__)No

RN License Number | License State | Basic School of Nursing | Grad. Mo/Yr (basic program)

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See other side for membership rates

Full Rate
(__) Employed full or part-time

75% Full Rate
(__) Second year of membership for new graduates who joined within 12 months of graduating from basic nursing program

50% Reduced Rate
(__) Not employed
(__) First year of membership for new graduates from basic nursing education program who join within 12 months of graduating
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25% Special Rate
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(__) **Electronic Dues Payment Plan (EDPP)** – Monthly payments will be deducted from your checking account. Sign authorization below and enclose check payable to Ohio Nurses Association for the first month's EDPP payment.

AUTHORIZATION to provide monthly electronic payments to Ohio Nurses Association (ONA): This is to authorize ONA to withdraw monthly dues payments on or after the 15th day of each month from my checking account designated by the enclosed check for the first month's payment. I understand this amount includes a monthly service fee of 33 cents. ONA is authorized to change the amount by giving the undersigned thirty (30) days notice. The undersigned may cancel this authorization upon receipt by ONA of written notification of termination twenty (20) days prior to the deduction date as designated above. ONA will charge a $5.00 fee for any returned drafts.

Signature for EDPP Authorization_____

(__) **Payroll Deduction** – Available only at facilities where there is an agreement between the employer and ONA. If you are not sure, contact your payroll department or ONA. A payroll deduction authorization form must be signed before deductions can begin. Contact ONA for the deduction amount.

Mail to: ONA Dues Processing Department, P.O. Box 14845, Columbus, Ohio 43214-0845

One dollar ($1.00) per month of your dues goes to an account set up to support ONA's political efforts. You may choose at anytime to opt out of this dues designation. If you are interested in opting out, please contact the Director of Health Policy at 614/237-5414.

ONA Dues are not deductible as a charitable contribution for federal income tax, but can be partially deductible as a business expense. A percent of the dues not deductible is calculated each year based on the amount spent lobbying. When preparing your taxes, contact ONA for the percentage that is deductible in the year you make this payment.

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Ohio Nurses Association Membership Assessments and Dues Rates

RATES EFFECTIVE 01/01/2008

Check below to determine your district. ONA Bylaws state that you must live or work in your district. Indicate choice if you live in one district and work in another.

District Name and Counties

01 Ashtabula County: Ashtabula
06 Defiance-Williams: Defiance, Williams
03 District Three: Columbiana, Mahoning, Trumbull
10 District Ten: Butler, Darke, Greene, Mercer, Miami, Montgomery, Preble, Shelby
07 Erie-Huron: Erie, Huron
16 Greater Cleveland: Cuyahoga, Geauga
23 Hi-Point Tecumseh Trail: Champaign, Clark, Logan
17 Jefferson-Harrison-Tuscarawas: Harrison, Jefferson, Tuscarawas
18 Knox-Licking: Knox, Licking
19 Lake County: Lake
24 Lorain County: Lorain
12 Mid-Ohio: Delaware, Fairfield, Fayette, Franklin, Madison, Pickaway, Union
05 Mohican: Ashland, Crawford, Marion, Morrow, Richland
28 Muskingum Valley: Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry
35 Northwest Ohio: Fulton, Henry, Lucas, Ottawa, Sandusky, Seneca, Wood
30 Ross County: Highland, Jackson, Ross, Vinton
14 Southern Hills: Athens, Gallia, Hocking, Meigs
15 Southern Ohio: Adams, Lawrence, Pike, Scioto
08 Southwestern Ohio: Brown, Clermont, Clinton, Hamilton, Warren
33 Stark Carroll: Carroll, Stark
34 Summit and Portage: Portage, Summit
37 Washington County & Eastern Valley: Belmont, Monroe, Washington
22 Wayne-Holmes-Medina: Holmes, Medina, Wayne
13 West Central Ohio: Allen, Auglaize, Hancock, Hardin, Paulding

Use this dues table if you ARE NOT an ONA COLLECTIVE BARGAINING MEMBER (ONA Non-Union Member)

Non-collective bargaining membership assessments and dues include the annual American Nurses Association (ANA) fee of $134.00, Ohio Nurses Association (ONA) fee of $250.00 and district fee.

Non-Collective Bargaining Members	Full Rate		75% Reduce Rate		50% Reduce Rate		25% Special Rate	
District Number	Annual	EDPP	Annual	EDPP	Annual	EDPP	Annual	EDPP
01	399.00	33.58	299.25	25.27	199.50	16.96	99.75	8.64
03	542.44	45.53	406.83	34.23	271.22	22.93	135.61	11.63
05	390.50	32.87	292.88	24.74	195.25	16.60	97.63	8.47
06, 07, 15, 17, 18, 19, 22, 24	394.00	33.16	295.50	24.96	197.00	16.75	98.50	8.54
08	414.00	34.83	310.50	26.21	207.00	17.58	103.50	8.96
10	436.50	36.71	327.38	27.61	218.25	18.52	109.13	9.42
12	434.00	36.50	325.00	27.46	217.00	18.41	108.50	9.37
13, 14	397.00	33.41	297.75	25.14	198.50	16.87	99.25	8.60
16	448.00	37.66	336.00	28.33	224.00	19.00	112.00	9.66
23, 28	390.00	32.83	292.50	24.71	195.00	16.58	97.50	8.46
30	395.00	33.25	296.25	25.02	197.50	16.79	98.75	8.56
33	438.50	36.87	328.88	27.74	219.25	18.60	109.63	9.47
34	442.00	37.16	331.50	27.96	221.00	18.75	110.50	9.54
35	429.00	36.08	321.75	27.14	214.50	18.21	107.25	9.27
37	387.00	32.58	290.25	24.52	193.50	16.46	96.75	8.39

Use this dues table if you ARE an ONA COLLECTIVE BARGAINING UNION MEMBER (ONA Union Member)

Collective bargaining membership assessments and dues include the annual American Nurses Association (ANA) fee of $134.00, Ohio Nurses Association (ONA) fee of $331.84, United American Nurse (UAN) fee of $30.16 and district fee.

Collective Bargaining Members	Full Rate		75% Reduce Rate		50% Reduce Rate	
District Number	Annual	EDPP	Annual	EDPP	Annual	EDPP
01	511.00	42.91	390.79	32.90	270.58	22.88
03	654.44	54.87	498.37	41.86	342.30	28.86
05	502.50	42.21	384.42	32.36	266.33	22.52
06, 07, 15, 17, 18, 19, 22, 24	506.00	42.50	387.04	32.58	268.08	22.67
08	526.00	44.16	402.04	33.83	278.08	23.50
10	548.50	46.04	418.92	35.24	289.33	24.44
12	546.00	45.83	417.04	35.08	288.08	24.34
13, 14	509.00	42.75	389.29	32.77	269.58	22.80
16	560.00	47.00	427.54	35.96	295.08	24.92
23, 28	502.00	42.16	384.04	32.33	266.08	22.50
30	507.00	42.58	387.79	32.65	268.58	22.71
33	550.50	46.21	420.42	35.36	290.33	24.52
34	554.00	46.50	423.04	35.58	292.08	24.67
35	541.00	45.41	413.29	34.77	285.58	24.13
37	499.00	41.91	381.79	32.15	264.58	22.38

Independent Studies

One of the purposes of the *Ohio Nurse* is to help nurses meet their obligation to stay current in their practice. On the following pages are 3 independent studies:

- A Nursing Malpractice Primer
- Chronic Kidney Diseases: Stages and Nursing Care
- Medication Aides: What the Law and Rules Say

FEES

The 3 independent studies in this edition of the *Ohio Nurse* are free to members of the Ohio Nurses Association. There is a fee of $12.00 for non-members. If you order any additional independent studies from the list on page 22 & 23, there is a $12.00 fee plus shipping and handling for both ONA members and non-members.

GENERAL INSTRUCTIONS

1. Please read the independent study article carefully.
2. Complete the post-test, evaluation form and the registration form. We will accept copies of these forms so that you can keep the original in your files.
3. When you have completed the post-test, evaluation form and the registration form, return them to: Ohio Nurses Foundation, Dept. LB-12, PO Box 183134, Columbus, OH 43218-3134 with applicable fees (see FEES above).

The post-test will be reviewed upon receipt. If a score of 70 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent is not achieved, a letter of notification of the final score and a second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 70 percent is achieved on the second post-test, a certificate will be issued.

If you have any questions, please feel free to call Sandy Swearingen, at 614-448-1030, or Zandra Ohri, MA, MS, RN, Director, Nursing Education, 614-448-1027.

Chronic Kidney Diseases: Stages and Nursing Care

INDEPENDENT STUDY

This independent study has been developed for nurses to better understand chronic kidney disease.

1.5 contact hours will be awarded for successful completion of this independent study.

This independent study was developed by: Barb Walton, MS, RN, NursesNotes, Inc., Milan, Michigan.

The planners and faculty have no conflict of interest. There is no commercial support for this independent study.

OBJECTIVES

Upon completion of this independent study, the learner will be able to:

1. Describe the four states of chronic kidney disease.
2. Discuss the nurse's role in caring for patients in each state of chronic kidney disease.

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

Expires 12/2009

Stages of Chronic Kidney Disease

Chronic kidney disease may develop as a result of many conditions. Some causes include heart disease, diabetes, hypertension, peripheral vascular disease, renal artery stenosis, pyelonephritis, analgesic abuse, polycystic kidney disease, allergic reactions, glomerulonephritis, systemic lupus erythematosus, sickle cell disease, carcinomas, chemotherapy and/or radiation therapy, scleroderma, dyslipidemias, and bacterial endocarditis. No wonder with so many commonly occurring diseases causing kidney damage, we see so much chronic kidney disease. As the baby boom ages, we will see even more chronic kidney disease in the future. Even scarier is the thought that chronic kidney disease is a silent problem, becoming well advanced before an individual even begins to experience symptoms of the problem. Besides having many causes, chronic kidney disease causes many problems itself. If one thinks about it, when metabolic waste products aren't eliminated, they begin to accumulate in the blood and organs. These waste products cause damage to cells, thus resulting in an acceleration of diabetes, atherosclerosis, bone disease, and hypertension, just to name a few. With the accumulation of metabolic waste products, the body attempts to perform all of its physiologic functions in a toxic waste dump. No wonder we see such wide reaching effects of this disease. It ravages every physiologic system. In this module we will be discussing the newest model of chronic kidney disease. This model enables us to recognize chronic kidney disease earlier in patients who are at risk, so that we might intervene and help the patient to manage the problem much earlier on.

A. Kidney Concepts: Before we begin our discussion of chronic kidney disease, let us briefly review some concepts regarding the kidney.

The Nephron: as you will recall is the functional unit of the kidney. There are approximately one million nephrons in each kidney. Nephrons are able to compensate for the loss of other nephrons by hypertrophying and handling a larger volume of solute. *Cortical nephrons* are located in the outer region of the cortex of the kidney, have shorter loops of Henle and have a lesser capacity for sodium reabsorption. *Juxtamedullary nephrons* are located in the inner region of the cortex next to the medulla of the kidney, have long loops of Henle and have a great capacity for sodium reabsorption and therefore concentrate urine.

Functional Units of the Nephron: Each nephron has two portions, a vascular side and a tubular side. The vascular side begins with the *renal corpuscle.* The renal corpuscle is comprised of the glomerulus and Bowman's capsule. **Bowman's capsule** is the specialized end portion of the proximal convoluted tubule that houses the glomerulus. The *glomerulus* is a capillary bed composed of three cellular layers (endothelial, basement membrane and endothelial cells), which gives the glomerulus a semipermeable quality. The semipermeable membrane is permeable to water, electrolytes, nutrients and wastes and is impermeable to large protein molecules, albumin and erythrocytes. The vasa recta is the remaining portion of the vascular side of the nephron. The vasa recta wraps itself around the renal tubules. When substances are reabsorbed from the tubules, the substances are returned to the blood in the vasa recta. The tubular side of the nephron begins at Bowman's capsule and ends at the collecting ducts. Each portion of the renal tubule has specific functions as follows.

Summary of the Main Functions of the Renal Tubules:

Proximal Convoluted Tubule: reabsorbs 60 to 80% of the filtrate that comes from Bowman's capsule. Its major function is to reabsorb sodium and water. Acid-base regulation takes place via hydrogen ion secretion and bicarb ion- reabsorption. The proximal convoluted tubule is also responsible for secreting foreign substances such as drugs.

Loop of Henle: has two distinct sections.

Descending Loop: permeable to water and impermeable to sodium.

Ascending Loop: has an active pump for sodium and chloride, and is impermeable to water.

The main function of the loop of Henle is to concentrate or dilute urine via the *countercurrent mechanism.* The countercurrent mechanism maintains a hyperosmolar concentration in the interstitium of the renal medulla thus allowing for the reabsorption of water.

Distal Convoluted Tubule: Reabsorbs water, sodium chloride and sodium bicarb, secretes potassium, ammonia and hydrogen ions or acids. The distal convoluted tubule is the target organ for two hormones. *Antidiuretic hormone* (ADH) controls or influences water reabsorption here, while sodium reabsorption is controlled by *Aldosterone.* The distal convoluted tubule and the glomerulus comprise the juxtaglomerular apparatus, which is our major mechanism for blood pressure control.

Collecting Duct: is influenced by Antidiuretic Hormone and Aldosterone. These hormones make final adjustments in urine concentration before the urine enters the renal pelvis and progresses to the ureter and bladder.

Renal Hemodynamics: In order for the kidney to function, it is dependent on adequate blood flow. It is important to understand renal hemodynamics as this often yields the origins of chronic kidney disease. As the blood flow to the organ becomes impaired, loss of nephrons results. While nephrons are able to compensate for a period of time, eventually there is enough nephron loss or damage to nephrons, they can no longer adequately remove waste products and perform the other physiologic functions necessary. Hypertension is often the major cause of chronic kidney disease. Many healthcare practitioners think of hypertension as a cardiovascular disease, while others think of hypertension as a kidney disease that has cardiovascular complications. It is believed that hypertension often starts in the juxtaglomerular apparatus and/or the renin-angiotensin-aldosterone systems. This complex system is the *autoregulation mechanism* for the kidney. Remember autoregulation mechanisms are nothing more than mechanisms to maintain adequate blood flow to an organ.

Juxtaglomerular apparatus: is actually the distal portion of the distal convoluted tubule that sits next to the glomerular bed. The juxtaglomerular apparatus is made up of specialized cells that respond to arterial blood pressure and sodium levels. Juxtaglomerular cells synthesize and house an inactive form of renin.

Juxtaglomerular cells are smooth muscle cells that sit along the afferent and efferent arterioles. The afferent and efferent arterioles feed into and away from the glomerulus. The juxtaglomerular cells contain granules of inactive renin.

Macula Densa is a portion of the distal tubule that makes contact with the afferent and efferent arterioles of its respective glomerulus.

Renin-angiotensin-aldosterone system: You will recall from a physiology class that when the juxtaglomerular cells release renin, angiotensin I is converted to angiotensin II. Angiotensin II is a potent vasoconstrictor, which in turn elevates blood pressure. Angiotensin II initially will cause vasoconstriction of the afferent and efferent arterioles, but with prolonged release, will cause a systemic rise in blood pressure. At the same time angiotensin II is created, aldosterone is released from the adrenal cortex. Aldosterone causes sodium and water to be reabsorbed, thus increasing blood volume and elevating blood pressure. Here are some examples of how this system works.

Let's say I become dehydrated, perhaps I had a fever accompanied by some nausea and vomiting and didn't consume enough fluids to keep up with the fluid loss I was experiencing. At this point I am slightly hypovolemic. As my blood volume and possibly blood pressure drops, the macula densa senses this. The macula densa sends messages to the juxtaglomerular cells along the afferent and efferent arterioles. The juxtaglomerular cells release renin, which in turn converts angiotensin I to angiotensin II. Angiotensin II causes vasoconstriction of both the afferent and efferent arterioles, thus maintaining the perfusion pressure of the glomerulus and my kidneys continue to perform their multiple functions. Once angiotensin II is released, aldosterone is released from my adrenal cortex. Aldosterone causes me to reabsorb both sodium and water via the distal convoluted tubules and the collecting ducts, thus increasing my blood volume and boosting my blood pressure.

Here's another example of renal hemodynamics and autoregulation. Let's say I go to my favorite fast food restaurant and consume a meal of cheeseburger, fries-the largest size of course and a super sized soft drink. With this meal I've just consumed an inordinate amount of sodium, especially since I also added a liberal sprinkling of salt! With the ingestion of all that sodium I retain a lot of water to dilute the sodium level down. Unfortunately as I retain all that water and sodium, I become hypervolemic and my blood pressure rises. In order to protect the glomerular bed from damage from the high blood pressure and excess volume, my juxtaglomerular apparatus is again activated. The macula densa senses the high blood pressure and extra volume and causes the juxtaglomerular cells to release renin from afferent arterioles only. Renin converts angiotensin I to angiotensin II, which causes vasoconstriction of the afferent arteriole only. As the afferent arteriole constricts, this will act to hold back the excessive blood flow and high pressures, thus protecting the glomerulus. However remember, when angiotensin II is created, it also causes a

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release of aldosterone. Aldosterone causes me to reabsorb sodium and water, further boosting my blood volume and blood pressure. But because of my autoregulation mechanism the glomerulus is protected, eventually I will diurese off the excess water and sodium and things return to normal again. However, what happens if I turn around and consume another sodium-laden meal, then another followed by another? It is believed that our sodium-laden diets continually stimulate this juxtaglomerular apparatus, causing the release of renin, angiotensin II and aldosterone, thus resulting in hypertension.

Renal Prostaglandins: is another group of substances released from the kidneys that provide a modulating effect on blood pressure. The renal prostaglandins modulate the effects of the renin-angiotensin-aldosterone system and help keep our blood pressures in check. Major prostaglandins PGE_2, PGD_2 and PGI_2 are vasodilators while PGA_2 is a vasoconstrictor. Prostaglandins overall create a diminished arterial blood pressure and an increase in renal blood flow via vasodilatation and a suppressed response to antidiuretic hormone. Medications that inhibit prostaglandins include the non-steroidal anti-inflammatory agents such as Aspirin, Motrin, Indocin, and Naprosyn. So if your patient has hypertension, it is best to advise them to avoid non-steroidal anti-inflammatory medications as taking these medications can contribute to hypertension.

Physiologic Roles of the Kidneys: The kidneys do much more than eliminate waste products for us. Here is a review of the kidneys' major physiologic functions.

1. **Kidney Control of Blood Pressure:** involves five major mechanisms.
   a. Maintenance of extracellular fluid volume and composition via reabsorption & secretion of sodium and water.
   b. Aldosterone-sodium balance determines extracellular fluid volume.
   c. Renin-Angiotensin-Aldosterone System discussed above.
   d. Renal Prostaglandins discussed above.
   e. Kallikrein-kinin System: are protease (protein enzymes) substances that stimulate the renin-angiotensin-aldosterone system and the prostaglandin system.
2. **Kidney Regulation of Body Water:** involves three mechanisms
   Thirst Mechanism: Our thirst center is located in the anterior hypothalamus and is stimulated by intracellular dehydration (elevated intracellular sodium). An elevated sodium level produces thirst sensation in the parietal lobe of our brains. The parietal lobe sends this thirst message to the frontal lobe and we recognize this as being thirsty. Once we recognize this thirst, we seek water intake, i.e., get a drink of water. When we have consumed enough water to dilute the elevated sodium level, our thirst mechanism is no longer triggered and we experience this as having our thirst quenched.
   Antidiuretic Hormone (ADH): is synthesized by the hypothalamus and released by the posterior pituitary gland. Release of antidiuretic hormone occurs when there is an increase in serum osmolality (i.e., greater than 295 mOsm/L), or when there is a low volume of circulating blood thus causing a relaxation of the stretch receptors located in the left atrium. In the presence of antidiuretic hormone, water is reabsorbed in the distal tubule and collecting ducts, thus diluting an elevated sodium level and/or serum osmolality and boosting our blood volume. This activation of antidiuretic hormone is also known as "water conservation". In the presence of antidiuretic hormone, one will still produce urine, but it will be small in quantity and concentrated.
   Countercurrent Mechanism: Concentrates or dilutes urine, thereby regulating body water.
   a. Isotonic glomerular filtrate leaves the proximal tubule and enters the Loop of Henle at 300 mOsm/L.
   b. Descending Loop is permeable to water only. This water is gradually drawn into the hypertonic medullary interstitium resulting in:
      i. Gradual increase in the osmolality of the glomerular filtrate as it becomes dehydrated; at the hairpin turn, osmolality is dramatically increased by removal of water and NaCl pumping action; osmolality will reach 1000 to 1200 mOsm/L.
      ii. Medullary interstitium concurrently becomes hypotonic.
   c. Ascending Loop is permeable to NaCl and impermeable to water. The medullary interstitium becomes more hypertonic as its NaCl concentration is increased by pumping action of the ascending Loop.
   d. A dilute filtrate reaches the distal tubule.
3. **Kidney Role in the Excretion of Metabolic Waste Products:**
   The primary role of the kidneys is to eliminate more than 200 waste products. Because waste products are just that, they are freely filtered by the kidneys and are not reabsorbed for any purpose. Historically we have measured two such waste products and have used these laboratory results to interpret and define renal function.
   Urea: the nitrogen waste product of protein metabolism filtered and excreted along the entire length of the nephron. It is an unreliable measure of GFR (glomerular filtration rate) since urea excretion can be influenced by a number of situations. Urine flow (an increase in urine flow may increase reabsorption of urea); catabolic states (fever, starvation, severe infections); extrarenal factors (hypoperfusion); changes in protein metabolism (malabsorption syndromes, high protein diets, protein malnutrition), drugs, and GI bleeding may all influence urea levels. Historically, elevations in both urea and creatinine (at a 10:1 ratio) indicate kidney disease.
   Creatinine: a waste product of muscle metabolism that is proportionate to the amount of muscle mass and occurs at a constant rate. A normal kidney will excrete creatinine equal to the kidney's GFR as creatinine is freely filtered. Creatinine is a more reliable reflection of kidney function, however consuming a diet containing a lot of meat may cause a false elevation of creatinine. Generally though, an elevated serum creatinine level can directly be related to a change or deterioration in kidney function.
4. **Kidney Role in Acid-Base Balance:** regulates acid-base balance via a series of buffer systems. You will remember from a chemistry class that buffer systems are chemical reactions that produce both and acid and a base. Then it is a simple matter of retaining the one you need and eliminating the one you don't need to maintain your pH balance. A lot of pH balance is achieved by reabsorbing bicarbonate in the proximal tubule. Some common buffers are as follows.
   Secreting H+ in the form of ammonia (NH_4+) and phosphoric acid (H_2PO_4-).
   Buffers: H_2CO_3 (carbonic acid) ⇔ H+ and HCO_3-
   H+ and HPO4- ⇔ H_2PO_4- (phosphoric acid)
   NH_3 and H+ ⇔ NH_4+
5. **Renal Role in Red Blood Cell Maturation:** Erythropoietin, produced and secreted by the kidneys, stimulates the production of red blood cells in the bone marrow and prolongs the life of erythrocytes. Erythropoietin deficiency is the primary cause of anemia in chronic kidney disease.

B. Definition of Chronic Kidney Disease

The National Kidney Foundation has defined chronic kidney disease as follows:

- Kidney damage present for 3 months or longer, as defined by structural or functional abnormalities of the kidneys, with or without decreased glomerular filtration rate (GFR); such damage may become evident through either pathologic abnormalities or markers of kidney disease (abnormal blood, urine or imaging tests).
- GFR's less than 60 ml/min/1.73m^2 for 3 months or longer, with or without kidney damage.

Diagnostic Guidelines for Chronic Kidney Disease: The National Kidney Foundation has also defined diagnostic guidelines for chronic kidney disease that are as follows.

Proteinuria screening:

- For the general public, screening can be done with a general urine dipstick during annual physical examinations.
- For those with risk factors for chronic kidney disease, an albumin specific dipstick test is completed. If the patient tests **positive for proteinuria** a urine albumin to creatinine ratio test is completed by a laboratory.
- For patients with risk factors and an albumin to creatinine ratio greater than 30mg/g, further diagnostic work-up is indicated.
- For patients without risk factors, if albumin to creatinine ratio is elevated, the test is repeated in 1 to 2 weeks. Patients with 2 or more albumin to creatinine ratios greater than 200mg/g, should be referred for further diagnostic work-up.

Glomerular Filtration Rate (GFR): is now the standard used to diagnose and define stages of chronic kidney disease. The GFR is calculated based on serum creatinine, taking into consideration age, sex, race, and mean body surface area. National Kidney Foundation offers a free calculator at: www.kidney.org/kls/professionals/gfr_calculator.cfm. You can see the calculation below. Because the variation in urea and creatinine can cause misleading results, it is felt the GFR is a better indicator of kidney function.

GFR = (140 - age) X weight (kg) / Serum Creatinine (mg/dl) X 72 (0.85 for women)

For patients over 90, use age 90
For obese patients use ideal body weight
For men 50 kg + 2.3 kg for every inch over 5 feet.
For women 45.5 kg + 2.3 kg for every inch over 5 feet.

C. Stages of Chronic Kidney Disease:

As managed care becomes more evident in our practices, we are seeing a movement toward staging diseases. By staging diseases it enables healthcare providers to more easily recognize disease trends in patients as well as provide guidelines for care. Recently, the National Kidney Foundation set forth stages of chronic kidney disease. Below is a chart that compares the historical model of chronic renal failure to the new model of chronic kidney disease.

The new model is beneficial for a number of reasons. One benefit of the new model is that by adding Stage 1 it enables us to be more proactive in recognizing patients who are at risk for developing kidney disease. In the past, we always waited for the patient to present with elevated blood urea nitrogen and creatinine levels, and then they were diagnosed with chronic renal failure. A problem with using the historical model for chronic renal failure is that patients weren't diagnosed with renal failure until both blood urea nitrogen and creatinine levels were elevated. As you look at the chart below, notice that creatinine levels correlate to the percentage of nephron loss. By the time both blood urea nitrogen and creatinine levels become elevated, patients would have experienced the loss of 50% of their nephrons. That is one entire kidney's worth of nephrons that have ceased to function! Plus typically most renal patients wouldn't begin to experience symptoms of renal failure until they are into the "renal insufficiency" stage of chronic renal failure, where they have now experienced a functional loss of 75% of their nephrons. In other words, by the time the patient begins to feel ill, they are already in renal insufficiency and are a candidate for dialysis when they are diagnosed for the first time. Chronic renal failure is a silent disease until it becomes quite advanced. With the new model of chronic kidney disease, diagnosis is made much sooner, treatment can be initiated sooner and hopefully we may assist the patient in slowing or preventing the progression of the problem.

Chronic Renal Failure compared to Chronic Kidney Disease

Chronic Renal Failure	**Normal to Early Disease**	**Diminished Renal Reserve**	**Renal Insufficiency**	**End Stage Renal Disease**
Creatinine levels	normal	2 times normal	8 times normal	10 mg/dL with dialysis
Nephron Loss	none to 25 %	50 %	75 %	90 % or more

Chronic Kidney Disease	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**
GFR (normal = 90 mL/min/1.73^2)	Normal or greater than 90	Mildly decreased 60 to 9	Moderately decreased 30 to 59	Severely decreased 15 to 29	Kidney failure Less than 15

Staging in the historical model of chronic renal failure is done based on the patient's creatinine levels. In the new model for chronic kidney disease, staging is done based on the patient's GFR. Once the stage is identified there are treatment guidelines set forth by the National Kidney Foundation.

Nursing Care and Interventions for Chronic Kidney Disease

As we discuss the various stages of chronic kidney disease and nursing care, bear in mind these are guidelines. Be aware the patient may have additional health care problems that will also need to be addressed and may complicate the treatment of their chronic kidney disease.

A. Stage 1: Patients in Stage 1 do not actually have chronic kidney disease yet, however they are at risk of developing the disease. Their GFR is normal or even higher than normal. Nursing interventions include:

- Identify and treat the specific cause of chronic kidney disease, as well as other comorbidities. Assess for the presence of kidney problems that could result in chronic kidney disease such as polycystic kidney disease, kidney tumors, kidney stones, kidney trauma, and exposure to nephrotoxic medications, chronic urinary or kidney infections. Be sure to treat these problems appropriately. Monitor the patient's adherence to treatment as well as their knowledge base of any pre-existing condition.
- Assess for risk factors: diabetes mellitus, hypertension, dyslipidemia (elevated cholesterol, LDL's, and/or triglycerides), coronary artery disease, heart disease, obesity, peripheral artery/vascular disease, previous kidney disease or problems such as kidney stones or kidney trauma. Also consider lifestyle risk factors such as diet, current or past history of smoking, sedentary lifestyle, and use of recreational drugs.
- GFR should be measured at least annually. The GFR should be trended from year to year so that chronic kidney disease can be identified and treated as soon

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as possible.

- Ongoing evaluation of patient's response to treatment is essential. In Stage 1 we are attempting to be proactive. We are attempting to stave off and manage risk factors in an effort to prevent the patient from progressing into advanced stages of chronic kidney disease. For example: Is this patient being treated for hypertension? If so are they compliant with treatment? Is the treatment effective in controlling their hypertension? Are they taking their medications correctly? Do they have adequate access to medications? Do they know what medications they are taking and for what reason they are taking that medication? Do they know/can they recognize side effects of their medications? Do they recognize the importance of maintaining a controlled blood pressure? Do they recognize hypertension as a risk factor for kidney disease? Are there any financial issues regarding their medications? Are they able to monitor their blood pressure at home? Is the patient successfully following a specific diet? What other risk factors or health problems does the patient have? Are those problems being adequately managed? Is the patient knowledgeable regarding the management of these additional problems and risk factors?
- Note: for a more detailed discussion of managing health risk factors such as hypertension and dyslipidemias, please see the ONA independent study called "Heart Failure: A New Look at an Old Problem", by Barb Walton, MS, RN
- Vigilant monitoring of blood pressure, cholesterol and weight should be completed with each patient visit and minimally on an annual basis.

B. Stage 2: In Stage 2 chronic kidney disease, the patient's GFR will begin to fall to the 60 to 90 mL/min /1.73^2 range. The individual most likely will not be experiencing any signs or symptoms of chronic kidney disease yet. So by monitoring the GFR, the problem can be diagnosed earlier and appropriate interventions applied. For patients in Stage 2, continue the interventions identified in Stage 1 and add the following.

- Monitor for progressing proteinuria, hypertension, elevated Hemoglobin A_{1C} especially in diabetic patients, or patients at risk of developing diabetes.
- If the patient smokes, smoking cessation, or at least a decrease in the amount they smoke. There are many smoking cessation programs as well as a variety of medications and nicotine products available that may assist the patient in reaching smoking cessation goals.
- Promote healthy lifestyle management. Encourage a diet rich in fiber, low in saturated fats, and/or avoid sodium-laden foods. Refer the patient to a nutritionist of dietitian for counseling and assistance with meal planning and dietary changes. Assess their level of exercise and promote some form of physical activity such as a walking program. Assess the patient and family for stress and recommend stress management ideas for them. Is the patient getting enough sleep? Is caffeine intake interfering with sleep? Does the patient have *supportive* significant others? We have all seen patients who have significant others that are dysfunctional and know that it hinders the patient doing as well as he or she might. Helping them recognize supportive individuals and fostering those relationships may be quite beneficial to the individual, especially as the disease progresses.
- Note: For more discussion regarding healthy lifestyle management, please see the ONA independent study called "Heart Failure: A New Look at an Old Problem", by Barb Walton, MS, RN.
- Self blood pressure and glucose monitoring. If the patient has hypertension and/or diabetes, are they performing self- monitoring of blood pressure and/or glucose? Are they performing the procedures correctly in order to obtain accurate readings? If they are not performing self-monitoring, assess their willingness to do so. Instruct the patient regarding the importance of self-monitoring and instruct them regarding the proper procedures to do so. Have the individual track their data.

C. Stage 3: Signs and symptoms of chronic kidney disease will begin to become evident in Stage 3 as the patient's GFR drops to the 30 to 59 mL/min/1.73^2 range. In this stage, the patient will begin to feel ill due to the chronic kidney disease. Besides continuing the appropriate interventions identified in Stages 1 and 2, the following interventions are added.

- Teach the patient signs and symptoms of chronic kidney disease. See the charts below "Nursing Care for Chronic Kidney Disease" and "Uremic Syndrome". Bear in mind each patient is an individual and will present in an individual manner. One patient with chronic kidney disease may experience problems with anemia in Stage 3, while another patient may not have anemia problems until Stage 4. It is important for patients and their significant others to know and be able to recognize signs and symptoms of the disease, so that they might report them to their healthcare practitioner and care can be rendered. However, this is a lot of information that is contained in these two tables. Assess the patient's willingness to learn and how much they can assimilate at any one time. The National Kidney Foundation has many very helpful printed materials patients may obtain for free or for minimal cost. These materials are a wonderful adjunct to any teaching you might conduct with the patient. Plus they can take these items home and re-read the information as needed. The National Kidney Foundation website appears at the end of this module. Be sure to ask patients about signs and symptoms at each visit that they may be experiencing. This will also serve to re-educate them as to what the signs and symptoms of chronic kidney disease are.
- Monitor & treat complications of anemia & bone disease. Because of a lack of erythropoietin from the diseased kidneys, patients may begin experiencing anemia problems. Patients with chronic kidney disease may begin to have elevated phosphorous levels (PO_4-), as the kidneys are no longer able to excrete this waste product as efficiently. If you recall back to a physiology class, phosphorous has an affinity for binding with calcium. In some cases because the patient has a higher level of phosphorous and in order to bind it with calcium, calcium is actually pulled from teeth and bone stores. As the calcium is pulled from the teeth and bones, this causes demineralization of the teeth and bones. This is a condition we call *osteomalacia or renal rickets*. If not corrected, osteomalacia may become severe and result in pathologic fractures and loss of teeth.
- Set specific health goals regarding lifestyle management. Continue working with the patient on any lifestyle management efforts they are making such as smoking cessation, exercise or stress management.
- Teach benefits of disease management. Being proactive in managing problems such as diabetes, hypertension, dyslipidemias, anemia and or osteomalacia will contribute to the overall well being of the patient. It is important for the patient to understand this and take control of the disease as opposed to the disease controlling him or her.
- Parathormone (PTH), calcium ($Ca+^2$), phosphorous (PO_4-) and hemoglobin should be checked at least annually. Parathormone is the hormone that is released from the parathyroid glands and causes calcium to be absorbed through the gastrointestinal tract, and causes calcium to be pulled from teeth and bones. In patients with Stage 3 kidney disease and with more advanced osteomalacia, one may expect to see an elevated phosphorous level, low calcium level and an elevated parathormone level. For some patients, the parathormone level becomes so elevated, they are diagnosed with a *secondary hyperparathyroidism*. In this instance the patient may undergo a parathyroidectomy (removal of the parathyroid glands) in order to manage the hyperparathyroidism. Hemoglobin levels are monitored for the development of anemia. Remember the kidney produced erythropoietin. As the kidney disease progresses, anemia may present itself.
- Support efforts to maintain independence. Because patients begin to experience signs and symptoms of kidney disease in Stage 3, they may find the disease will impact their activities of daily living. Electrolyte imbalances and the accumulation of metabolic waste products may result in feelings of fatigue, nausea, vomiting, restless leg syndrome, pruritis, poor appetite, or sleep disturbances, just to name a few. Continue to educate the patient regarding signs and symptoms in order to help them identify them when and if they do occur. Assist them with appropriate interventions when the signs and symptoms do occur. We will discuss this in more detail in the charts "Nursing Care for Chronic Kidney Disease" and "Uremic Syndrome" that follow. Help them identify energy conservation techniques, stress management methods and ways they can take care of themselves.
- Involve significant others in planning care as the patient desires. Often in Stage 3 we begin to discuss renal replacement therapies, also known as dialysis. As the patient progresses further into Stage 3, devices such as AV fistulas are placed so they can be ready for use when the patient enters into Stage 4. It is important to involve the patient's significant others in planning for future care of this individual. The patient may have to rely on family and/or friends to drive them to and from dialysis treatments. Some patients with chronic kidney disease undergo personality changes due to electrolyte imbalances, fatigue, or sleep deprivation. Besides helping the patient to understand their symptoms, it is important to help the significant others understand this as well. Allow family, with the patient's permission, to vent some of their feelings and share their observations of possible symptoms with you. As the patient begins to feel more fatigue in Stage 3, more household duties as well as outside employment may fall on the shoulders of the significant others. This can bring about a myriad of feelings including resentment. The significant other may feel they "have to do it all", and in some cases the patient may see this disease as a way out of having to work at all. Other patients may become resentful of their spouses, as the patient is no longer able to work and may take it out on the spouse. There can be any number of psychosocial and emotional responses to chronic kidney disease-both on the part of the patient and their family members. Prepare all of them with information. Refer the family and patient to the American Association of Kidney Patients and National Kidney Foundation websites. Often there are local chapters of these organizations that have support groups and on-line chat rooms. Have open honest discussions with them. Chronic kidney disease effects the entire family unit, not just the individual patient.
- Review progress and revise plan of care. As the patient progresses further into the disease, other needs will arise. Review medications and current treatment modalities for effectiveness as well as for the need to continue treatment. In some cases, medications will need to be discontinued or diets may need to be changed.
- Make referrals to other disciplines. Is this a diabetic patient who is having a great deal of difficulty controlling their hemoglobin A_1C? Should they be referred to an endocrinologist? What is this patient's eating habits and laboratory results? Should they be referred to a dietician or nutritionist? Is there evidence of cardiac disease-should they be referred to a cardiologist? What is their oral hygiene? When is the last time they saw a dentist? Are they or their family members having difficulty adapting to the changes this disease is creating? Would they benefit from some counseling or family therapy? Has the patient been referred to the National Kidney Foundation? Is there a local chapter in the patient's home town?
- Continue to identify patient and significant other concerns. Each time you see the patient and their significant others ask them what concerns or questions they have. Try to avoid asking them "Do you have any questions?" Often the response you receive is "no". By asking "What concerns or questions do you have" it may elicit more information that will give you insight into the situation, as well as be more helpful to the patient and significant others.

D. Stage 4: In Stage 4, the patient's GFR has now dropped to the 15 to 29 mL/min/1.73^2 range. You would also expect to see elevated blood urea nitrogen and creatinine levels as well as electrolyte imbalances such as elevated potassium, phosphorous, and magnesium levels. Bear in mind though laboratory results can be as individual as the patient can. The patient will generally complain of more signs and symptoms of chronic kidney disease. Besides continuing with appropriate interventions identified in Stages 1, 2 and 3, patients will also require the following.

- Parathormone levels, calcium, phosphorous- and hemoglobin should be checked minimally every 3 months. See Stages 2 and 3 for rationale for monitoring these laboratory values.
- Initiate renal replacement therapy: peritoneal or hemodialysis. We will discuss the various forms of dialysis in a later section of this module. However, patient teaching and patient capabilities are key issues in making the decision as to which form of dialysis a patient chooses.
- Initiate more intensive management of cardiovascular complications, bone disease (osteomalacia), and anemias. Refer the patient to the appropriate specialist, i.e., cardiologist, endocrinologist, orthopedist, and/or dietician as necessary. Achieve optimal control of problems such as diabetes mellitus, hypertension, and dyslipidemias.
- Continue patient teaching to recognize and manage uremic syndrome to include altered sleep, fatigue, itching and loss of appetite. Be sure to include the patient's significant others in any teaching as previously mentioned so they might recognize problems as well.
- If the patient has not seen a nephrologist, definitely refer the patient to a nephrologist when the GFR is less than 30. Hopefully the patient has seen a nephrologist prior to Stage 4, but in some areas where nephrologists are not very plentiful or for any other reason the patient has not seen a nephrologist, they should be referred to one now. It is essential they see a nephrologist as they begin renal replacement therapy.
- Discuss the potential for *renal transplant*. In the past, kidney transplants were implemented as a "last resort" form of therapy. In other words, when the patient had exhausted even what dialysis could accomplish for them, then the patient became a transplant candidate. Today, transplants are considered much earlier in the progression of kidney disease. One advantage of a transplant is that the patient may no longer require dialysis, thus freeing them from the daily and/or three times per week routine of dialysis. Generally with transplants, patients experience an improvement in their quality of life and are often able to return to their "pre-kidney disease" status. Even though transplants and the anti-rejection medications required afterward are

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expensive, transplants are more cost-effective than dialysis. Furthermore, with a functioning kidney, it slows the progression of kidney disease and prevents the complications of uremic syndrome. In recent years, Medicare has begun to pay for a portion of the costs of the anti-rejection medications for the first three years. Medicaid will also cover some costs for patients who qualify. Refer patients to medical social work to determine eligibility for these benefits. The website for Social Security appears at the conclusion of this module. You may refer to this website for kidney disease criteria.

E. Stage 5: The patient who presents with a GFR less than 15 mL/min/1.73^2 is in End Stage Renal Disease, or Stage 5. Besides continuing appropriate interventions already identified in Stages 1, 2, 3, and 4, the following may need to be added.

- Parathormone and hemoglobin are minimally checked every 3 months. Calcium and phosphorous are minimally checked every month. We have previously discussed the necessity for monitoring these laboratory results and treating the resulting problems.
- Assess for home care and hospice needs. Is the patient now home bound? Do they have a significant other to help provide care? Would the patient benefit from the services of a home health aide? Home health aides can assist with bathing, dental hygiene, meal preparation and feeding, and toileting. Does the individual require more frequent monitoring? Do they need assistance with medication administration? Some home care organizations even provide housekeeping services that may be of benefit to your patient. Is the patient expected to live for six months or less? If so the patient is a candidate for hospice services and should be referred to hospice. Would providing home care and hospice provide some much needed respite for the significant other?
- Assess for end of life decisions. Does your patient have medical advanced directives? If so, where is a copy of the document? Often medical advanced directives are completed at an earlier time in the individual's life. Over time, their wishes and the presence of a chronic illness may alter their wishes regarding end of life care. Have the patient review his or her advanced directives to be sure it does indeed reflect what they now desire. Who is designated as the medical advocate or medical power of attorney? Is there a will or trust for the patient's estate? Is there and who is the financial power of attorney for this individual? Do these documents still reflect the patient's wishes? It may be necessary to refer the patient back to the attorney who drafted the original documents for updates. One may also refer the patient and family to their county Bar Association for a referral to a local attorney who may establish documents that may be needed.
  The county Bar Association phone number may be found in the local phonebook or through directory assistance. While many of these topics regarding the end of life are very difficult to discuss, and many individuals are reluctant to discuss them, it is critical to have these discussions. Certainly it is easier if the patient and family already have made these decisions earlier. As chronic kidney disease progresses, patients often experience dementias and sleep deprivation that may cloud their abilities to think rationally. Making end of life decisions while they are still able to and appointing trusted individuals who will execute their desires when they are no longer to be able to be their own advocate, will serve to insure that their wishes are carried out as indicated.

F. General Nursing Care for Chronic Kidney Disease: The following nursing care is appropriate for any stage of chronic kidney disease. Because patients present so individually, care must be customized to meet the patients needs. Not all patients will require all that is listed here. Some patients will require all of these interventions, plus others due to their disease and co-morbidities.

1. Renal Diet Guidelines: There can be great variances in the renal diet due to stage of disease, caloric needs, presence of other metabolic diseases such as diabetes, thyroid diseases, the presence of wounds, and level of physical activity. It is essential the patient be referred to a dietician or nutritionist for the appropriate diet prescription. The American Association of Kidney Patients offers a free nutrition counter. This is an invaluable tool for kidney patients to assist them with meal planning, and stay within their diet restrictions. The nutrition counter gives a breakdown of sodium, potassium, phosphorous and protein content for commonly consumed foods as well as commercially prepared foods. The patient uses this nutrition counter to plan meals, much like how a diabetic patient plans meals taking into account grams of carbohydrate. In general, the following are guidelines for diet therapy.

- Protein Intake is calculated as follows: Protein = weight (kg) X 0.6 and 0.8 (to give a range of protein). This is actually a normal protein intake. In the American culture and with some specific diets, protein intake tends to be much higher than needed. Some patients find this is a small amount of protein compared to what they have been accustomed to consuming. Instruct the patient to consume "high quality" proteins such as meat, fish, poultry and egg whites as these produce less metabolic waste products. Beans, legumes and nuts are also sources of proteins, however they produce a lot of metabolic waste products. Caution patients to limit their intake of these items.
- Phosphorous: 800 to 1000 mg/day. Not all dietary labeling offers phosphorous content. Be sure to teach patients to read the list of ingredients as well as the nutritional labeling on foods. The American Association of Kidney Patients' nutrition counter will prove invaluable in giving phosphorous content of foods that is not provided on food labels. Caution patients to avoid cola colored soft drinks as the coloring in these products contains a lot of phosphorous. Milk, cheese, dried beans, peas, nuts, and peanut butter should also be avoided or limited as these all contain high amounts of phosphorous. Canned tuna, salmon, sardines and other small fish should be limited due to the fact that in processing the fish, many of the smaller bones are crushed into the product. Thus when eaten the bone material containing phosphorous is also consumed. Frozen foods and especially the frozen meals also contain a lot of phosphorous in the preservatives that have been added to give these items shelf life. Be sure to caution patients regarding this and have them read the labels.
- Calcium: less than 2000 mg/day. While some food labeling provides this information, again the American Association of Kidney Patients' nutrition counter will be useful. Caution patients to limit intake of dairy products. In some instances patients are limited to one half cup of milk per day.
- Potassium: intake is adjusted to maintain blood levels between 3.5 to 5 mEq/L. In some instances patients may need to supplement potassium intake. For example, in early stages of chronic kidney disease, if they have hypertension, they may need to replace potassium loss due to diuretic therapy. In later stages of the disease, as more kidney function loss results in hyperkalemia, potassium restrictions will be necessary. Teach the patient to avoid high potassium containing foods such as apricots, avocados, bananas, beets, brussel sprouts, cantaloupe, clams, dates, figs, lima beans, milk, nectarines, oranges and orange juice, pears, peanuts, potatoes *, prunes and prune juice, raisins, sardines, spinach, tomatoes, winter squashes and yogurt. * A note about potatoes: by peeling, soaking the potatoes overnight, draining, rinsing, then boiling them, a lot of the potassium will be removed.
- Sodium: less than 2000 mg/day. Again teach the patient to avoid salty foods and to read nutritional labeling on foods or consult the nutrition counter available from the American Association of Kidney Patients.
- Vitamins: Nephrocaps™ are the vitamins that are generally prescribed for kidney patients. They are generally "low dose" vitamins that will not create any vitamin toxicity problems for the individual. It is important to instruct patients to take their vitamins *after* any hemodialysis, as hemodialysis will only remove the vitamins from their system.

2. Medications for Kidney Patients: Generally medications are given in reduced dosages and/or increased intervals of time between doses of medications. Often pharmacy services are utilized to monitor for drug toxicities and calculate dosages of medications based on the patient's laboratory studies. Be sure to teach patients signs of medication overdoses and toxicities. Advise patients not to take any over the counter medications, including vitamin, mineral and herbal supplements without first checking with their healthcare professional.

3. More General Nursing Care for Chronic Kidney Disease Patients: Below is a table summarizing common problems encountered with chronic kidney disease and nursing considerations.

System/Problem	Nursing Considerations and Care
Fluid Volume Excess usually seen in Stage 5.	Implement fluid restrictions as prescribed and monitor for compliance. Monitor daily weights or "dry" weight that is the patient's weight after dialysis. Evaluate effectiveness of dialysis. Assess edema and promote skin integrity. Assess lung sounds for rales and signs of fluid overload.
Electrolyte imbalance	Correct any electrolyte imbalance as they present. Most common imbalances that occur are hyperkalemia, hypocalcemia, and hyperphosphatemia. Use phosphate binding antacids such as Phoslo, Calcium Citrate, Calcium Carbonate, Renagel, or Fosrenal for long term control. Be sure the patient takes phosphate binders with their meal. These medications bind the phosphorous as it is ingested and simply passes through the gastrointestinal tract without being absorbed. Hold these medications if the patient is not eating. It is essential patients take phosphate binding antacids as dialysis does not remove phosphorous. Avoid consumption or use of phosphate containing products such as cola colored soft drinks, phosphate enemas.
Metabolic Acidosis	Most metabolic waste products tend to have an acidic pH, thus as these chemical accumulate, the patient will develop a metabolic acidosis. Assess effectiveness of dialysis for control of metabolic acidosis. Dialysis bath contains acetate or lactate that is converted into bicarbonate. This will help to neutralize the acidosis, as well as dialysis will remove the metabolic waste products. Oral sodium bicarbonate may be necessary for long term. Monitor for Kussmaul respirations. Kussmaul respirations are seen as an elevated respiratory rate and depth of respiration, and indicate respiratory compensation for acidotic states. Correcting the patient's pH will eliminate Kussmaul respirations.
Anemia	Beside the lack of erythropoietin causing anemia, the red blood cells the patient does possess will have a shorter life-span and be more fragile, thus compounding the anemia problem. Maintain hemoglobin at, but not greater than 11g/dL for the general hemodialysis population, with epoetin. Epoetin alfa is a DNA recombinant erythropoietin, and usually one will see a near normal Hgb after 3 months of administration. Watch for higher than normal hematocrit and adjust epoetin dose accordingly. High hematocrit or hemoglobin values will cause increased blood viscosity, which may lead to problems with dialysis, shortened life of fistula, or contribute to hypertension.

Continued on Page 8

Chronic Kidney Disease Stages and Nursing Care . . .

Continued from Page 7

4. Dealing with Uremic Syndrome: Patients in Stage 3, 4, and 5 will begin to experience various signs and symptoms of uremic syndrome. Again, because each patient is different, they will present differently and may not develop all of the symptoms of uremic syndrome. Be sure to educate the patient and his or her significant others regarding uremic syndrome. Then as symptoms present themselves, the patient can bring these to our attention so that we may intervene appropriately. As you will see, uremic syndrome affects every physiologic system. Remember the body is functioning in a toxic waste dump and it is the accumulation of metabolic waste products that is damaging each system, thus creating the wide range of problems.

Uremic Syndrome	
Cardiovascular	Pericarditis: pericardial friction rub, chest pain, ST elevations. Chest pain due to pericarditis is usually relieved by sitting up and leaning forward. Cardiac tamponade: severe hypotension, decreased cardiac output. Pulmonary edema: seen with fluid overload and left ventricular failure. Arteriosclerosis acceleration: the most common cause of death in hemodialysis patients. Hypertension (due to hypersecretion of renin), hypertensive retinopathy, hypertensive encephalopathy. Keep BP under control.
Pulmonary	Pleural effusions: may need to be drained. Uremic pneumonitis may mimic Adult Respiratory Distress Syndrome in severe cases. Usually due to fluid overload. Manage airway with pulmonary toilet, antibiotics, oxygen, and more frequent dialysis.
Neuro/Sleep Patterns	Encephalopathy usually due to electrolyte imbalances and accelerated atherosclerosis, may present as fatigue, confusion or as a dementia. Peripheral neuropathy: restless leg syndrome, burning sensation in feet progressing to paresthesia, intense pain, foot drop, impaired gait. Peripheral neuropathies, especially restless leg syndrome may be treated with gabapentin or Mirapex™ Seizure risks: precautions should be taken, may need anticonvulsants. Assess sleep patterns using **BEARS** tool: **B**edtime environment and habits **E**xcessive daytime sleepiness **A**wakenings during the night **R**egularity and duration of sleep **S**leep-disordered breathing
Endocrine/Metabolic	Gout (joint pain and inflammation, low-grade fever, HTN) due to accumulation of uric acid is usually treated with allopurinol. Secondary hyperparathyroidism: High calcium and demineralization of the bone is treated by limiting phosphorous intake and with a parathyroidectomy. Hyperlipidemia due to an increase in lipoproteins commonly seen with chronic kidney disease. Adjust dietary intake of fats, may treat with low dose corticosteriods to reduce serum lipid levels. Treat with statin medications. Glucose intolerance: due to loss of glucose threshold. Dialysis may improve glucose levels, may need to initiate insulin therapy and diabetes mellitus care.
Sexuality/Fertility	Sexual dysfunction: anemorrhea, impotence, infertility, decreased libido. Transplant may normalize sexual function. Dialysis may provide some improvement.
Gastrointestinal	The presence of metabolic waste products and electrolyte imbalances usually are the cause of gastrointestinal problems. Anorexia, nausea, vomiting, diarrhea, constipation, malabsorption syndrome, weight loss, fatigue, peptic ulcer, may all be minimized with dialysis, protein restricted diet, Zinc may improve taste sensation. Patients should be referred to a dietician or nutritionist.
Hematologic	Platelet dysfunction: decrease in platelet adhesiveness, a shortened lifespan for platelets, accompanied by mild thrombocytopenia, which will lead to bleeding tendencies. Usually this problem can be corrected with dialysis, iron and folic acid supplements. Monitor the patient for bleeding tendencies. If they are a dialysis patient, they will be anticoagulated, be sure to monitor INR, PT and PTT levels.
Osteomalacia	Also known as "Renal Rickets": seen in end stage renal disease: Hypocalcemia with Hyperphosphatemia (due to kidney's inability to convert Vitamin D to its active form), bone pain, pathologic fractures, poor dentition due to great bone demineralization. Usually treated with Calcitriol (vitamin D so they are able to absorb calcium back into bone), Calcium supplements and phosphate binding antacids. Monitor for periodontal disease (increases risk of infection, cavities, poor dentition). Monitor for soft tissue calcification. This occurs when calcium phosphate accumulates in the soft tissues, brain, lungs and heart walls. The patient's skin will actually feel gritty. Soft tissue calcification will accelerate dementias, heart failure and hypoxia problems.
Vaccinations	It is recommended chronic kidney disease patients receive vaccinations for influenza and pneumonia, but should always consult their health care provider first. Prior to beginning hemodialysis, patients should be screened for hepatitis B antigen and antibody, and if negative, administer hepatitis B vaccination and follow up tests for antibody are necessary.
Psychosocial	Assess for depression using the Medical Outcomes Study Short Form-36 (SF-36), or the Kidney Disease Quality of Life Instrument. The websites for these tools are included at the end of this module. These tools assess the patient's psychosocial status and used consistently will yield a baseline for comparison. Assess the patient's emotions, social/family roles, and feelings of vitality. Assess the significant others' as well as the patient's capacity for coping with chronic illness.

5. Dialysis: Dialysis works based on the following principles.

Osmosis: movement of water across a semipermeable membrane from an area of low to higher osmolality.

Diffusion: movement of molecules from an area of high to lower concentration.

Ultrafiltration: (also known as convection) is the movement of particles through a semipermeable membrane by hydrostatic pressure.

Hemodialysis: The hemodialysis filter provides the semipermeable membrane and the dialysate or dialysis solution provides the medium to remove excess fluids, electrolytes and metabolic waste products. Patients must be hemodynamically stable to tolerate hemodialysis and are anticoagulated prior to initiating hemodialysis, thus monitor for bleeding tendencies. Hemodialysis requires approximately 250 mL to prime the system from patient to filter and back to the patient again. So the patient has to be able to tolerate a 250 mL blood loss while on hemodialysis. A typical hemodialysis run will last 3 hours, usually 2 to 3 times per week. After hemodialysis the patient may sense an increased level of fatigue due to the increased heart rate and cardiac output they experience during hemodialysis. Often patients describe this fatigue as feeling like they just ran a marathon for three hours and they can be absolutely exhausted. Be sure to provide proper care for the patient's particular access site and monitor circulatory status of affected limb. Blood pressures should never be taken and blood should never be drawn from the affected limb. One wants to do as much as possible to maintain the integrity of the access devise. Be sure to monitor patients for **"Dialysis Disequilibrium Syndrome"** that may occur anywhere from immediately after to 48 hours after dialysis. Dialysis disequilibrium syndrome is due to the rapid removal of fluids, waste products and blood urea nitrogen with dialysis. This causes a drop in blood osmolality. Fluids then shift into the cells, causing hypotension, headache, vomiting, seizures, confusion, and even cerebral edema. If not treated, dialysis disequilibrium syndrome can become life threatening. Treating hypotension with a normal saline fluid bolus usually will recover most patients. Prevent dialysis disequilibrium syndrome by administering dialysis for shorter periods of time. If this does happen to the patient, be sure to let the hemodialysis staff know so they might alter either the dialysis or give some additional fluids with dialysis so it does not occur again.

Access Devices for Hemodialysis:

Arteriovenous Fistula (AVF): consists of a surgical anastomosis of an artery to a vein. AV fistulas allow for high flow arterial blood, resulting in venous enlargement. However vein enlargement that is adequate for hemodialysis may take weeks or months to develop, thus AVF should be placed when the patient is in late Stage 3 or early Stage 4 disease. AVF have a history of the lowest incidence of infection and the longest patency rates and are thus the device of choice.

Arteriovenous Graft (AVG): consists of surgical anastomosis by implanted tubing, either synthetic or biologic, to an artery at one end and a vein at the other end. An AVG can be used immediately, but has higher rates of thrombosis and infections. AVG are not the first choice device for hemodialysis.

Central Venous Catheters (CVC): can be used immediately, but are not recommended for long-term use. A dual lumen catheter is typically placed in the internal jugular, femoral or subclavian vein, with two distal ends used to connect to hemodialysis. As with all catheters, these are susceptible to infection and occlusion, plus patients usually do not find these as comfortable.

Peritoneal Dialysis: mainly uses diffusion and osmosis. Ultrafiltration may be achieved either by administering a vasopressor agent thus causing vasoconstriction of the peritoneal blood vessels and an increase in hydrostatic pressure; or by skipping the dwell time, and instilling dialysis fluid as rapidly as possible; draining immediately; thus creating a siphoning effect and negative pressure promoting water removal. Peritoneal dialysis may be used for patients who are not hemodynamically stable or for those with a less acute problem. Many patients choose peritoneal dialysis because they are able to perform the procedure themselves versus having to go to a dialysis center three times per week. Peritoneal dialysis can be performed during the day or during the night while the patient is sleeping, thus giving the patient more control of their dialysis. An advantage of peritoneal dialysis is that it yields slow steady removal of wastes. Peritoneal dialysis patients tend not to experience the "highs and lows" that a hemodialysis patient experiences as waste products build up in the blood, causing them to not feel well, followed by a period of feeling fine after hemodialysis. Infection is the number one complication of peritoneal dialysis, so be sure to teach the patient sterile technique in handling all equipment. Monitor the patient's technique and performance of procedures and troubleshoot any problems you notice so as to avoid complications.

Types of Peritoneal Dialysis:

Continuous Ambulatory Peritoneal Dialysis (CAPD): usually consists of 4 to 5 cycles per 24 hours with 4 to 6-hour dwell times. The cycles are completed during the day while the last exchange dwells over night to allow for uninterrupted sleep.

Continuous Cycle Peritoneal Dialysis (CCPD): requires a machine or cycler and usually consists of 3 to 6 cycles administered during the night while the patient sleeps. The final fill remains in the patient throughout the day. CCPD also limits the opening of the abdominal catheter to 2 times per day, vs. 4 to 5 times with CAPD. This greatly reduces infection and peritonitis rates.

Intermittent Peritoneal Dialysis (IPD): is typically cycled 3 to 4 times per week in 10 to 14 hour cycles, giving much flexibility to the patient.

In this module we've covered a lot of material about this very complex, but interesting disease. It is hoped the reader will have a better understanding of chronic kidney disease and the nursing ramifications as a result of completing this module. Below are a list of references and helpful kidney disease websites. Use these websites for yourself, or give them to your patients so they might take an active role in learning about this very challenging disease.

Helpful Kidney Websites and References:

- American Association of Kidney Patients: www.aakp.org
- Free Nutrition Counter: www.aakp.org/AAKP/nakphos.htm
- Free Portion size Reference: http://hin.nhlbi.nig.gov/portion/servingcard7.pdf
- National Kidney Foundation: www.nkf.org
- 36 item Medical Outcome Study: www.sf-36.org/tools/sf36.shtm (Assessment tool for quality of life)
- Polycystic Kidney Disease Research: www.pkdcure.org
- National Kidney & Urologic Diseases Information Clearinghouse: www.niddk.nih.gov
- Clinical Practice Guidelines for CKD: Evaluation, Classification and Stratification: www.kidney.org/professionals/kdoqi/guidelines_ckd/toc.htm
- American Kidney Fund: www.kidneyfund.org
- American Nephrology Nurses Association: www.annanurse.org
- National Kidney Disease Education Program: www.nkdep.nih.gov
- Renalinfo: Support Resources for People with Kidney Disease: www.renalinfo.com
- Social Security Online: Special provisions relating to coverage under Medicare for End Stage CKD: www.ssa.gov/OP_Home/ssact/title02/0226A.htm
- United Network for Organ Sharing: www.unos.org
- Forum of End Stage Renal Disease Networks: www.esrdnetworks.org/networklist.htm

Chronic Kidney Diseases—Post-Test

Name:_____ Final Score: _____

Please indicate whether the answer is True or False. There is only one correct answer.

TRUE OR FALSE ANSWERS

___ 1. Chronic kidney disease is easily recognized early in its development.
___ 2. Chronic kidney disease only effects the kidneys and no other physiologic system.
___ 3. Nephrons are capable of enlarging to handle a larger volume of solute.
___ 4. Proximal convoluted tubules are responsible for secreting foreign substances such as drugs.
___ 5. The distal convoluted tubule is the target organ for antidiuretic hormone and aldosterone.
___ 6. Hypertension is often a cause of chronic kidney disease and is believed to start in the juxtaglomerular apparatus and the renin-angiotensin-aldosterone systems.
___ 7. Angiotensin II causes vasodilation and is part of the autoregulation mechanism of the kidney.
___ 8. High sodium intake has no effect on kidney function.
___ 9. It is best to advise patients with hypertension to use non-steroidal anti-inflammatory drugs to treat pain they may have.
___ 10. When released, antidiuretic hormone acts on the nephron to cause water conservation.
___ 11. Blood urea nitrogen and creatinine levels are reliable indicators of kidney function and are not influenced by any other factors.
___ 12. Erythropoietin is a substance released from the kidneys that stimulates the production of red blood cells.
___ 13. Chronic kidney disease is now defined based on the patient's GFR.
___ 14. The new model of chronic kidney disease enables health care providers to recognize patients at risk for the development of the disease earlier.
___ 15. In Stage 1 chronic kidney disease, patients have low GFR readings and are at risk of developing the disease.
___ 16. Modifying risk factors such as managing hypertension, diabetes, and dyslipidemias is an intervention for Stage 1 chronic kidney disease.
___ 17. In Stage 2 chronic kidney disease patients begin to experience signs and symptoms of the disease.
___ 18. As in Stage 1, healthy lifestyle choices and management of risk factors for chronic kidney disease should be continued.
___ 19. If they are not already doing so, for the chronic kidney disease patient with hypertension and/or diabetes, self monitoring of blood pressure and/or blood glucose should be initiated in Stage 2.
___ 20. In Stage 3 chronic kidney disease, patients begin to experience signs and symptoms of the disease.
___ 21. An important nursing intervention for Stage 3 is to teach the patient signs and symptoms of chronic kidney disease and uremic syndrome so they will be able to recognize and report signs and symptoms as they present themselves.
___ 22. Anemia results in chronic kidney patients due to a lack of iron.
___ 23. Osteomalacia or renal rickets results when high phosphorous levels demineralize teeth and bones.
___ 24. Parathormone is the hormone that controls potassium levels and plays a role in the development of osteomalacia and secondary hyperparathyroidism.
___ 25. In Stage 3, involving the significant others as you continue to educate the patient regarding signs and symptoms of chronic kidney disease and self-care becomes an important nursing intervention.
___ 26. In Stage 4, renal replacement therapy usually is initiated.
___ 27. In Stage 4, we no longer have to consider treatment for anemias or osteomalacia.
___ 28. Minimally, the patient should be referred to a nephrologist in Stage 4.
___ 29. Renal transplants are now performed earlier, have proven to be more cost effective than dialysis and improve the quality of life for chronic kidney disease patients.
___ 30. Stage 5 is also known as end stage renal disease and all treatment is stopped in this stage.
___ 31. A benefit of home care is that it may provide much needed respite for the patient's significant other.
___ 32. An aspect of Stage 5 care is to have end of life discussions and decisions such as advanced medical directives and power of attorneys in place.
___ 33. All kidney disease diets are basically the same for each patient.
___ 34. The American Association of Kidney Disease Patients offers a free nutrition counter to patients.
___ 35. Protein intake for chronic kidney disease patients is severely restricted.
___ 36. Beans, legumes, and nuts are good sources of protein for chronic kidney disease patients.
___ 37. It is alright for chronic kidney disease patients to consume cola colored soft drinks.
___ 38. Potassium intake is always restricted for chronic kidney disease patients.
___ 39. It's OK for chronic kidney disease patients to take over the counter medications, herbal and vitamin supplements.
___ 40. Chronic kidney disease causes metabolic alkalosis due to an accumulation of waste products and is treated with dialysis and sodium bicarbonate tablets.
___ 41. To monitor fluid status in dialysis patients, use the dry weights for comparison.
___ 42. Peripheral neuropathies such as restless leg syndrome and complaints of burning sensations of the feet may occur as part of uremic syndrome.
___ 43. Diabetes and gout may develop as a result of chronic kidney disease.
___ 44. Besides anemia, the chronic kidney disease patient may develop thrombocytopenia which will result in more frequent blood clotting.
___ 45. Besides keeping phosphorous levels in check with phosphate binding antacids, Calcitriol is also administered to control osteomalacia.
___ 46. Chronic kidney disease patients should not take any type of vaccinations.
___ 47. Patients do not need to be hemodynamically stable to perform hemodialysis.
___ 48. Dialysis disequilibrium syndrome is due to a fluid shift and results in hypotension and is treated with normal saline.
___ 49. Arteriovenous grafts are the first choice to be used as an access devise for hemodialysis.
___ 50. An advantage of peritoneal dialysis is that it gives slow and steady removal of waste products and patients do not experience the highs and lows that a hemodialysis patient does.
___ 51. Teaching the patient sterile technique is key in preventing infection which is the number one complication of peritoneal dialysis.
___ 52. There is a higher infection rate associated with continuous cycler peritoneal dialysis.
___ 53. Patients may access information for themselves by utilizing some of the websites regarding chronic kidney disease.

Evaluation–Chronic Kidney Diseases

1. Were the following objectives met?
   a. Describe the four stages of chronic kidney disease. YES NO
   b. Discuss the nurse's role in caring for patients in each stage of chronic kidney disease. YES NO

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

Registration Form–Chronic Kidney Diseases

ONA MEMBERS
Each study in this edition of the Ohio Nurse is free to Members of ONA. Any additional independent studies that an ONA member would like can be purchased for $12.00 plus $3.00 S/H by filling out the enclosed order form on page 22 & 23.

NON-MEMBERS
Each study in this edition of the Ohio Nurse is $12.00 for non- members. Any additional independent studies that a non-member would like can be purchased for $12.00 plus $3.00 S/H by filling out the enclosed order form on page 22 & 23.

Name (please print clearly): _____

Address:_____

City: _____ **State:** _____ **Zip:**_____

Day phone number: (___) _____ - _____ **RN or LPN?:** RN LPN **ONA Member:** YES NO

ONA Member Number (if applicable)_____

CHARGE TO: ___ Visa ___ MasterCard ___ Discover ___ American Express

Card #: _____ - _____ - _____ - _____ **Exp. Date (mm/yyyy):** ____/____ **Verification #:**

Signature: _____

Please send **check or credit card information** along with this completed form to: Ohio Nurses Foundation, Dept. LB-12, PO Box 183134, Columbus, OH 43218-3134.

ONA OFFICE USE ONLY

Date Received: _____ Amount: _____ Check No: _____

No Lift is a Safe Lift . . .

Continued from Page 2

The conclusion of the study facilitates the importance of staff input. It was helpful in identifying problems and solutions that can be useful in designing ergonomic programs. The recommendations included:

- Increase the number of patient transfer devices.
- Deliver training programs.
- Increase the size of rooms and or adjust the room set-up ergonomically.
- Hire additional nurses and or aides to assist with turns and transfers.
- Realize the differences in jobs and staff accordingly. (Vieira, 2005)

Evidence-based practice has identified some solutions through the use of engineering, administrative, and behavioral and work practice controls. Engineering controls are the availability of proper assist-lift equipment. Administrative controls promote no-lift policies, lift teams and ergonomic protocols with continual assessment of each. Lastly, behavioral and work practice controls involve refraining from old techniques and providing effective and consistent education. (Nelson, 2005)

The National Institute for Occupational Safety and Health (NIOSH) released a study in 1997 showing the impact of lift devices. The study population included 57 nursing assistants. After implementation of assistive devices, injuries decreased from 83 to 43 per 200,000 working hours. More importantly, no restricted or lost work days were taken four months post study with the use of the equipment. (Cohen, 1997) The research conducted 10 years ago indicated the importance of lift assist equipment. Recent research indicates the need still exists to prevent devastating MSIs.

Conclusion

MSIs are occurring at epidemic proportions in the profession of nursing. Nurses are at high risk for this injury, which results in physical and emotional pain. These types of injuries are adding to the critical bedside nurse shortage.

The physical strain, increased patient size and an aging nursing workforce are factoring into the increasing incidence of MSIs. These injuries are generally cumulative in nature with 52 % of nurses complaining of back pain. Old lifting techniques are not effective in preventing MSIs. Preventative programs are in place and are being refined in an attempt to further address this critical workplace issue.

My story is a prime example of an MSI. With the proper equipment, education, and attitude my life-changing injury may have been prevented. Research is indicating the need for entities to collaborate and provide a safe work environment. The ANA, ONA, the General Assembly as well as the Ohio BWC continue to promote policy changes, programs, and employer incentives.

Nurses must also become more knowledgeable about MSIs and proactive in efforts to protect themselves by serving on committees and offering input regarding no-lift policies and lift assist equipment. The physical demands of a nurse's practice exacerbate the nurse shortage. Therefore, policies must be adopted and implemented so that workplace MSIs are not considered an expected part of the job. The "grin and bear it" mindset must give way to proactive advocacy regarding the need for lift assist devices and related workplace policies. Begin by making your employer aware of the important new program offered by BWC. Remember–safer lifting is better patient care. Protect yourself, your career, and your patients.

References are available upon request. For a list of references, please contact Shannon Richmond at srichmond@ohnurses.org.

Our Rolling Stone That Gathers No Moss: June 3 and 4, 2008

Join the Ohio Nurses Foundation for this 2-day CE event that discusses the path to fixing the health care system; unique factors that can affect individual health; and an update on Ohio nursing law and rules and nursing initiatives in Ohio.

Tuesday, June 3, 2008–Objectives:

1. Describe two issues contributing to the breakdown of the healthcare system.
2. Discuss updates in Ohio nursing law and rules.
3. Discuss the value of pets to the well being of people.
4. Define health literacy in relation to the older adult.

9:00 a.m. Registration
9:45 a.m. Welcome and Introductions
10:00 a.m. **Path to Fixing the Health Care System**
Speaker: Jim Hofferberth
12:00 p.m. Break
12:15 p.m. Lunch
Ohio Nursing Law and Rules Update
Speaker: Jan Lanier, JD, RN
1:15 p.m. Break
1:30 p.m. **Health Benefits of Caring for Pets**
Speakers: Jane Flores, DVM
Joelle Nielsen, MSW, LSW
3:30 p.m. Break
3:45 p.m. **Health Literacy**
Speaker: Sandra Cornett, PhD, RN
4:45 p.m. Wrap up and Evaluation
5:00 p.m. Concluded
5:30 p.m. Picnic and Network (Bring your own beverages)

Networking Following Day 1 (June 3), there will be a picnic at the ONA Headquarters. Please join us for networking and discussions.

Wednesday, June 4, 2008–Objectives:

1. Explain the importance of individual disaster plans.
2. Identify the relationship between weather and health.
3. Discuss the future of nursing in Ohio.
4. Examine strategies to assist others in healthy retirement.

7:30 a.m. Registration
8:00 a.m. Retired Nurses Forum Meeting
8:30 a.m. **Disaster Preparedness**
Speaker: Deborah Arms, PhD, RN
10:30 a.m. Break
10:45 a.m. **Effects of Weather on Health**
Speaker: Jon Loufman
12:45 p.m. Break
1:00 p.m. Lunch
Nursing Initiatives in Ohio
Speaker: Barbara Nash, MS, RN, BC, CNS
2:15 p.m. **Healthy Living in Retirement**
Speaker: Gingy Harshey-Meade, MSN, RN,CAE, CNAA, BC
3:15 p.m. Wrap up and Evaluation
3:30 p.m. Concluded

Nearest Hotel Country Inns and Suites, 6305 E. Broad Street, Columbus, OH (614-322-8000). Please mention ONF to receive the ONF discount rate.

Speakers

Deborah Arms, PhD, RN, *Chief Prevention, Ohio Department of Health*
Sandra Cornett, PhD, RN, Director, *OSU/AHEC Health Literacy Initiative*
Jane Flores, DVM
Gingy Harshey-Meade, MS, RN, CAE, CNAA, BC, CEO, *Ohio Nurses Association*
Jim Hofferberth
Jan Lanier, JD, RN, Deputy Executive Officer, *Ohio Nurses Association*
Jon Loufman, Weather Anchor/Meteorologist. *WOIO-TV, Cleveland*
Barbara Nash, MS, RN, BC, CNS, *President, Life Wise, Inc. and President, Ohio Nurses Association*
Joelle Nielsen, MSW, LSW, *Program Coordinator, Honoring the Bond: The OSU Veterinary Teaching Hospital*

Contact Hours

6.0 Contact Hours Includes 1.0 contact hour of Category A (Law and rules) on Day 1.

6.0 Contact Hours on Day 2.

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

Criteria for successful completion include attendance at the entire event and submission of a completed evaluation form.

Conflict of Interest The planners and faculty have declared no conflict of interest.

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Substitutions Substitutions will be accepted. Refunds will be given with a 48 hour notice and minus a $25.00 administrative fee.

Registration Information Visit www.ohnurses.org to register for this event. Registrations can be faxed to 614-237-6074. To register by mail, fill out the following information and mail to: Ohio Nurses Foundation, LB-12, PO Box 183134, Columbus, OH 43218-3134. Please return form and seminar payment no later than one week prior to the event. Contact Sandy Swearingen (614-448-1030) or sswearingen@ohnurses.org with any questions.

Nurses as Legislative Partners: Transforming Health Care: April 2, 2008

Statistically, 1 in every 50 voters is a nurse. There is power in nursing! Yet every day the Ohio General Assembly and various state regulatory agencies make decisions that impact a nurse's ability to practice, sometimes without any input from that nurse–You!

Shouldn't there be a group or groups in the state to give you the tools you need to communicate with legislators? Shouldn't a group of nurses who understand your professional life be advocating for you? Is anyone watching these state decision makers closely and providing you the opportunity to learn all about laws or rules important to nursing or the greater healthcare community?

Be a part of the action as experts not only provide you with the timely legislative news and information you need but also help you unlock your potential to be an influential part of Ohio's political process. Learn to communicate effectively with those in power; hear success stories of nurses in action; see a behind-the-scenes look at the Ohio Statehouse and its history; watch legislative committees discussing issues pertinent to nursing; and educate your individual legislators about health care issues closest to you and your daily life.

This valuable day will provide you with tools and resources to personally get to know your state elected officials, understand the issues and be able to communicate your views to all levels of the government. Take this important opportunity to advocate for nursing!

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Cost:
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Legal Regulations and Professional Standards for Ohio Nurses Guide Now Available

The second edition of *Legal Regulations & Professional Standards for Ohio Nurses* is now available for purchase from the Ohio Nurses Association (ONA). Much has changed in the health care environment since the initial publication of this resource ten years ago and this new, updated edition will enable students and registered nurses alike to become more familiar with the law, rule, and professional standards that define nursing practice.

This resource is available as an Adobe© PDF sent to you via email or as a PDF on a CD. To order your copy, please contact Kathleen Morris, Director of Nursing Practice, at kmorris@ohnurses.org or (614) 448-1026.

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A Nursing Malpractice Primer

INDEPENDENT STUDY

This independent study has been developed to provide an introduction to malpractice as it applies to nurses. It takes approximately 60 minutes to complete this independent study. 1.0 contact hour will be awarded for successful completion of this independent study.

OBJECTIVES

Upon completion of this independent study, the learner will be able to:

1. List four components of malpractice.
2. Define a variety of legal terms as they apply to nursing.

This independent study was developed by: Barbara G. Walton, MS, RN. The author has no financial vested interest. The planners and faculty have no conflict of interest. There is no commercial support for this independent study.

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

Expires 1/2010.

Introduction

The idea of being named in a malpractice case is terrifying to most nurses. However, even with the best of care, you may still find yourself being named as a defendant. Being a nurse suddenly thrown into the legal world is like being in a foreign country. What are all these new terms the attorneys are using? How do these terms impact you? In this module, we will be answering those questions.

Components of Malpractice: There are four components to a malpractice case. It is the responsibility of the plaintiffs to prove all four components, or there is no malpractice case. The plaintiff is the person who is suing you. The plaintiff may be the patient, a member of the patient's family or a representative or guardian of the patient. The four components of malpractice are as follows:

Duty: The plaintiff has to prove you had a duty to do something for the patient. This is applied very broadly in healthcare settings. If you saw, knew or were aware of a problem or situation, you have a duty to do something for that patient. Some attorneys say, "any nurse has a duty to any patient". Let's say you are on your way to lunch one day. You are walking down the hallway of a nursing unit that is not your unit. However while walking down the hall, you hear a patient, who is not your patient, call out for help, stating "Help, I'm having trouble breathing!" Do you have a duty to do something for this patient? The answer is yes. You have a duty to minimally go into the room and assess the patient. Depending on what your assessment reveals you may also need to render any emergency care and/or seek out the nurse who is assigned to care for that patient.

Breach of Duty: is the second component that plaintiffs must prove in a malpractice case. In establishing breach of duty, the plaintiff proves you didn't do what you should have done. You failed to recognize a situation or you failed to take appropriate action. Using our example above, upon hearing a patient call out for help, you simply kept walking, or told the patient, "Put your call light on, I'm not your nurse." In this example, you breached duty because you failed to go into the patient's room and assess the situation, yet you were aware of the fact the patient was requesting assistance.

Damages: Plaintiffs will next establish how the patient was injured or damaged. Damages usually have to be significant. Examples of damages may include loss of life, loss of limb, disfiguring scars, burns, loss of abilities and/or independence, loss of income and companionship. If a patient takes a prescribed dose of insulin, suffers a hypoglycemic reaction, but recovers from the episode, there would be no damages. However, for our patient who has been crying out for help and has difficulty breathing, if he ends up dead, he would have sustained damages.

Causation: This is often the most difficult portion of a malpractice case to prove. Causation is where the plaintiffs make a link between your breach of duty and the damages sustained by the patient. In other words, your breach in duty caused the injury to the patient. Because you continued on your way to lunch, yet heard this patient calling out for help, you failed to assess and intervene on behalf of the patient, the patient died. Loss of life would be the damage in this example.

Causation is further defined as to being *direct causation* or *proximate causation*. In *direct causation*, there is a direct linkage between the breach in duty and the damages. Our example of the patient crying out for help, the nurse failing to assess and intervene, and the patient dies, is an example of direct causation. In *proximate causation* there is a linkage between what you did or did not do to the damages, but your actions, or lack thereof did not by themselves cause the damages. In other words, what you did or didn't do did not cause the injury, but your actions contributed to the injury. An example of proximate causation would be as follows. On a particularly busy shift you fail to change the dressing on a pressure sore. Over the next five days, no one changes the dressing on this wound. Soon the patient is experiencing signs of wound infection and sepsis. While missing one dressing change may not have resulted in sepsis, missing dressing changes over five days did in this example. So there would be proximate causation here in that you contributed to the development of sepsis, but so did all the other caregivers who failed to change the dressing over this five-day period.

Here is a case study. Is this a malpractice case? A patient with a wound infection is to receive 80 mg of Gentamycin® IVPB. The nurse mixes and gives 800 mg of Gentamycin® to the patient. After receiving this dose of Gentamycin®, the patient experiences loss of hearing and renal failure. Is this a malpractice case? Think of the four components of malpractice and write your answers below.

What is the *Duty* in this case?
What is the *Breach* of Duty?
What are the *Damages*?
What is/are the *Causation*?

Answers:

Duty: The duty for a nurse in administering medication is the "five rights". Did the nurse administer the correct medication and dose at the right time via the correct route to the correct patient? There is a duty for the nurse in this example.

Breach of Duty: The breach of duty in this example is the nurse failed to administer the correct dose of Gentamycin®. She gave 800 mg versus the 80 mg ordered.

Damages: This patient experienced ototoxicity and nephrotoxicity after receiving this medication, so yes there are significant damages.

Causation: Did administering the wrong dose cause the loss of hearing and renal failure? Given the patient had a normal BUN and creatinine prior to receiving this medication, most likely the cause of these damages is the incorrect dose of medication. Ototoxicity and nephrotoxicity are classic complications of a Gentamycin® overdose. As a matter of fact this would be a good example of direct causation. The medication error caused the loss of hearing and renal failure.

Let's look at this example. Again a patient is to receive 80 mg of Gentamycin®, yet the nurse mixes and gives 800 mg. Only this time, the patient experiences no untoward outcomes. Is this malpractice? Again, look at the four components of malpractice and write your answers below.

What is the *Duty* in this case?
What is the *Breach* of Duty?
What are the *Damages*?
What is/are the *Causation*?

Answers:

Duty: Again the five rights of medication administration are present, so there is duty.

Breach of Duty: Again the nurse failed to administer the correct dose, so there is a breach of duty in this example.

Damages: Because the patient did not experience any renal failure or loss of hearing, there are no damages. The patient was not injured. His wound infection cleared up and you were able to discharge him two days earlier than expected! Therefore, because there are no damages, there is no malpractice case in this example. There certainly is a medication error, but there is no malpractice.

Let's look at one more example. The patient is to receive 80 mg of Gentamycin®, and does indeed receive 80 mg of Gentamycin®. However after receiving this medication, the patient experiences ototoxicity and nephrotoxicity. Is this malpractice? Again, look at the four components of malpractice and write your answers below.

What is the *Duty* in this case?
What is the *Breach* of Duty?
What are the *Damages*?
What is/are the *Causation*?

Answers:

Duty: There is duty again, the five rights of medication administration still exist.

Breach of Duty: There is no breach of duty in this example. The nurse did everything correctly.

Damages: The patient certainly did experience injuries, which were probably a result of the medication he received.

Causation: Were the damages caused by the medication the patient received? Yes, in this example. However, even though there were damages that were caused by something the nurse did, there is no malpractice in this example, because there was no breach in duty. This example is what is called a medical misadventure. A medical misadventure occurs when everything was done correctly, but the patient still experiences an untoward outcome.

Other Legal Terms: Here are some other legal terms as they apply to nurses.

Respondeat Superior: This is an old legal doctrine that places liability on the employer versus employee. It originally meant the master is responsible for the acts of his slaves. It is based on three items.

1) *Hiring and Firing:* As an employer, I decide who works for me and who doesn't. If I knowingly hire and retain an incompetent employee, I may be held just as liable for that employee's actions as the employee may. This has important ramifications for nurse managers who actively hire and evaluate staff nurses.
2) *Policies and Procedures:* As an employee, I am obligated to follow policies and procedures set forth by my employer. If I do not follow policies and procedures, I could be found to be practicing outside the scope of my employment. We will talk about this definition later.

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3) *Deep Pockets:* Who has the resources to pay for the damages? Who has the kind of money to pay an award of 10 million dollars? Typically it is the corporate employer, not the staff nurse. This is where the term "deep pockets" comes from. In other words, who has the deep pockets, capable of holding a lot of money?

Most nurses are employees; thus Respondeat Superior applies to nurses. However if you are working as an independent contractor, Respondeat Superior may not apply in some situations. Thus the nurse may be named individually in a malpractice matter. Also know that Respondeat Superior would not apply should you render care at the scene of an accident or at your child's soccer game. These situations would be outside of your job; therefore your employer is not responsible for your actions outside of work.

Captain of the Ship Doctrine: This is another old legal term that places liability on the person in charge. Historically this applied in operating suites, where the surgeon is the "Captain of the Ship" and is in charge of all that occurs during that surgical procedure. During the course of an operation should the surgeon direct the scrub nurse to do something that ultimately injured the patient, the surgeon would be held liable for this. In more recent years Captain of the Ship Doctrine has been questioned. For example, in the operating room, it is a nursing responsibility to count instruments, needles and sponges. Based on the nurses telling the surgeon the count of these items is correct, the surgeon then closes the incision. In the past if a sponge or surgical instrument was left inside the patient, the surgeon, being the Captain of the Ship, was held liable for this. Because these counts have now been recognized as a nursing responsibility, should an instrument or sponge be left in a patient, the liability usually falls on the nurses completing the count and the employer.

Are there Captain of the Ship ramifications for staff nurses? Yes, in some cases. Let's say you work with unlicensed assistive personnel (UAP). We have many titles for these individuals ranging from patient care technicians to nursing assistants. One of the job responsibilities at your place of employment for the unlicensed assistive personnel (UAP) is to take vital signs. Let's say you ask Mary, the UAP to go to Mr. Jones' room, take his blood pressure and report the reading back to you. Mary has been through the employer's orientation and you know she is competent to take blood pressures. Mary goes to Mr. Jones' room, and proceeds to take his blood pressure by wrapping the cuff around his neck. In the process of doing this, poor Mr. Jones has a stroke and dies! Is there Captain of the Ship liability for you? After all, you are the one who directed Mary to take this blood pressure. What do you think?

I think:

The answer is no. In this situation, you directed Mary, the UAP to do something she has been oriented, trained and deemed competent to do. Furthermmore, it is well within her job description and normal duties to perform the task of taking blood pressures. In other words, you delegated appropriately and you had every expectation that Mary would take the blood pressure appropriately. The liability in this case would rest on Mary, as she is the one who undertook the procedure incorrectly and injured Mr. Jones. Think about it this way, if we couldn't delegate and expect someone to undertake the delegated task appropriately, we would have to go with them and observe them do the task. If we have to constantly observe, why even have the UAP? However, once you became aware of the fact she took the blood pressure incorrectly you would have an obligation to report this to your manager, or another appropriate person in the chain of command.

Remember the definition for duty? If you saw Mary taking Mr. Jones' blood pressure incorrectly, do you have a duty to Mr. Jones? Remember duty occurs when you have knowledge of a situation. In this instance since you observed Mary taking the blood pressure incorrectly, you would have duty to intervene on behalf of the patient.

What do you think about Captain of the Ship liability for you in this scenario? You direct Mary the UAP to go to Mr. Jones' room and insert a Foley catheter into Mr. Jones. This time Mary says to you, "I don't think I should do that. I don't remember them covering that in orientation." You reply, "Just go ahead and do it. Do the best you can." Mary in turn goes to Mr. Jones' room, inserts the catheter and kills Mr. Jones. Is there any Captain of the Ship liability for you here?

I think:

The answer is yes. You directed Mary to do something that she was not qualified, educated or competent to do. Further more Mary told you "I don't think I should be doing that." In other words, she is telling you this is not in my job description; this is something I should not be doing. She also tells you she doesn't know how to do this procedure when she says "I don't remember them covering this in orientation." These are important comments made by Mary that you should have heeded. So yes, because you directed Mary to insert this catheter and it injured the patient, there would be Captain of the Ship liability for you. Is there also liability for Mary? The answer is again yes. Mary is liable because she went ahead and did it. She undertook a procedure she knew she should not be doing and she knew she had not been trained to do.

Another ramification for nurses in regard to Captain of the Ship is in making patient care assignments. Many of us have worked together for many years on the same unit. We develop a knowledge base as to the skills and capabilities each staff nurse possesses. However let's say you are the charge nurse and a "float nurse" comes to your unit. You don't know this nurse, nor do you know her skill level. It behooves you as the charge nurse when you give this nurse her assignment, to ask her if she can handle the assignment. If she answers yes, she is taking professional responsibility and liability for this assignment. If she answers no, it would probably be best to ask her what it is about the assignment that is problematic. You may need to rework the assignment, or provide some orientation for her. If you force the nurse to take an assignment she says she is not competent to handle, you could be held just as liable for her actions as she is. In other words, you are the Captain of the Ship when you make the assignment.

Res Ipsa Loquitor: In the United States, we are deemed innocent until proven guilty. In a medical malpractice matter, it is the burden of the plaintiff to prove your guilt. However if a matter meets the requirements of Res Ipsa Loquitor, you are guilty until proven innocent and it is the burden of the defendant (you, or the person being sued) to prove your innocence.

Res Ipsa Loquitor means "let the injury speak for itself." Res Ipsa Loquitor consists of four items. 1) The patient was injured while he or she was under your care. 2) The injury was not something the patient did to him or herself. 3) The exact cause or time of injury is not known, nor would the person causing the injury be known. 4) The injury occurred because something was done incorrectly, or is something that would not normally occur.

Here is an example of Res Ipsa Loquitor. A thirty five-year-old healthy woman is admitted for right knee surgery to correct a problem from an earlier car accident. She undergoes the surgery without any evident problems. However in the Post Anesthesia Care Unit, the nurse notices this patient has a third degree burn on the back of her left calf. Does this case meet the requirements of Res Ipsa Loquitor? Write your answers to the questions below.

1) Was the patient injured while under your care?
2) Did the patient injure herself?
3) Who, what, when and how did this injury occur?
4) Is this injury something that would normally occur?

The answers are as follows:

1) *Was the patient injured while under your care?* Yes, the patient was injured while under the care of the operating room staff.
2) *Did the patient injure herself?* No, the patient was under the effects of general anesthesia, so was not able to injure herself.
3) *Who, what, when and how did this injury occur?* We do not know who, what, how or exactly when this injury occurred. All that is known is the injury occurred in the operating suite.
4) *Is this injury something that would normally occur?* No, patients undergoing right knee surgery should not normally sustain third degree burns to the left calf.

The requirements for Res Ipsa Loquitor are met, thus it would be the operating room staff's burden to prove their innocence. The operating room staff would have to explain how and why a patient would reasonably expect to sustain a third degree burn to the back of the left calf while undergoing right knee surgery. In this example, no explanation could be offered; thus, the patient would most likely receive a monetary award.

Assumption of Risk: There are risks to undertaking various procedures, but we know this and proceed anyway. Assumption of risk is where a person knows or should know the risks involved in performing or omitting certain acts, but proceeds forward to his own detriment. For example, there are risks in administering intramuscular injections. We may induce an infection, cause an abscess, or injure a nerve in the process of giving that injection. However, we know these risks and give the injection anyway. This is why we learned the correct procedure for administering intramuscular injections.

Besides the five rights of medication administration, this procedure includes: correctly land marking the injection site, cleansing the injection site, using the proper needle size and length, using the correct angle of insertion, and making sure you are not in a vein. Nursing practice tells us if we follow the correct procedure, we minimize the risk of causing injury to a patient. If a nurse chooses to administer an intramuscular injection without land marking the injection site, the risk of injuring a nerve greatly increases. If a nurse chooses to omit cleansing the skin prior to an injection, the risk for abscess and infection greatly increases. Failing to undertake the procedure correctly, the nurse then assumes the risk that he or she may injure the patient.

Assumption of risk may also be used as a defense strategy particularly when dealing with noncompliant patients. For example you have taught Ms. Smith to use the call light should she need to get out of bed. Ms. Smith states she knows she is to use the call light and has demonstrated she knows how to use the call light. However Ms. Smith persists in getting out of bed without activating the call light. Should she fall and injure herself, the assumption of risk could be placed on the patient, particularly if the nurse had documented this. You may want to consider writing a note indicating your instructions and repeated reminders, Ms. Smith's competence in using the call light and her persistence in being noncompliant. Perhaps your note would read: "For her safety, Ms. Smith has been instructed

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and reminded numerous times to utilize the call light when getting out of bed. The patient demonstrates use of the call light in making other requests, however does not do so when getting out of bed. The patient has been found out of bed a number of times and each time has been re-instructed to use the call light. The patient persists in getting out of bed with out assistance."

Assumption of Risk has important uses for nurses particularly in the areas of patient education and noncompliance. Don't forget noncompliance is a nursing diagnosis and can be an effective tool for us. Think of all the ways you might be able to use this diagnosis and shift responsibility for the patient, to the patient. Here are some suggestions:

- "Patient has been instructed about the importance of taking his blood pressure medications, however patient persists with noncompliance in regard to medications, his blood pressure is 200/140."
- "Patient has been given information and instructions regarding smoking cessation. Patient states health ramifications of continued smoking, however, patient continues to smoke three packs per day."

What are some ways you might utilize this tool? Write your ideas down.

Borrowed Servant: A Borrowed Servant is one who, while in the general employment of one agent is subject to direction and control by another agent. Let's say you are assisting a physician with the insertion of a chest tube. During this procedure the physician directs you to do something, you comply with his request as it seems to be a reasonable request, but the patient sustains an injury. In this scenario, the liability would fall on the physician and you would be the Borrowed Servant. Often Borrowed Servant is used in conjunction with Captain of the Ship.

Borrowed Servant may also apply when a facility utilizes the services of a nurse-staffing agency. The nurse is an employee of the staffing agency, but is the Borrowed Servant of the facility, say a hospital or nursing home, that is utilizing the staffing agency. In this instance, the nurse is subject to the direction and control of the hospital or nursing home while on the job, but is the employee of the staffing agency.

Due Care: Ordinary or due care means the degree of care that would be exercised by the ordinary careful person in the same circumstances. For example an ordinary careful nurse would land mark an injection site prior to administering an injection. An ordinary careful nurse would maintain a sterile field when inserting a Foley catheter.

Reasonable Person: This is a phrase used to denote a person who is accepted by society as possessing the mental capacity and activity consistent with the acceptable norms of society. This is one of the major reasons we have licensing examinations and mandatory continuing education. By passing our licensing examination, fulfilling mandatory continuing education requirements and maintaining our license to practice nursing, society accepts us as possessing the knowledge and skill to render nursing care. This is often used as the test for negligence, where doing or failing to do something is considered contrary to what a reasonable person would have done under the same or similar circumstances. Any reasonable nurse would land mark an injection site prior to administering the injection. A negligent nurse administers the injection without land marking the injection site.

Standard of Care: Nurses use this term in a variety of ways. We have applied this name to everything from nursing care plans to nursing policies and procedures. In the legal sense a Standard of Care is a general statement indicating the minimum requirements by which nurses can be evaluated. Standards of Care may be widely applicable to a variety of situations and incorporate terms that require mandatory conditions such as: must, will, or shall. Nurses shall land mark an injection site prior to administering an injection is an example of a standard of care. Nurses shall assess patients is also a Standard of Care. Note how these are general statements and there may be a variety of methods a nurse may choose to meet the requirements of these standards.

Consent: Patient consent can either be implied or informed.

Implied Consent: By virtue of the patient's behaviors, consent may be implied. For example you state that you need to obtain a blood specimen and the patient holds his arm out to you, the patient is implying consent.

Informed Consent: Informed consent is a physician responsibility. Physicians have a duty to explain to the patient all the possible hazards, complications, expected or unexpected results from medical procedures. While nurses are often asked to witness consent forms, the only thing the nurse is witnessing is the signature. This means you saw this particular patient sign this particular piece of paper. You are not witnessing that the patient had an understanding of what was going to occur. Reasonable nurses who encounter a situation where they believe a patient does not have all the needed information, will contact the physician to obtain further information for the patient or request that the physician discuss the procedure again with the patient.

Scope of Employment: This refers to the actions of an employee included within the description and duties of his or her job. Scope of Employment is often used to determine Respondeat Superior. As a nurse it is within my scope of employment to assess patients' vital signs. However, it is not within the scope of employment as a staff nurse to insert chest tubes. If you as a staff nurse inserted a chest tube, you would not be practicing within the scope of employment and you could be named as an individual in a malpractice suit.

Complaint: The complaint is a legal document prepared by the plaintiffs that outline the facts of the case. The complaint will also list specifically what was done incorrectly or omitted. This portion of the complaint is often called "The Counts". If you find yourself named in a malpractice case, ask to see the complaint. By reading the complaint you will have an indication of just what the plaintiffs believe to be the problems and you will be better prepared to offer a possible defense.

Managing Risk

Every professional, whether a doctor, lawyer, accountant, dentist or nurse is at risk of being sued. Changes over the past few years in healthcare, such as managed care and changes in healthcare financing have increased the risks of being sued. We have all seen that patients admitted to hospitals are more acutely ill. They are discharged sooner to alternative care sites such as rehabilitation centers or home care. Furthermore nurses have taken on more independent roles in healthcare settings, further increasing liability. We see patients in alternative care settings and make recommendations for other services such as physical therapy or nutritional counseling. We find ourselves responsible for the management of care delivery teams and monitor the results of such teams. Many nurses are responsible for the supervision of UAP's. With increased responsibilities comes increased liability risks.

One way to help manage the risk of liability is to purchase **professional liability insurance**. While the insurance carrier will *not accept liability* for the nurse's actions, they will accept *financial responsibility* for damage awards and legal fees incurred in the nurse's defense. Each nurse must determine for him or herself if liability insurance and type of coverage is right for them. One point to bear in mind is whether or not there has been true liability; there will be legal fees. Legal fees could amount to thousands of dollars to prove there was no negligence. The modest cost of a liability policy could save one a lot of money in the long run.

Some nurses believe if they purchase professional liability insurance, it will increase their risk of being named in a claim. In fact, some employers potentiate this myth. It is easier and more economical for the employer to manage a claim if the individuals involved are not being individually represented by counsel (lawyer). Besides, lawsuits are filed long before anyone knows whether one has a liability insurance policy or not. It is during the discovery phase of a lawsuit that liability insurance information is disclosed.

Many nurses believe their employer's liability policy covers them completely. This is not necessarily true. If for example, the nurse did something that was totally outside of or contrary to the policies and procedures established by the employer and the employer is sued, the employer could file a claim against the nurse to recover any awarded damages and attorney fees. In this instance the nurse may be found to be practicing outside the scope of employment, leaving the nurse open for what is sometimes called a counter claim.

While this does not happen frequently, it can happen. It is also important to know what your employer's policy covers. It might be advisable to request a copy of your employer's policy, review it yourself and perhaps have it reviewed by an insurance professional or your personal attorney.

Another reason to consider having professional liability insurance is to provide protection for acts performed outside the scope of employment. Perhaps the nurse has taken a second job. The first employer is not going to provide coverage while on duty at a second job. How often have you been called upon by family, friends or neighbors to suggest or even provide care? If erroneous advice or care is provided resulting in an injury, the employer's policy will not cover the nurse.

Most states have *Good Samaritan laws* that provide some protection to individuals who assist in emergency situations. However the person you assisted decides to claim gross negligence. At this point the Good Samaritan statutes may be waived. Whether or not Good Samaritan laws prevail, you still find yourself named in a lawsuit. You still have to prepare a defense. You still have to retain an attorney. You will still have legal fees. Having a professional liability policy will pay for your legal defense whether you are guilty or not.

If you decide you want to purchase a professional liability insurance policy, there are a number of things to consider. Because many medical and/or nursing lawsuits may be filed 2 years or more after an incident has occurred, having an insurance company with financial stability is critical. You certainly want your insurer to be there for you if and when you ever need them! All insurance companies are rated by A.M. Best Co., with a letter grade given to signify the financial health of the company. An A++ is the highest rating possible. Consider how long the company has been in business and how long the company has been providing professional liability insurance. You might also check with trusted colleagues as to the coverage they have. Ask if they have ever had to file a claim and how satisfied they are with the services provided by their insurer. Also consider consulting your insurance agent who provides your home

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or auto insurance. In some cases you might receive a multi-policy discount. If you have an attorney, you may also want to consider consulting him or her for advice. Be sure to ask questions not only about the type of coverage you need, but the amount of coverage you need as well.

Some things to consider when purchasing a policy are as follows. Most coverage in professional liability policies are fairly standard. The insurer agrees to defend you, pay legal fees and pay damages up to the limits of the coverage you have selected if you are found negligent. Pay attention to the *settlement clause* of your policy. Some insurers retain the right to settle a claim based on monetary considerations with no input from you or regardless of how this may effect your reputation or career. It is important to seek coverage where the insurer may not seek settlement without your input and written consent. This allows you to be a participant, not just a bystander.

What *type of coverage* should you purchase? Basically there are two types of professional liability insurance: occurrence or claims-made coverage. With an *occurrence policy*, the policy in effect at the time the incident occurred is the policy to respond to the claim. An advantage of occurrence policies is that you know you have coverage, even if the claim is filed many years after the adverse event occurred. One disadvantage is that the amount of coverage may not be adequate. Let's say you purchased an occurrence policy with claim limits of $50,000 in 1985. Now in 2007 along comes a claim for an event that occurred in 1985, you have coverage for up to $50,000, but a jury awards damages of $150,000. You would find yourself personally responsible for any award in excess of the $50,000 claim limit. With a claims-made policy, the adverse incident must occur and the claim must be filed during the period the policy is in effect. An advantage here is that the current conditions and terms and claim limits of the policy would better correlate to the claim.

However, most cases are not generally filed quickly. In fact some plaintiffs' attorneys wait until the statute of limitations is almost expired before they file the claim. They do this purposefully to place more time between the event and your memory. A disadvantage of claims-made policies is the need to purchase what is generally called a *tail coverage* policy. There are a variety of tail funding policies available that will extend coverage for you beyond the terms of a claims-made policy. Be sure to know what type of policy you are purchasing and consult the insurer or your attorney regarding the need for tail coverage.

When you receive your policy, be sure to read it and familiarize yourself with the terms of your coverage. Parts of your policy may be as follows. The *Professional Liability Declaration* shows the name, address, professional occupation, period of time the coverage is in place, the company's limits of liability and list of endorsements required by the individual state in which you practice. Be sure this information is accurate. The *Coverages Section* will describe for what the company agrees to insure you.

Generally there is a listing of all coverages with defined limits. For example professional liability is listed showing the $1,000,000 per case limit you selected with a $6,000,000 aggregate. Defense costs, usually defined in a per case and per policy period will be listed as well. Some policies may provide coverage for loss of earnings reimbursement, medical expenses related to bodily injury to you or damage to your personal property if you are assaulted at work, first aid reimbursement should you provide first aid to someone, and reimbursement should you damage another's personal property. Be sure to read your policy to know what is covered.

It is also important to know what is not covered or is *excluded* in your professional liability insurance policy. Common exclusions may include the following. The policy is in essence a contract covering *you only*. Your policy will not provide liability coverage for anyone other than you. The insurance company will not cover any claims made against you unless you maintain and hold the proper license or certifications. The insurance company will only cover you for the occupation or profession that is stated on the professional liability declaration portion of the policy. For example, if this is a policy covering you as a Registered Nurse and you are performing duties as an Emergency Medical Technician and an event occurs, your policy would not cover you. The insurance company will not cover any claims that result from you physically assaulting, abusing, molesting, or sexual assaulting another individual. Any sexual act whether intentional, negligent, inadvertent or believed to be consensual will not be covered. Some companies may provide a defense for you for these types of allegations until such time there is either an admission or judgment of guilt that establishes the policyholder caused the injury. The insurer will not generally pay any damages for such judgments. Again, be sure to read your policy and know what is covered as well as what is not covered. Questions you may have about your specific policy should be directed to the insurance company or insurance agent.

What to do if you are named in a claim. Clearly this may be one of the most traumatic experiences a nurse may face during the course of a career. Even if innocent, it is still time consuming, expensive and nerve wracking. The process of a lawsuit begins with the plaintiffs filing a complaint and individuals named in the case will be served summons. The nurse who receives a summons should first make a copy of the summons to keep for his or her own records. Then a copy of the summons should be forwarded to the nurse's employer at the time of the incident. It is best to mail and phone the employer's risk management department. Another copy of the summons should be sent to the nurse's professional liability insurance company. It may also be a good idea to set up a file or procure a large envelope in which the nurse can keep all papers organized and readily available. Lawsuits can drag on for long periods of time, so keeping things organized will be of assistance. Be sure to keep all correspondence and materials received regarding the matter. Do not discuss the case with anyone else.

When you receive notification of a lawsuit, it may be beneficial to take time to think about the incident. Write down aspects regarding the event that you remember. If you don't remember anything, you will have an opportunity to consult the patient's medical record. That may refresh your memory of an event, or it may not. If you don't remember, you don't remember. As you think, try to identify who, what, where, when, how and why regarding the details of the event in question.

Besides mailing a copy of the summons to your insurance agent, you will also want to call them. Be sure to consult you policy and follow any instructions contained within the policy. Document with whom you spoke, date and time the call was made, what the next steps would be, and what instructions were given to you. It is advisable to keep a log or notes of all phone calls regarding the lawsuit. It is also beneficial to keep a log of when items are mailed and to whom, and when you receive items in the mail. Because this is going to be a trying time, keeping logs will help keep you on track.

Your insurance agent will forward the lawsuit to the insurance carrier and a claim representative will be assigned to handle the case. The claims representative will generally contact you within 24 to 48 hours of receiving notification of the lawsuit. You can expect to be interviewed over the phone by the claims representative. Here's where any notes you made about your recollections of the event will be helpful. The claim representative will discuss with you and confirm what your policy will cover. If they do not discuss this with you, be sure to ask about your coverage or any other questions that you may have. The claims representative may also give you a file number or claim number. Be sure to write down this number, as that will expedite communication between you and your insurance company.

The claims representative will next advise you what law firm will be used to represent you. You should expect to have an attorney who has expertise in handling medical malpractice defense cases. Be sure to note the name of the firm, phone number and address. If the claims representative knows the specific attorney who will be handling your case, be sure to obtain his or her name as well. Next you can expect a meeting and interview with the attorney who is assigned to your case. Feel free to inquire as to the attorney's credentials, experience, trial experiences and outcomes of cases he or she has handled. If at any time you are not satisfied with the attorney assigned to your case, immediately notify the claims representative. The insurance company wants to be sure you are being represented by a qualified attorney and want to provide customer service.

The insurance company needs to know if there is a problem with the attorney to whom you have been assigned. The lawsuit will then move into what is called the *discovery period*. During this time both plaintiffs and defendants investigate the event. Your attorney will interact with you via letters, phone conversations and perhaps e-mails. If you have any questions or do not understand something, be sure to ask your attorney to explain things to you. Should you receive any correspondence or phone calls from plaintiff's attorney, do not respond until you have consulted with your attorney first. During this time it is not unusual to receive a list of questions from the patient's attorney. Again, answer them only after consulting your attorney. It is also common during the discovery period to be asked to give a deposition. Depositions are done in the presence of a court reporter and all attorneys involved in the case. Your attorney will/should prepare you for a deposition. The purpose of the discovery period is to obtain information that can be used to try to reach a settlement, or to be used at a trial.

The insurance carrier will evaluate each case for its *merits*. Was there a breach in the standard of care? Is there causation? What were the damages? Based on the merits of the case, information discovered and advice of the attorney, the case may be settled out of court. The insurance carrier will evaluate the dollar amount of the case and determine the nurse's fault as a percentage of the total amount of damage. At this point, with your consent, a matter may be settled. Sometimes matters are settled and damages are paid even when the insured professional is not at fault. Cases are settled purely based on economics. It may be more costly for the insurance company to provide a defense, or the nurse may make a poor witness on his or her behalf, or the medical record may not support what the nurse said happened. Some cases may be settled to avoid the unpredictability of a jury verdict and award for damages.

Should a case not settle, here is what the nurse may expect at a *trial*. Each attorney will make opening statements, which outline their case for the jurors. Plaintiffs will present their case first, and then the defense will present their case. If the plaintiffs do not meet the criteria for making a valid case and proving malpractice, the defense can move for a directed verdict against the plaintiffs. Should the court agree to this, the trial ends. If the court does not agree to a directed verdict, the trial continues with the jurors hearing any additional evidence. Next, closing statements are given by plaintiff and defense attorneys. Jurors are then given any instructions by the judge and are dismissed to the jury room for deliberations and return to the courtroom to render a verdict. The verdict can be appealed. Should the verdict be against you, then you, your attorney and insurance company will discuss the next steps to take.

Testifying at a trial can also be nerve wracking. Again, your attorney should prepare you for any testimony. Some tips for testifying are as follows. Do get a good night's sleep and try to take care of yourself during this trying time. Remember you are a professional, dress like one when appearing in court or at depositions. Have a clear understanding of the facts of the case. Speak clearly, unemotionally and directly to the jurors. Do not use any sarcasm or wisecracks. Do not blurt out answers. Be sure you have listened to the entirety of the question being asked, think about your response, and then respond.

If you are asked about a document, be sure to ask to see the document before you answer. Don't be evasive. Answer the question you are being asked. If it requires a yes or no response, answer with a yes or no. Do not offer additional information. Your attorney will have an opportunity to ask additional questions of you to clarify anything. If you find yourself becoming tired or needing to use a restroom, do not hesitate to ask for a short break.

Do what your attorney advises. Discuss concerns and ask any questions you have with your attorney. Do not guess at answers. If you don't know the answer to a question just say so. You do not want to give a wrong answer. Don't apologize. If you don't remember just say "I don't recall." Don't be defensive. Tell the truth in a straightforward manner. Do not answer "off the record" questions. Be aware that attorneys use a variety of tactics. Some may begin by appearing very friendly, the switch suddenly to a hostile manner. They may be very loud, then switch to a very soft tone of voice, all in an effort to manipulate you. Don't be caught off guard. If you didn't hear a question or understand a question, be

Continued on Page 15

A Nursing Malpractice Primer . . .
Continued from Page 14

sure to ask the question to be repeated or restated. Do not answer anything you have not heard completely or do not understand completely. Do not use medical jargon; be sure to speak in laymen's terms.

Remember it is the jury you are speaking to. Do not take any documents to a deposition or trial other than what your attorney has asked you to bring.

Once a verdict is delivered, the insured nurse can expect his or her defense costs and any monetary awards be paid by the insurance company. Your insurance company, within the next 30 days of making a payment, will submit a report to *The National Practitioner Data Bank*. Hospitals and healthcare professional associations must report to The National Practitioner Data Bank within 15 days of taking action against practitioners. While you cannot change the report in The National Practitioner Data Bank, you can review and add a statement to the report. Attorneys, insurance companies and individuals from the general public are prohibited from receiving any information about a specific practitioner from The National Practitioner Data Bank. Hospitals are required to query the data bank before granting privileges to and every two years for practitioners on staff. State licensing boards query the data bank anytime a complaint is filed regarding an individual practitioner. Individual healthcare professionals may make a query only about themselves at any time. To make a self query go to www.npdb-hipdb.hrsa.gov/welcomesq.html and follow the instructions.

Hopefully you will never be named in a malpractice matter. But by completing this module, if you do find yourself in the role of a defendant, you will be a little better prepared and perhaps not so intimidated by the legal system.

Resources Available Upon Request Contact Sandy Swearingen at 614-448-1030 or Zandra Ohri at 614-448-1027 to request a list of resources.

Post Test–Nursing Malpractice

Name:_____ Final Score: _____

Please indicate whether the answer is True or False. There is only one correct answer.

___ 1. The plaintiff is the person being sued.
___ 2. If you are unaware of a problem, you still have a duty to do something for the patient.
___ 3. Breach of duty is when plaintiffs prove you did not do something you should have done for the patient.
___ 4. Damages may include injuries, loss of companionship or loss of income.
___ 5. Causation is the easiest component of malpractice to prove.
___ 6. Proximate causation occurs when a nurse's actions or inactions contributed to the occurrence of an injury.
___ 7. The five rights of medication administration are part of the duty a nurse has in giving medicines to patients.
___ 8. Duty, breach of duty and damages are the only components of malpractice.
___ 9. A medical misadventure occurs when everything was done correctly, yet the patient still experiences an untoward outcome.
___ 10. Respondeat Superior means the employee is responsible for the acts of the employer.
___ 11. Respondeat Superior is based on all these itens: proximate cause, deep pockets, hiring and firing, policies and procedures.
___ 12. As an employee, I am obligated to follow employer's policies and procedures.
___ 13. Respondeat Superior does not apply to nurses.
___ 14. While on vacation, you stop at the scene of an accident. If the accident victim sues you, Respondeat Superior would apply.
___ 15. Captain of the Ship Doctrine applies only to physicians.
___ 16. If a staff nurse sees another healthcare professional doing something incorrectly that may harm a patient, the staff nurse has no obligation to do anything.
___ 17. Res Ipsa Loquitor means let the injury speak for itself.
___ 18. In Res Ipsa Loquitor the defendant is innocent until proven guilty.
___ 19. If there are risks to procedures, we should not undertake the procedure.
___ 20. Following procedures correctly helps to minimize the risks of causing injury to the patient.
___ 21. Assumption of risk may not be used as a defense strategy particularly when dealing with noncompliant patients.
___ 22. Due care is what any reasonable nurse would do in the same or similar situation.
___ 23. By passing licensing examinations, fulfilling continuing education requirements and maintaining our nursing licenses, society accepts us as reasonable persons capable of rendering nursing care.
___ 24. In the legal sense, Standards of Care indicate the maximum requirements of nursing practice.
___ 25. A patient implies consent by willingly submitting or cooperating with a nurse's request.
___ 26. When witnessing a signature on a consent form, the nurse is attesting to the fact the patient understood all information presented by the physician.
___ 27. Scope of employment refers to the description and duties of a nurse's job.
___ 28. The complaint is a document prepared by the defendant.
___ 29. The counts in a complaint will list the specific incorrect or omitted actions.
___ 30. Being named as a defendant in a malpractice case may prove to be intimidating and terrifying to some nurses.
___ 31. Because some nurses have taken on more independent roles, it has not increased their liability.
___ 32. Professional liability insurance carriers accept liability for the nurse's actions.
___ 33. Having professional liability insurance increases one's chances of being sued.
___ 34. Your employer's policy covers you completely for all nursing actions, therefore you don't need your own policy.
___ 35. Good Samaritan statutes will always cover you in the event you provide assistance at an accident.
___ 36. It is important to read your professional liability insurance policy and understand what it covers as well as what is excluded from coverage.
___ 37. With an occurrence policy, the policy in effect at the time the incident occurred is the policy to respond to the claim.
___ 38. You don't need to keep track of paperwork or phone calls if named in a lawsuit, as your insurance company will do that for you.
___ 39. Because your insurance company assigned your attorney, if you are not satisfied, you have no further recourse.
___ 40. During the discovery period information is obtained that can be used to settle a case.
___ 41. Sometimes cases are settled for economic reasons even when the professional is not at fault.

The following questions apply to giving testimony.

___ 42. In testifying at a trial, it doesn't matter how you dress.
___ 43. Evasive answers should be used to avoid direct responses.
___ 44. If you do not remember something, simply state "I don't recall" and don't apologize for not knowing.
___ 45. If asked about documents, be sure to ask to see the documents before answering any questions

Evaluation–Nursing Malpractice

1. Were the following objectives met?
   a. List four components of malpractice. YES NO
   b. Discuss the nurse's role in caring for patients in each stage of chronic kidney disease. YES NO
2. How long did it take you to complete the study, the post-test, and the evaluation form? _____

Registration Form–Nursing Malpractice

ONA MEMBERS
Each study in this edition of the Ohio Nurse is free to Members of ONA. Any additional independent studies that an ONA member would like can be purchased for $12.00 plus $3.00 S/H by filling out the enclosed order form on page 22 & 23.

NON-MEMBERS
Each study in this edition of the Ohio Nurse is $12.00 for non- members. Any additional independent studies that a non-member would like can be purchased for $12.00 plus $3.00 S/H by filling out the enclosed order form on page 22 & 23.

Name (please print clearly): _____

Address:_____

City: _____ **State:** _____ **Zip:**_____

Day phone number: (___) _____ - _____ **RN or LPN?:** RN LPN **ONA Member:** YES NO

ONA Member Number (if applicable) _____

CHARGE TO: ___ Visa ___ MasterCard ___ Discover ___ American Express

Card #: _____ - _____ - _____ - _____ **Exp. Date (mm/yyyy):** ____/____ **Verification #:**

Signature: _____

Please send **check or credit card information** along with this completed form to: Ohio Nurses Foundation, Dept. LB-12, PO Box 183134, Columbus, OH 43218-3134.

ONA OFFICE USE ONLY

Date Received: _____ Amount: _____ Check No:_____

Ohio Nurse Wins National Cherokee Inspired Comfort Award

Caring LPN honored for selflessness

For her constant acts of selflessness, Margaret Stewart is one of only 10 people nationwide to receive the prestigious *Cherokee Inspired Comfort Award* in 2007. The award is granted annually by Cherokee Uniforms to recognize nurses and other non-physician healthcare professionals who demonstrate exceptional service, sacrifice and innovation and have a positive impact on others' lives.

Stewart was nominated for the award by her colleague and friend, Kathy Fletcher, who has experienced Stewart's dedication firsthand. When Fletcher's husband fell ill with renal failure, Stewart did something only a truly loving person would do—she contacted a transplant coordinator and had herself tested as a possible donor. She was a match and donated her kidney. The transplant resulted in an amazing recovery for Fletcher's husband and his health improved exponentially. For Stewart, complications arose and she was unable to return to nursing for 13 months. Fletcher expressed, "Maggie Stewart is truly the essence of courage, strength, goodness, kindness and selfless giving."

While recovering from the transplant, Stewart initiated what she likes to call "comfort blankets." She makes each and every blanket by hand, embroiders them with a spiritual message and personally delivers them to people who are going through a rough time. Most of the people who receive these blankets are seriously ill, and the blankets help to lift their spirits. To this day, she gets requests for her comfort blankets from places as far away as Florida and she has never turned down a request.

"Precious moments and lasting friendships are reason enough to choose a career in nursing," expresses Stewart. "I love the people; I love caring for them and making a difference in their lives."

As a Top National Winner in the award's LPN/LVN category, Stewart receives an all-expense-paid trip to a 2008 medical conference of her choice, annual membership to her preferred clinical association, a $500 donation to her preferred nonprofit organization, a crystal award and a wardrobe of Cherokee healthcare apparel. She also will appear in the nationally distributed Cherokee Inspired Comfort Award 2008 calendar.

"We are truly delighted to honor a nurse who has touched the lives of so many," says Wendell Mobley, who directs Cherokee Uniform's charitable and scholarship programs. "The award is a modest token of appreciation for Margaret's dedication to those in need."

Since the Cherokee Inspired Comfort Award was established in 2003, more than 5,300 healthcare professionals have been nominated in the Registered Nurse, Advanced Practice Nurse, Licensed Practical Nurse/Licensed Vocational Nurse, Student Nurse and Non-Physician Healthcare Professional categories. A panel of nursing professionals and Cherokee representatives evaluates nominations and grants the awards.

For every nomination received in 2007, Cherokee Uniforms donated $1 to national health-centered charities. The total amount was divided equally among the American Cancer Society, American Heart Association and the Alzheimer's Association. Since 2005, Cherokee has donated over $3,300. Proceeds from Cherokee Uniforms products support healthcare professionals through initiatives such as the Cherokee Inspired Comfort Award, an annual calendar and the *A Nurse I Am* Film and Scholarship Program. Cherokee Uniforms will be accepting nominations for the 2008 Cherokee Inspired Comfort Award beginning March 1, 2008 through May 31, 2008. For further information on the award, please visit www.CherokeeUniforms.com.

About Cherokee

Cherokee Uniforms, Tooniforms and Rockers Footwear are leading brands in healthcare apparel, recognized for helping to foster a warmer, friendlier, more comfortable environment for healthcare workers and their patients. For more information, visit www.CherokeeUniforms.com or contact Krista Goch, Blattner Brunner Public Relations at 412-995-9597.

Third Annual CE and Staff Development Educators Conference, April 11, 2008

Purpose

This event is designed for CE or staff development educators from any setting who are interested in the topics.

Objectives

1. Identify new technologies that could assist the staff development educator in providing educational programming.
2. Discuss factors that need to be considered when using new technology.
3. Discuss financial management strategies in staff development.
4. Describe strategies that may be used in conveying information in a fun and interesting way.
5. State the Ohio nursing law and rules that apply to precepting students in the clinical setting.
6. Discuss how these law and rules can be applied in the clinical setting.
7. Identify issues and trends in continuing education.

5.5 Contact hours will be awarded, including 1 contact hour of Category A.

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

Speakers

Mary Moon Allison, MHSE, BSN, RN, *Director, ANCC Accreditation Program, Silver Spring, MD*

Deborah Bauer, MSN, RN, *Patient Safety Coordinator, Louis Stokes VA Medical Center, Cleveland*

Judith Beeler, MSN, RN, BC, *Staff Development Coordinator, Med-Surg Nursing, University Hospitals of Cleveland.*

Pam Dickerson, PhD, RN, BC, *President, PRN Continuing Education, Columbus*

Julie McAfooes, MSN, RN, BC, *Vice President for Software Development, FITNE, Logan*

Wynne Simpkins, MS, RN, *Nurse Consultant, Centerville*

Schedule

8:00 a.m.	Registration
9:00 a.m.	Introductions and Welcome
9:05 a.m.	Enhancing Continuing Education in the New Age of Technology Speaker: Julie McAfooes, MS, RN, BC
10:30 a.m.	Break (and move to concurrent sessions)
10:45 a.m.	Concurrent sessions: A. Proving Your Worth: Financial Management in Nursing Staff Development and CE Speaker: Pam Dickerson, PhD, RN, BC B. Making Educational Activities Fun Speaker: Deborah Bauer, MSN, RN
12:00 p.m.	Lunch (provided)
12:30 p.m.	Poster Presentations
1:15 p.m.	Precepting Students: Applying Ohio Law and Rules to Percepting* Speakers: Wynne Simpkins, MS, RN Judith Beeler, MSN, RN, BC
2:15 p.m.	Break
2:25 p.m.	Keynote: The Continuing Education Superhighway: Where We Are and Where We're Going Speaker: MaryMoon Allison, MHSE, BSN, RN
3:25 p.m.	Summary and Evaluation
3:30 p.m.	Concluded

*Category A Session

Registration Information $85 ($80 for second or more individuals from same provider unit). Registration fee includes continental breakfast, lunch, and materials.

Pre-registration is required. Space is limited. Substitutions are accepted. If you must cancel, written notice must be received by ONF no later than April 1, 2008 to qualify for your registration fee to go towards your next ONF event. Late registrations will be subject to space availability. Contact Sandy Dale-Swearingen at ONF for details or questions, 614-448-1030 (Sswearingen@ohnurses.org). Registrations may be faxed to: 614-237-6074.

Location and Directions Ramada Plaza (formerly the Midwest Hotel and Conference Center), 4900 Sinclair Road, Columbus, OH 43229. 614-846-0300. www.themidwesthotel.com. For directions please contact the Ramada Plaza or contact Sandy Dale-Swearingen for further directions. *The Ramada Plaza is offering a room rate of $76.00 plus applicable taxes. When registering, please let them know you are with ONF to receive the ONF discount rate.*

Registration Form (PLEASE FILL OUT A SEPARATE REGISTRATION FORM FOR EACH INDIVIDUAL FROM YOUR FACILITY)

Name _____

Address _____ City _____ State _____ Zip _____

Daytime telephone: _____ E-mail: _____

I would like to be on the mailing list for ONF's future events. _____ Email US Mail _____

I would like to attend:
10:45 a.m. Concurrent Session:
___ Proving Your Worth: Financial Management in Nursing Staff Development and CE
___ Making Educational Activities Fun
___ I would like a vegetarian meal.

FEE: $85 ($80 for second or more individuals from the same facility). Registration fee includes continental breakfast, lunch, and materials.

_____ Check Enclosed _____ Visa _____ Mastercard _____ Discover _____ American Express

Card #: Expiration Date (mm/yyyy) _____ Verification #____

Signature _____

Please return form and seminar payment one week prior to event to Ohio Nurses Foundation, Dept. LB-12, PO Box 183134, Columbus, OH 43218-3134 or fax to 614-237-6074. Email to: Sswearingen@ohnurses.org

The Art of Giving Well: 7th Annual Nurses Choice Awards and Scholarship Luncheon

The Ohio Nurses Foundation continually strives to enrich the lives of nurses, nursing students, individuals and organizations that support nursing in Ohio. One of the ways in which the Foundation meets this objective is through the ONF Scholarship Fund, which gives at least $10,000 annually directly to nursing students and nurse researchers that meet scholarship and grant criteria.

Join the Foundation on May 6, 2008 at the Blackwell Hotel and Conference Center at the Ohio State University in Columbus, Ohio to support the Foundation and discover *the art of giving well.*

The Art of Giving Well

Studies have shown that giving and volunteering improve physical health and happiness. People who donate money are 43% more likely to say that they are "very happy" and 25% more likely to say that they are in good or excellent health than people who do not give charitably.

In other words, giving well makes us well. But what if you think you can't give?

A USA Today poll asked people to finish the following sentence: "I'd give more, but…" Here are some of the responses:

84% said they doubted their donation would be put to good use.

You can be sure that your donation to the Ohio Nurses Foundation Scholarship Fund will be put to good use. Since its inception in 2001, the Foundation has proudly distributed over $50,000 in scholarship dollars, research grants and continuing education dollars directly to exceptional nurses and nursing students.

80% said job demands left them no time to participate, and 70% said family commitments consumed their extra time.

We know your time is valuable, and that it may not be feasible to travel to Columbus to attend this annual event. For those who want to give but don't have time, you can donate to the Scholarship Fund through our website, or you can mail your donation to the Ohio Nurses Foundation, Attn: ONF Scholarship Fund, 4000 East Main Street, Columbus, Ohio 43213.

79% said they had no excess income to give.

If you don't have excess income but you have time to give, please consider becoming a Table Captain for the Annual Scholarship and Awards Luncheon. The role of a Table Captain is to find 10 people to fill a table at the luncheon. The Foundation provides you with materials and support to help you fill your table. If you are interested in becoming a Table Captain for this or next year's event, please contact Shannon Richmond at srichmond@ohnurses.org.

Why do you give?

The Ohio Nurses Foundation gives because it knows that doing so will improve the lives of nurses and the profession as a whole. Register to attend the 7th Annual Nurses Choice Awards and Scholarship Luncheon and instead of finishing this sentence "I'd give more, but…" you can finish this one: "I give because…."

Visit our website at www.ohnurses.org and click on "Events" to register. For more information, please contact Shannon Richmond at srichmond@ohnurses.org.

Medication Aides—What the Laws and Rules Say ©

INDEPENDENT STUDY

This independent study has been developed for nurses to better understand the new laws and rules relative to medication aides. 1.27 contact hours of Category A will be awarded for successful completion of this independent study.

Developed by: Janice K. Lanier, RN, JD, Deputy Executive Officer, Ohio Nurses Association. The planners and faculty have no conflict of interest. There is no commercial support for this independent study.

OBJECTIVE

Upon completion of this independent study, the learner will be able to:

1. Describe the training an individual must complete to become a Certified Medication Aide.
2. Identify three prohibitions relative to medication administration by a Certified Medication Aide.

 This study was revised 2007.

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

Expires 12/2009.

Medication Aides
Introduction

Beginning in May, 2006 non-nurses started administering certain medications in nursing homes and assisted living or residential care facilities. Although nurses may no longer be performing the actual task of handing a medication to a resident; applying a topical medication; or administering eye, ear, or nose drops, they will continue to be responsible for the overall safety of the residents relative to medication administration. For that reason, it is essential for nurses to know the extent of the authority granted to medication aides by Ohio law and the extent of the nurses' ongoing duties when delegating medication administration to a certified medication aide. This study provides background information regarding the new law, reviews principles of delegation and communication essential for safe practice, outlines the Board of Nursing rules that define how medication aides will be trained and regulated, and highlights nursing responsibilities relative to medication aides in a nursing home or residential care facility utilizing certified medication aides.

Historical perspective

For many years the long-term care industry urged the Ohio General Assembly to join the growing number of states that authorize non-nurses to administer medications in nursing homes and assisted living (residential care) facilities (RCFs). Nursing organizations such as the Ohio Nurses Association (ONA) and consumer groups were able to repeatedly defeat the proposal, citing resident safety issues. Then in 2004-2005, despite nursing's ongoing concerns, the powerful long-term care lobby was able to convince legislative leaders and key individuals in Governor Bob Taft's administration that "medication aides" were necessary. Because of the shortage of nurses working in long-term care and the expected cuts in Medicaid reimbursement to nursing homes necessitated by state budget constraints, the idea of medication aides became a foregone conclusion to state health policy makers. Nursing's legislative fight then became focused on ways to best assure resident safety. The result of those efforts are reflected in the safeguards that ultimately became part of the statutory language enacted by the legislature.

On July 1, 2005 Ohio law that specifies who can administer medications was expanded when Gov. Taft signed HB 66 (the 3,000 page state budget bill) giving the Ohio Board of Nursing authority to regulate a new entity--certified medication aides (medication aides–certified or MA-Cs), and to develop the mechanisms needed to appropriately train would-be MA-Cs. Sections 4723.61 through 4723.69 of the Revised Code were added to the Nurse Practice Act, and the Board of Nursing was directed to have regulatory rules in place to implement the statutory mandate no later than February 1, 2006.[1]

In response to nursing's concerns about the lack of any data to show whether medication aides pose a risk to resident safety, the legislature required the use of medication aides to first be tested in limited pilot programs to be operated between May 1, 2006 and June 30, 2007. The use of medication aides was to become a statewide reality on July 1, 2007 unless the General Assembly expressly acted to curtail the practice pending the results of the pilot program. In late 2006, it became apparent that the Board did not have sufficient data to produce a reliable report; therefore, the General Assembly enacted language (in HB 119) that extended the pilot aspect of the program until the Board certifies at least 75 medication aides who then administer medications for at least 91 days. At that point, the reporting requirements are triggered. Within 181 days, the Board is to submit its report to the legislature so that 30 days later, the use of medication aides can extend statewide. The Board is required to notify the public when the actual end date for the pilot program has been determined. The Board's rules governing medication aides can be found in Chapter 4723-27 of the Ohio Administrative Code.

Who are medication aides?

Not just anyone can call himself/herself a "medication aide." Only individuals certified by the Board of Nursing may use that title and administer medications. To be eligible for this certification by the Board, an individual must:

- Be at least 18 years of age;
- Hold a high school diploma or GED;
- Be a state tested nurse aide if working in a nursing home or have at least one-year of direct care experience if working in an RCF; and
- Complete a criminal records check.

Eligible individuals must also satisfactorily complete the required medication aide training program, pass a board authorized standardized examination, and obtain certification from the Board of Nursing. Certification as a medication aide must be renewed biennially with the MA-C required to complete 15 hours of continuing education each renewal cycle. The continuing education must include one hour related to Chapter 4723 of the Revised Code and the rules of the Board of Nursing; one hour related to establishing and maintaining professional boundaries; and 10 hours related to medication or medication administration. The remaining three hours may cover any other related topic.[2]

The Board will not issue a medication aide certificate by endorsement. That means if someone has been a medication aide in a state other than Ohio, that individual must still complete the required training program, pass the examination, and meet all other criteria set forth by the Board to be eligible for a medication aide certificate.

If a medication aide allows his/her certificate to go inactive or lapse for more than two years, that person must retake and successfully complete the medication aide training program within six months prior to submitting an application to re-instate the certificate.

Practice Tips

Individuals who qualify to be an MA-C by virtue of having one-year of direct care experience in an RCF may not administer medications in a nursing home. Their certification document will include documentation of this restriction. If these individuals subsequently satisfy the requirements to become a state tested nurse aide, the Board will issue an unrestricted certificate.

Throughout the duration of the medication aide pilot program (May 1, 2006 until the pilot program end date), MA-Cs may administer medications only in nursing homes or RCFs approved by the Board to participate in the pilot. The certificates issued to these MA-Cs will be considered "pilot program medication aide certificates." Between the pilot program end date and April 30th of the next even-numbered year, the Board will issue "interim medication aide certificates." Beginning on May 1st of the next even-numbered year following the pilot program end date, the Board will begin to issue certificates that must be renewed biennially.

Nurses in administrative roles should check the wallet-sized certificates issued by the Board to determine the extent of the MA-C's authority with respect to medication administration and to verify that the certificate is current and valid.

The Board may take disciplinary action affecting a medication aide's certificate according to processes used to take action involving licensed nurses and other individuals regulated by the Board. The same infractions that can result in disciplinary action for licensed nurses apply to MA-Cs as well and are set out in Rule 4723-27-09 of the Administrative Code. Board action involving MA-Cs will be posted on the Board's web site (www.nursing.ohio.gov) and publicized in the Board's quarterly publication, "Momentum."

What medications may an MA-C administer?

The enabling statute is relatively non-specific regarding the medications that may be given by a medication aide.[3] The law states that the MA-C may give oral medications, topical medications, medications administered as drops to the eye, ear, or nose; medications given rectally or vaginally, and medications requiring administration on an as-needed basis only if a nursing assessment is completed before the medication is administered. The Board rules go on to define "oral medication" as anything that can be taken by mouth,[4] which would therefore include metered dose inhalers. Nose drops are interpreted per Board rule as including nasal sprays (aerosols, nebulizers and inhalers provided no oxygen is included in the administration), and ointments include preparations that are to be administered to the eyes or ears.[5] Topical medications may be applied to intact skin only.

Practice Tips:

A medication aide is not limited to administering unit dose medications provided there is no dosage calculation or "pill splitting" required.

Medication aides may administer medications prescribed by any authorized prescriber, including an advanced practice nurse holding prescriptive authority.

Medications administered by a medication aide must come from a properly labeled container that includes the medication name, the medication dose, the name of the resident to whom the medication is to be given and the expiration date of the medication. Although the rules do not directly address whether an aide may administer a contingency drug, the language in the standards rule (4723-27-02 OAC) recognizes by inference that the aide may administer these drugs provided they are stored and supplied in accordance with pharmacy board rules AND are supplied by the delegating nurse to the medication aide. In other words, the MA-C may not have independent access to contingency medications.

Medication available over-the-counter must include the original manufacturer's label and must be purchased and prescribed for the resident.

Medication aide authority—Delegation[6]

A medication aide has no independent authority to administer medications. Rather, an MA-C's authority arises solely through delegation by a registered nurse (RN) or licensed practical nurse (LPN) acting at the direction of an RN. Further, the delegating nurse must hold a current valid license authorizing medication administration that has no medication-related restrictions on it imposed by the Board of Nursing. Nurses who are participating in one of the Board's alternative programs (the alternative program for chemical dependency or the practice intervention and improvement program) may delegate medication administration unless the participation agreement entered into with the Board restricts the authority of the nurse to administer medications.

Although the law and rules state that nurses may not withdraw delegation on an arbitrary basis or for any purpose other than those related to resident safety,[7] nurses remain responsible for fulfilling their own duties relative to delegation. These duties include evaluating both the resident's needs and the aide's skills and abilities, communicating the parameters of the delegated responsibility, and supervising the aide's performance. It is through this evaluation and assessment process that the nurse determines whether there are safety reasons for withholding/withdrawing delegation. A registered nurse or licensed practical nurse who delegates in accordance with standards for delegation will not be liable in damages for injury, death, or loss to person or property that arises from the actions or omissions of an MA-C.[8]

Evaluation

The principles underlying the delegation of medication administration to a certified medication aide are similar to those guiding delegation of any nursing task or activity. That means the nurse must evaluate the resident's mental and physical stability, the medication to be administered, the time frame during which the medication is to be administered, the route of administration, and the ability of the medication aide to safely administer the medication in light of the above considerations. For example, an MA-C is passing medications and one of the residents who is to receive an antibiotic begins to complain of nausea and pruritus. In addition, the resident, who in the past has been compliant with the medication regimen, is suddenly adamant about not taking the medication. Even though the MA-C has been safely administering the drug for several days, it is the nurse's responsibility to assess the resident's status and take appropriate steps to assure that the antibiotic is not administered if doing so would jeopardize the resident's safety. Similarly, if one of the medications the MA-C is to administer is an eye drop, the nurse must verify that the aide actually demonstrated competence using that route of administration during the medication aide training program.[9] If the aide has not administered eye drops, a nurse must personally oversee the aide's performance of that task (and any others not completed according to the checklist) until the nurse is satisfied the aide can safely perform the requisite task.

Communication

The safety of delegation is inherently dependent on the clarity of the communication between the delegating nurse and the delegatee. The nurse who is delegating medication administration must clearly communicate information regarding the residents to whom the aide is to administer medications, the medications to be administered, the time frames during which the medications are to be given, and any special instructions concerning the administration of medications to specific residents. Much of this information can be written on the medication administration record (if applicable) or on other documents typically used for medication administration purposes in a particular facility.

Of equal importance, the nurse must clearly identify how the aide is to respond to the unexpected or to the abnormal, in other words, what to report to the nurse. The curriculum content required by the Board in the medication aide training program includes four hours on communication and interpersonal skills and four hours on circumstances for reporting to the licensed nurse.

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Nonetheless, it is the delegating nurse who must clearly set forth his/her expectations in this regard, taking into consideration the residents actually being cared for on any given day and any other variables that may be involved.

Supervision

In a nursing home setting a nurse must provide on-site supervision of an MA-C. In a residential care facility, supervision may be provided by a nurse who is not on site BUT who is immediately and continuously available through some form of telecommunication.

Delegation of as-needed or PRN medications

Because administration of an as-needed medication inherently requires a nursing assessment, the law and rules treat nursing homes and residential care facilities differently when a resident has an order for a PRN medication. If a nurse is not on-site in an RCF to determine the resident's need for the medication, the aide may administer only over-the-counter PRN medications. Further, the off-site nurse must first determine the resident's need for the medication based on his/her knowledge of the resident's health status, the resident's clinical record, the data provided by the aide, and the nurse's determination of the safety of having the aide administer the medication. This determination must be made each time a resident's health status appears to warrant administration of a PRN medication.

When a nurse is available on-site, delegation of an as-needed medication is not limited to over-the-counter medications. However, the nurse must first make certain a nursing assessment performed by a registered nurse is on record. The nurse must then determine the resident's need for the medication and evaluate other resident-related safety factors on a case-by-case basis. In other words, a nurse cannot give blanket approval for an MA-C to administer all PRN medications to a particular resident who is repeatedly expressing a specific complaint. The MA-C and nurse must communicate with each other about the resident's request or demonstrated need for a the medication, and the nurse must determine whether the medication should be administered by the MA-C.

What may NEVER be delegated—Prohibitions

Certain activities may not be performed by an MA-C even if a nurse were willing to delegate them. These general prohibitions include:

- Medications to be administered to a pediatric resident;[10]
- Medications administered through a gastrostomy or jejunostomy tube or through an oral or naso gastric tube;
- Oxygen;
- Medications containing a schedule II controlled substance. The aide may not even have access to these drugs;
- Inhalants, nebulizers, aerosols, or other medications requiring dosage calculations;
- Medications that are not approved drugs;
- Medications administered as part of a clinical trial;
- Injections, including intravenous procedures;
- Splitting pills for purposes of changing the dose being given;[11]
- Receiving, transcribing or altering a medication order; and
- Administering the initial dose of a medication.

Practice Tips:

Nurses who delegate medication administration to an MA-C are expressly responsible for the following:

Completing the assessment of a resident to whom an as-needed medication is to be given and determining the resident's need for the medication;

Reviewing the medication delivery process to assure there have been no errors stocking or preparing the medication;

Accepting, transcribing, and reviewing medication orders;

Monitoring the resident for side-effects or changing health status;

Reviewing the documentation completed by the MA-C; and

Supervising the medication aide.

The rules for delegation of medication administration, just like the rules for delegating any other nursing task, do not address how the delegation process is to be documented. If a nurse (or MA-C) is suspected of inappropriate delegation, the Board of Nursing will review all relevant records and interview the parties involve to determine whether the principles of delegation have been followed. For example, in the case of an as-needed medication, documentation should reflect that a nurse was contacted and authorized administration of the medication by the MA-C. The Medication Administration Record may be reviewed to determine whether it clearly communicated the parameters for administering a particular drug to a particular resident.

Standards of practice for a Certified Medication Aide[12]

Standards of practice for an MA-C parallel the expectations established for licensed nurses and others regulated by the Board of Nursing. That means, in part:

- Certified medication aides are responsible for documenting accurately, timely, and completely the medications they administer. (Nurses should not document medications administered by MA-Cs);
- The MA-C to whom the task of medication administration has been delegated, may not delegate that task to any other person;
- An MA-C may not perform nursing tasks unrelated to medication administration when engaged in administering medications;
- The MA-C must wear his/her applicable title (medication aide-certified or MA-C) at all times when administering medications;
- The MA-C must maintain resident confidentiality;
- The MA-C must treat each resident with respect and dignity;
- The MA-C must maintain professional boundaries with each resident; and
- The MA-C must demonstrate competence and accountability in the task of medication administration, including appropriate recognition, referrals, and consulting with the delegating nurse.

Medication aides are expected to take measures to ensure resident safety that include reporting to the nurse in a timely manner the following:

- The potential need for an as-needed medication based on expressions of discomfort demonstrated by the resident or other indications;
- Refusal by the resident to comply with medication administration;
- Any deviation from the delegated procedure;
- Any unanticipated reaction by the resident to the medication; and
- Anything about the condition of the resident that should cause concern to the MA-C.

Standards also require that MA-Cs:

- Verify the identity of the resident to whom the medication is to be given;
- Witness the resident swallow an oral medication that is to be ingested or otherwise take the medication as prescribed; and
- Utilize the medication delivery process in use in the nursing home or RCF.

If a certified medication aide fails to conform to these standards that would be grounds for disciplinary action by the Board of Nursing.[13]

Practice Tips:

Nurses should take special notice of the limitation that MA-Cs may not perform tasks unrelated to medication administration while passing medications. This limitation is included as a resident safety measure to help assure that the MA-C is not distracted during a medication pass. [See Rule 4723-27-02 (L) OAC].

Unlike licensed nurses and others over whom the Board of Nursing has jurisdiction at all times when they are engaged in practice, the Board's jurisdiction over certified medication aides is limited to when they are performing tasks related to medication administration. That means when the individual is acting solely in his/her state tested nurse aide capacity, the rules of the Board are not applicable. How this will impact the Board of Nursing's disciplinary activities with respect to MA-Cs remains to be seen. In other states where medication aides are regulated by the Board of Nursing, the Board typically has jurisdiction over all nurse aides.

Training medication aides[14]

One of the keys to a nurse's comfort level with delegating medication administration to an MA-C will be the extent and quality of the training programs in place to prepare medication aides. While the statute requires a minimum 70 hours of training, the rules require 120 hours,[15] 80 of which must be the didactic (classroom) and laboratory component and 40 must include the actual administration of medications in a clinical setting with one-on-one supervision by a licensed nurse.[16] The Board of Nursing must approve the training program before the program can admit any would-be MA-Cs. Programs can use a model curriculum developed by the Board staff or may use their own curriculum provided it contains the requisite content. Required topic areas include:

- Communication and interpersonal skills—4 hours;
- Resident rights—1 hour
- Six rights of medication administration—3 hours
- Drug terminology—4 hours;
- Fundamentals of specific body systems—20 hours;
- Basic pharmacology—12 hours;
- Safe administration of medications—20 hours;
- Principles of infection control—2 hours;
- Documentation—2 hours;
- Circumstances for reporting to a licensed nurse—4 hours;
- Medication errors—4 hours; and
- The role of the MA-C—4 hours.

The training programs also must include a mechanism for evaluating whether the candidate possesses the reading, writing, and mathematical skills sufficient to assure safe medication administration.[17] A registered nurse must be the program administrator and a registered nurse must also teach the didactic and laboratory portions of the program. During the didactic and laboratory portion, students and instructors must be present in the same location. In other words, the instruction must be provided in person rather than by means of electronic communication. The rules do not constrain, however, who can conduct a program. Training programs may take place in a nursing home or residential care facility or may be conducted by community colleges or vocational schools, provided they meet Board standards and receive approval.

All training programs must provide each student with the clinical skills checklist used during the training program to indicate satisfactory performance of all skills needed for safe medication administration utilizing all of the approved routes. If a student has not had an opportunity to demonstrate a particular skill, that deficit will be reflected on the checklist. Before the MA-C may perform that skill outside of the training program, he/she must be supervised by a licensed nurse to determine that the aide uses the proper techniques. Once that requirement is met, the nurse should update the skills checklist accordingly. For example, although an MA-C is authorized to administer medications vaginally, there may not be a resident with a medication administered using that route during the actual training period. If an MA-C subsequently is expected to administer a vaginal medication, a nurse must supervise the performance of that task until satisfactory performance is demonstrated and appropriately documented on the checklist.

After completing the training, the MA-C candidate must pass a standardized examination administered by a board-approved independent testing entity. The test will include both written and clinical components. The aide must achieve an 80% score on the written test and 100% on identified critical elements of the clinical test in order to pass the examination. The test may be taken one additional time if a passing score is not achieved initially. After that, the individual must complete the training program again to be eligible to re-test. The tests will be given in locations throughout Ohio on a schedule established by the testing company.

In an attempt to address timeliness issues, the training program must be structured so that a class of students completes it in no fewer than 20 business days and in no more than 90 days. The examination must be taken no more than 60 days after the student completes his/her classroom and supervised clinical practice components of the program.

Pilot Program

Although approximately 16 states allow non-nurses to administer medications in nursing homes and 27 states recognize medication aides in residential care facilities, there is little data available regarding the safety implications of this practice. For that reason, medication aides will begin to function in Ohio only in nursing homes and RCFs selected by the Board of Nursing to participate in a pilot program. The statute allows no more than 80 nursing homes and 40 RCFs to be approved for purposes of the pilot.[18] In selecting facilities for the pilot, the Board will consider the applicants' geographic location, number of beds, and their compliance and safety history as evidenced by Ohio Department of Health (ODH) survey reports. Facilities must be free from deficiencies related to medication administration in the most recent ODH annual survey in order to be considered eligible for the pilot.[19]

During the duration of the pilot program, participating facilities must report medication errors to the Board using forms developed by the Board for that purpose. These reports will be confidential, and the data contained in them used by the Board to prepare a report to the General Assembly and others regarding whether medication aides are able to safely administer medications. The report must also address the financial implications associated with using medication aides in nursing homes and RCFs.

For purposes of reporting to the Board, medication errors are defined as the failure to follow the prescriber's instructions when administering the medication and include:[20]

- Administration of an out-dated medication;
- Administration of the wrong medication;
- Administration of the wrong dose;
- Failure to administer the medication as ordered;
- Administration by the wrong route;
- Administration to the wrong resident;
- Failure to prepare, store, or administer the medication in accordance with instructions of the manufacturer or pharmacist;
- Administration without nurse delegation or not in accordance with nurse delegation; and
- Administration using the wrong technique or method.

Practice Tips:

The error reporting form used during the pilot program phase requires the delegating nurse to provide a personal statement regarding the error. Nurses must be sure to complete the required paperwork when a medication error occurs as a result of the MA-C's practice. The reporting is NOT required, however, for medication errors that may be committed by a nurse.

During the pilot phase only facilities that are participating in the pilot program may utilize medication aides. If an MA-C leaves a pilot facility and is employed by a nursing home or RCF that is not a pilot participant, the aide may not administer medications in the new location until the authority is extended statewide. There is no requirement, either in statute or Board rules, that an MA-C be an actual employee of a pilot facility. Conceivably, an MA-C could be employed by a staffing agency. Again, the authority of the MA-C to administer medications would be limited to facilities participating in the pilot program.

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The statute provides that a person employed by a nursing home or residential care facility that utilizes medication aides who reports in good faith a medication error at the nursing home or residential care facility is not subject to disciplinary action by the Board of Nursing or any other government entity regulating that person's professional practice and is not liable in damages to any person or government entity in a civil action for injury, death, or loss to person that allegedly results from reporting the medication error.21 What this language fails to specify is to whom this report must be made. Interestingly, it could be interpreted that the act of self-reporting precludes disciplinary action by the Board of Nursing; whereas, a report made by a third party would not result in the same immunity for the individual actually committing the error.

How this section of the law will be interpreted by the Board remains to be seen.

The Board has limited jurisdiction over facilities participating in the pilot program only during the pilot phase. After the pilot is completed, the Board may not require a facility to demonstrate a certain level of performance in order to utilize medication aides. Further, only during the pilot may the Board withdraw the authority of a nursing home or RCF to use medication aides if the use poses a threat of serious and immediate risk to resident safety. Complaints of this nature would have to be directed to the Ohio Department of Health after the pilot program's end date.

Conclusion

The safety of using MA-Cs depends in large measure on how effectively nurses delegate the task to them. In the past, when non-nurses have been authorized to administer medications, some nurses would tend to separate themselves from the entire medication administration process. They often neglected to assess the effects the medications were having on the patient or resident as well as the patient's ongoing overall health status. While nurses may believe their practice has been eroded by the creation of medication aides, in reality only the task of actually giving the medication has been relegated to other individuals. The nurse remains responsible for all other aspects of medication administration. The new law may affect how nurses practice, but it will not alter their overall accountability for resident/patient outcomes.

References

1. To comply with this requirement, the Board of Nursing first adopted emergency rules effective for 90 days. No public testimony was heard prior to the effective date, however. In order to adopt permanent rules, the Board had to comply with certain requirements, including conducting a public hearing and submitting the rules to the Joint Committee on Agency Rule Review (JCARR) for a determination that all rule-filing processes were followed. The permanent rules became effective when the temporary rules expired May 1, 2006. A Medication Aide Advisory Council was established in the law to provide input regarding the rules. The Council is comprised of representatives from nursing organizations, the trade associations representing the long-term care and assisted living industries, consumer and family groups, long-term care ombudsmen, and state agencies involved in nursing home regulation and reimbursement.
2. Rule 4723-27-06 of the Administrative Code.
3. Section 4723.67 of the Revised Code.
4. Rule 4723-27-01 of the Administrative Code.
5. Rule 4723-27-02 (B) of the Administrative Code.
6. The rule that primarily addresses delegation is 4723-27-03 of the Administrative Code. Nurses should also review the rules in Chapter 4723-13 of the Administrative Code for general principles of delegation applicable to any nursing task.
7. Section 4723.67 (A) of the Revised Code & Rule 4723-27-03 (D) of the Administrative Code.
8. Section 4723.68 (A) of the Revised Code.
9. Each MA-C is required to have a skills checklist issued by the training program that indicates the skills the aide actually performed during the clinical portion of the training. Rule 4723-27-08 of the Administrative Code.
10. A pediatric resident is defined as someone under 18 years of age. Rule 4723-27-01 of the Administrative Code.
11. This language is taken directly from the statute. Efforts to add clarity during discussions about these rules were not successful.
12. Standards of practice can be found in Rule 4723-27-02 of the Administrative Code.
13. Rule 4723-27-09 (B) of the Administrative Code
14. Training program requirements and standards are found in Rules 4723-27-07 and 4723-27-08 of the Administrative Code.
15. Language in the law sets the requirement for a minimum number of hours in the training program; therefore, the Board of Nursing, through its rules, is able to require additional training hours without running afoul of the law.
16. The clinical practice component can only be provided in pilot facilities initially. Once the pilot phase ends, facilities utilized for clinical training purposes must be free from deficiencies related to the administration of medications and the provision of skilled care in the two most recent Ohio Department of Health surveys.
17. This requirement is in statute at Section 4723.66 (B)(2) of the Revised Code. How that requirement is met is left to the discretion of the training programs.
18. Section 4723.63 of the Revised Code.
19. Rules specific to the pilot program can be found in rules 4723-27-11 through 4723-27-14 of the Administrative Code. Language in these rules will be inapplicable once the pilot phase of the process is completed.
20. Rule 4723-27-01 of the Administrative Code.
21. Section 4723.69 (B) of the Revised Code.

When Your World Falls Apart–The LPN Still Stands

The Licensed Practice Nurse Association of Ohio, Inc. will hold its Annual Practical Nurse Student Convention on Tuesday, April 15, 2008 from 10:00 a.m. to 3:30 p.m. at the Aladdin Shrine Center located at 3850 Stelzer Road in Columbus, Ohio. The Aladdin Shrine Center is near the Easton Shopping Center and the Columbus International Airport.

While costs continue to increase for most everything, we are working to keep your costs at a minimum. The LPNAO Student Council decided to keep the per person charge to attend the Student Convention in 2008 at $30.00, as it has been for the past 6 years.

This event is open to LPNs, RNs and students. Additional information regarding this event will be available on the LPNAO website at www.lpnao.org.

Three Contact Hours–one in Category A–awarded to the participant upon satisfactorily completing the offering. "Contact the Provider at 1-800-222-5762 for information regarding approval status."

Registration Form (PLEASE PRINT)

Name:_____
(RN / LPN / Student)

Address: _____

_____

City _____ State _____ Zip _____

Email:_____

Daytime Phone (____) _____

You may contact me via this email address: YES NO

Ohio Nursing License Number: _____

FEE:

_____ LPNAO Member (Fee: $30.00)

_____ Student Nurse (Fee: $30.00)

_____ Not a member of LPNAO (Fee: $55.00)

IF PAYING BY CREDIT CARD, PLEASE COMPLETE ALL REGISTRATION INFORMATION

I am paying by: _____ Check
_____ MasterCard _____ Visa

AMOUNT:_____

Credit Card # _____

Expiration Date:_____

Verification # _____

Signature: _____

Please return form and seminar payment no later than March 17, 2008 to LPNAO, 1310 Saint Paris Road, Springfield, Ohio 45504-1693 (Fax: 937-399-2259) NO CONFIRMATION WILL BE SENT

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

New Publication: Guidelines for Managers Working With Impaired Nurses

The Ohio Nurses Foundation has a new publication that will be available soon titled **Guidelines for Managers Working With Impaired Nurses.** This publication was developed by the Ohio Nurses Foundation's Peer Assistance Program for Nurses and has been developed into an independent study.

Objectives:

a. Describe the signs and symptoms of chemical dependency.
b. Discuss the manager's role in identifying and managing the nurse who is chemically dependent and/or psychiatrically impaired.

If you are interested in doing this study, please visit our website at www.CE4Nurses.org or contact Sandy Swearingen at 614-448-1030 (sswearingen@ohnurses) for details on how to purchase this study.

Medication Aides–Post-Test

Circle the one correct answer selecting from the options provided. There is only one correct answer.

Name:_____ Final Score: _____

Multiple Choice:

1. An individual who is certified by the Board of Nursing as a Medication Aide
   a. May administer medications to residents of group homes for the mentally retarded/ developmentally disabled
   b. May administer medications independently without supervision of a licensed nurse.
   c. May administer medications to any nursing home resident regardless of the resident's age.
   d. Must complete 15 hours of continuing education every two years in order to be eligible to renew the medication aide certificate.
2. A registered nurse who is supplied by a staffing agency has never worked with medication aides. The nurse asks the medication aide to apply an antibiotic ointment to an open skin lesion on resident A's left heel. The aide should:
   a. Apply the antibiotic according to the nurse's delegation and document the administration in the resident's medical administration or clinical record.
   b. Explain to the nurse that the medication is something a medication aide cannot administer.
   c. Ask the nurse to supervise the application if the aide has never applied an antibiotic ointment to a skin lesion before.
   d. Not apply the medication and trust that the night shift nurse who is an employee of the facility will do it.
3. The Board of Nursing may revoke a medication aide's certificate to administer medications
   a. Only if the aide agrees to the revocation.
   b. At no time because the Department of Health regulates certified medication aides.
   c. If the Board has evidence that the aide took a schedule II controlled substance meant for a resident so that the aide would not have to leave work early due to the pain of a migraine headache.
   d. Whenever the Board receives a complaint that the aide was repeatedly late for work.
4. A medication aide may administer
   a. Oral medications that are given as part of a clinical trial.
   b. Oral medications requiring dosage calculation.
   c. A topical medication that is to be applied to intact skin.
   d. Insulin, provided it is not the first dose of the drug that a particular resident receives.
5. A medication is maintained by a nursing home as a contingency drug and stored in accordance with rules of the Pharmacy Board. A medication aide:
   a. May never administer a contingency medication.
   b. May administer the medication only if a nurse provides the appropriate dose of the medication and delegates administration of the drug to the aide.
   c. May administer the medication if ordered to do so by the nursing home physician.
   d. May take the medication from the contingency supply and administer it.
6. A certified medication aide is passing the 9 a.m. medications in the nursing home. The nurse on duty must attend to a resident who is demonstrating signs of renal failure and so the nurse is unable to take the vital signs of other residents who soon will be leaving the facility for doctor's appointments off site. The nurse should:
   a. Ask the medication aide to put off administering the medications and take the vital signs instead.
   b. Personally take over the medication administration task while the aide takes the vital signs.
   c. Ask the aide to take the vital signs when giving these particular resident's their medications.
   d. Ask another aide who is not assigned medication administration to take the vital signs.
7. A nurse may ask a certified medication aide to
   a. Administer an as-needed oral medication to a nursing home resident only after the nurse first determines the resident's need for the medication.
   b. Administer an as-needed oral medication that is a schedule II controlled substance only if the nurse has completed an assessment of the resident's need for the medication and supervises the aide when the drug is administered.
   c. Administer oxygen.
   d. Administer the first dose of an oral contraceptive to a 17-year-old female who is in a nursing home for rehabilitation following a serious car accident.
8. A nurse may withdraw delegation to a certified medication aide to administer medications when the nurse
   a. Decides that the aide has not been cooperating with co-workers with respect to resolving scheduling conflicts that arise periodically in the facility.
   b. Observes the aide violating facility policy by eating at the nurse's station.
   c. Determines that the aide has failed to attend in-service training on the use of resident tracking devices.
   d. Observes the aide put a medication at the resident's bedside and leave the room without observing the resident swallow the medication.
9. A staffing agency supplies an MA-C for the 7 p.m. to 7 a.m. shift as requested by the nursing home. The licensed nurse who will be delegating medication administration to the MA-C should do all of the following EXCEPT
   a. Personally observe the MA-C prepare and administer all the medications given throughout the shift.
   b. Ascertain that the MA-C's certificate to administer medications is not limited to RCFs.
   c. Review the aide's training program checklist to determine whether there are any skills the aide has not completed.
   d. Clearly communicate to the MA-C any special considerations applicable to particular residents relative to the medications the aide will be administering.
10. The nursing home physician has ordered that a newly admitted resident receive 750 mg Flagyl p.o. tid. The medication has been ordered but not yet delivered by the pharmacy; however, the home has Flagyl 375 mg available in the contingency drug box. This is the first dose of oral Flagyl for this particular resident. The nurse
    a. May delegate administration of the medication to an MA-C.
    b. May delegate administration of the medication to an MA-C only if the nurse removes the correct dose of the medication from the contingency box and gives it to the MA-C for administration to the resident.
    c. May use his/her own discretion regarding whether to delegate administration of the medication to the MA-C based on the nurse's concerns that the aide has previously made several serious medication errors.
    d. Is prohibited from delegating the administration of the medication to the MA-C.

Please indicate whether the answer is True or False

____ 11. A nurse is participating in the Board of Nursing alternative program for chemical dependency because he/she has diverted drugs. Part of the agreement restricts the nurse from administering schedule II controlled substances. This nurse may not delegate medication administration to an MA-C.

____ 12. A licensed nurse who works in an RCF may delegate administration of a PRN schedule III controlled substance to an MA-C if the nurse is available on site to determine the resident's need for the medication.

____ 13. A nurse who delegates medication administration to an MA-C in accordance with standards for delegation is not liable in damages if the aide administers an overdose of the drug.

____ 14. A nursing home that wishes to utilize medication aides may conduct its own training program and structure it so that participants are able to complete the required course work in two weeks.

____15. A nurse who has delegated medication administration to an MA-C must monitor the contents of the medication cart to assure that the medications supplied by the pharmacy are consistent with what has been ordered by the physician.

____16. A medication aide training program need only be 70 hours in length in accordance with section 4723.66 (B) of the Ohio Revised Code although Board of Nursing rules require 120 hours.

____17. A state tested nurse aide must have one year of direct care experience in order to be eligible for certification as a medication aide.

____18. Once the medication aide pilot program is completed, a nursing home utilizing MA-Cs may not be required to be free from deficiencies related to medication administration in surveys conducted by the Ohio Department of Health.

____19. The report prepared by the Board of Nursing regarding the safety implications of using MA-Cs will include an analysis of data comparing the error rate of MA-Cs with the error rate of licensed nurses administering medications.

____20. An MA-C may not administer nor have access to schedule II controlled substances.

____21. The nurse delegating medication administration to the MA-C tells the aide to administer the medication only if the resident has eaten breakfast. The aide leaves the medication at the resident's bedside because breakfast has not yet been served and tells the resident to take the pills when the meal tray arrives. The aide's actions are consistent with medication administration standards.

____22. Rules of the Department of Health governing the administration of medications by an MA-C can be found in Chapter 4723-27 of the Ohio Administrative Code.

____23. A nurse who delegates medication administration to an MA-C remains accountable for the overall resident outcome.

____24. The Ohio Board of Nursing may not take disciplinary action against an MA-C if the aide fails to document his/her medication administration because this documentation remains the nurse's responsibility.

____25. An MA-C must complete 24 hours of continuing education biennially in order to be eligible to renew his/her certificate.

Medication Aides–Evaluation

1. Were the following objectives met?
   a. Describe the training an individual must complete to become A Certified Medication Aide. YES NO
   b. Identify three prohibitions relative to medication Administration by a Certified Medication Aide. YES NO

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

Medication Aides–Registration Form

Name (please print clearly): _____

Address:_____

City: _____ **State:** _____ **Zip:**_____

Day phone number: (___) _____ - _____ **RN or LPN?:** RN LPN **ONA Member:** YES NO

ONA Member Number _____

ONA MEMBERS
Each study in this edition of the *Ohio Nurse* is free to Members of ONA. Any additional independent studies that an ONA member would like can be purchased for $12.00 plus $3.00 S/H by filling out the enclosed order form on page 22 & 23.

NON-MEMBERS
Each study in this edition of the *Ohio Nurse* is $12.00 for non- members. Any additional independent studies that a non-member would like can be purchased for $12.00 plus $3.00 S/H by filling out the enclosed order form on page 22 & 23.

CHARGE TO: ___ Visa ___ MasterCard ___ Discover ___ American Express

Card #: _____ - _____ - _____ - _____ **Exp. Date (mm/yyyy):** ____/____ **Verification #:**

Signature: _____

Please send **check or credit card information** along with this completed form to: Ohio Nurses Foundation, Dept. LB-12, PO Box 183134, Columbus, OH 43218-3134.

ONA OFFICE USE ONLY

Date Received: _____ Amount: _____ Check No: _____
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Independent Studies

Individual copies of independent studies are available to interested nurses at a nominal fee of $12.00 per study (plus shipping and handling). **The fee applies to both ONA members and non-members.** After completion of the packet, learners return their completed post-test, evaluation form, and registration information to earn contact hours. To order any of these independent studies, please fill out the order form attached and return to the Ohio Nurses Foundation, LB-12, PO Box 183134, Columbus, OH 43218-3134.

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

Accreditation/approval refers to recognition of educational activities only and does not imply Commission on Accreditation or Ohio Nurses Foundation approval or endorsement of any product.

Law and Rules

The following studies meet the OBN requirement for 1 contact hour in law and rules (Nursing Practice Act) governing nursing practice in Ohio required for renewal of an Ohio nursing license.

Delegation by Licensed Nurses—1.08 Contact Hours

This independent study has been developed to help nurses understand their rights and responsibilities regarding delegation by licensed nurses. Developed by Peggy Noble Maguire, JD, RN and Jan Lanier, JD, RN

Medication Aides—What the Laws and Rules Say - 1.27 Contact Hours

This independent study has been developed for nurses to better understand the new laws and rules relative to medication aides. Developed by Jan Lanier, RN, JD

Nursing Law and Rules in Ohio: An Overview—1.16 Contact Hours

This independent study has been developed for nurses who wish to learn more about nursing law and rules in Ohio in general. The study was designed to be utilized with both Section 4723 of the Ohio Revised Code (ORC), (commonly known as the Nurse Practice Act) and Chapter 4723 of the Ohio Administrative Code (commonly known as Board rules). Developed by Carol Roe, JD, RN

Professional Boundaries and Sexual Misconduct—1.0 Contact Hour

This independent study has been developed for nurses who wish to learn more about professional boundaries and sexual misconduct relative to nursing practice. Developed by Jan Lanier, RN, JD

The Scopes of Practice for Ohio RNs and LPNs*—1.5 Contact Hours

This independent study has been developed to help nurses who wish to learn more about the different scopes of practice of RNs and LPNs. Developed by R. Wynne Simpkins, MS, RN and Kathleen Morris, MSA, RN

**This study was developed by the Licensed Practical Nurse Association of Ohio, Inc. and the Ohio Nurses Foundation.*

Whistleblowing—How to Ensure That the Law Protects You—1.0 Contact Hour

This independent study has been developed to help nurses understand their rights and responsibilities regarding the provisions in the Nurse Practice Act and the law that protects nurses who blow the whistle from employer retaliation. Developed by Jan Lanier, JD, RN and Kathleen M. Blickenstaff, JD, MS, RN, CS

Advanced Practice Nurses

The following activity has been designed specifically for APNs. Non APNs are welcome to take these studies also. This study meets the OBN requirement for APN license renewal.

The Pharmacotherapeutics of Pain Medications—1.16 Contact Hours

This study was developed for nurses, especially advanced practice nurses who wish to learn more about the different pharmacotherapeutic aspects of pain medications. Developed by Phyllis A. Grauer, PharmD, RPh

Sponsored by an unrestricted educational grant from Purdue Pharma.

Pain

Assessment and Management of Neuropathic Pain—1.2 Contact Hours of Category B and D

This study was developed for nurses who wish to better understand neuropathic pain. Developed by Michelle A. Hobbs, MS, RN, CNP. *Sponsored by an unrestricted grant by Purdue Pharma L.P., Stamford, CT.*

Chronic Non-Malignant Pain—1.25 Contact Hours

This study has been developed for nurses who wish to better understand chronic non-malignant pain. Developed by Cathy D. Trame, MS, RN, CNS and April Hickey, MSN, RN, CNS. *Sponsored by an unrestricted educational grant by Purdue Pharma.*

Pain Management—An Overview—1.33 Contact Hours

This independent study was developed to help nurses increase their understanding about pain management. Developed by Elizabeth A. Macklin-Mace, BA, RN

School Nurses

BMI for Age—1.5 contact hours

This study was developed to improve school nurses' knowledge of Body Mass Index, how to calculate it, who to refer to physicians for further evaluation, and what should be included in school programs to deal with the problem of obesity in children. Developed by Dorothy Brystrom, MEd, RN, NCSN *and* Heidi Scarpitti, RD

Individual Health Care Plans: A Guide to School Nurses—1.66 contact hours

This study was designed to increase school nurses understanding of individualized health care plans used in schools in Ohio. Developed by Nancy Mosca, PhD, RN

Provisions of Nursing Services to the School Aged Population—2.27 contact hours

This study has been developed to increase school nurse understanding of school nursing and local health departments in Ohio. Developed by Kim Toole, MSN, RN, PNP, NCSN

Pediatric Skin Rashes—1.75 contact hours

This study was developed to increase school nurses understanding of skin rashes. Developed by Jane Carmean, BSN, RN

Community Health Workers

The Community Access Program (CAP) through the Community Care Coordination Collaborative (C4) has identified the core competencies for supervisors of community health workers. These modules were developed based upon the educational needs identified by agency administrators, supervisors and community care coordinators.

Nurturing Workers Using Performance Reviews—1.66 contact hours

This study has been developed to increase understanding about how to conduct performance evaluations. Developed by Fay Yocum, MS, RN

The Supervisor's Role in the Employment Process—1.66 contact hours

This study was developed to increase understanding about the hiring process. Developed by Gail Maier, PD, RN

Supervisors, Staff and Cultural Competency Skills—1.83 contact hours

This independent study is designed to increase understanding about cultural competency as a supervisor. Developed by Patricia Williams, BSSW

Supervising Licensed and Unlicensed Personnel's Documentation Skills—1.66 contact hours

This study was developed to increase understanding of principles of documentation and the responsibility of supervisors of community health workers. *Developed by* Michelle Mills, MSSA, LSW

Other Studies

A Nursing Malpractice Primer—0.87 Contact Hours

This study has been developed to provide an introduction to malpractice as it applies to nurses. Developed by Barbara G. Walton, MS, RN

A Profile of Nursing Abuse: What Can Be Done? 1.16 Contact Hour

This independent study was developed to increase understanding about nurses who become abusers of clients and what can be done about the problem. Developed by Joan Harkulich, MSN, RN

Alzheimer's Disease—1.08 Contact Hours

This independent study has been developed for nurses who wish to learn more about identification and treatment of Alzheimer's Disease. Developed by Mary Lou Burlingham, MSN, RN, CS, CDE

An Introduction to Peripherally Inserted Central Venous Catheters (PICC)—1.5 Contact Hours

This study was developed to improve the nurses' knowledge and understanding regarding the use and care of PICCs. Developed by Nancy L. Stone, RN, CCRN

Anxiety and Depression in Older Adults—1.16 Contact Hours

This study discusses the incidence of anxiety and depression in older adults, signs and symptoms, testing and management. Developed by Evanne Juratovac, MS, RN,CS. *Sponsored by an unrestricted educational grant by Bristol-Myers Squibb Co.*

Are You in Congestive Nursing Failure? Legal Issues, Critical Thinking and the Impact on Practice—0.91 Contact Hours

This independent study was developed for nurses to increase understanding about critical thinking. Developed by Barbara Walton, MS, RN

Arthritis—Rheumatoid and Osteo—1.26 Contact Hours

This independent study was developed for nurses who wish to learn more about identification and treatment of arthritis. Developed by Barbara A. Nash, MSN, RN, C, CNS

Asthma—1.13 Contact Hours

This independent study has been developed for nurses who wish to increase understanding about asthma in general. Developed by Lois Nelson, MD, FAAAAI and Sandy Oehrtman, PhD, RNC, CPNP

Balancing the Demands in Your Life through Humor—0.91 Contact Hours

In today's world, nurses find themselves constantly under pressure. We pressure ourselves to be good nurses, good spouses, and good parents, among other things. Learn how to make humor work for you at home and at work. Developed by Deborah A. Hague, MS, RN. **Sponsored by an unrestricted educational grant from Astra Merck, Akron.*

Becoming Politically Active—1.08 Contact Hour

This independent study has been developed for nurses who wish to increase their knowledge about how to become politically involved. Developed by Carol Roe, JD, RN

The Challenge of Critical Thinking—1.0 Contact Hours

This study was developed to better understand the process and application of critical thinking. Developed by Mary Lou Burlingham, MSN, RN, CS, CDE.

Changing Views: Influencing How the Public Sees Nursing—1.0 Contact Hour

This study has been developed to help nurses better understand the public's perception of nursing. Developed by Pam Dickerson, PhD, RN, BC

Chronic Kidney Disease: Stages and Nursing Care—1.5 Contact Hours

This independent study has been developed for nurses to better understand chronic kidney disease. Developed by Barb Walton, MS, RN.

Complementary Therapies from a Nursing Perspective—1.15 Contact Hours

This study was written to increase the understanding of various complementary therapies. Developed by Yvonne Smith, MSN, RN, CNS, CCRN.

Congestive Heart Failure—0.91 Contact Hours

Learn about the pathologic processes that are involved in the development of CHF, identify common signs and symptoms, and therapeutic interventions used when caring for a person with CHF. Developed by Barbara A. Nash, MS, RN and Pamela S. Dickerson, PhD, RNC. **Sponsored by an unrestricted educational grant by Merck & Co., Inc.*

Creative Teaching Strategies—0.86 Contact Hours

This study was developed to help nurse educators develop more creative teaching strategies. Developed by Pam Dickerson, PhD, RN, BC.

Demystifying the Immune System and Autoimmune Disease—1.25 Contact Hours

This independent study has been developed for nurses to better understand the immune system and autoimmune diseases. Developed by Barbara Walton, MS, RN.

Developing a Nursing Business: The Process—1.0 Contact Hour

This study has been developed to provide basic information on how to start your own nursing business. Developed by Pamela Dickerson, PhD, RN, BC and Deborah Hague, MS, RN, BC

Ethics—1.1 Contact Hours

This independent study has been developed for nurses who wish to increase their understanding about ethics. Developed by Elaine Glass, MS, RN, AOCN.

Facilitating Professional Growth: A Guide to Planning, Implementing and Evaluating Continuing Education in the State of Ohio—1.5 Contact Hours

This study was developed to assist the Ohio staff development educator or continuing education provider in the process of planning, implementing and evaluating continuing education. Developed by Pam Dickerson, PhD, RN, C.

Heart Failure: A New Look at an Old Problem—1.5 Contact Hours

This independent study has been developed to help nurses who wish to learn more information regarding heart failure. Developed by Barb Walton, MS, RN

Hidden Hazards in Health Care—0.98 Contact Hours

This independent study has been developed to educate nurses on the hidden hazards of waste products in health care. Developed by Patricia Reinhart, RN

Identification and Treatment of Alcohol Abuse, Dependence and Withdrawal—1.16 Contact Hours

This independent study addresses the prevalence of alcohol abuse and dependence in the general population; identifies effective screening and assessment tools; describes the indicators of alcohol abuse and the intervention; and referral actions that RNs should take upon identification of the patient at risk of withdrawing from alcohol. Developed by June A. Tierney, MSN, RN, CS.

Influenza Pandemic: Nothing to Sneeze About?—1.5 Contact Hours

This independent study was developed to help nurses to learn more about the influenza pandemic. Developed by Barbara Walton, MS, RN

Interpreting Common Lab Values—0.83 Contact Hours

Developed for nurses who wish to review common lab values, this study covers hematologic studies, blood chemistries, arterial blood gases, and urinalysis. Developed by Deborah Hague, MS, RN,C. **Sponsored by an unrestricted educational grant from Astra Merck, Akron.*

Interpreting Lab Values Affected by Kidney Function—1.6 Contact Hours

This independent study has been developed for nurses who wish to increase understanding about lab values which are affected by kidney function. Developed by Deborah Hague, MS, RN, C.

Lupus—1.08 Contact Hours

This independent study has been developed to help nurses to learn more about Lupus. Developed by Barbara Walton, MS, RN.

Making a Test That Gets Results—1.66 Contact Hours

This independent study has been developed to help nurses to learn more about how to write effective and valid test questions. Developed by Shirley Hemminger, MSN, RN, CCRN (Expires: 1/2008)

Continued on Page 23

Independent Studies . . .

Continued from Page 22

Medication Errors: The Challenge for Nursing—0.91 Contact Hours

This independent study has been developed for nurses who wish to increase their knowledge about the problems of medication errors in the U.S. health care system, and how nurses can keep them for happening. Developed by Barbara A. Nash, MS, RN, C, CNS.

Multiple Sclerosis: A Multi-faceted Disease—1.0 Contact Hour

This independent study has been developed to help nurses understand multiple sclerosis. Developed by Barbara Walton, MS, RN.

Parkinson's Disease—1.16 Contact Hours

This independent study has been developed to help nurses understand Parkinson's Disease. Developed by Barbara Walton, MS, RN

Political Activism: Being an Effective Advocate for Nurses and Nursing—1.08 Contact Hour

This study provides the learner information they will need to begin to effectively influence the legislative process on behalf of the nursing profession. Developed by Jan Lanier, JD, RN

Sorting Out the Viral Hepatitis Alphabet—1.0 Contact Hour

This study has been developed to help nurses better understand viral hepatitis. Developed by Marcia Schneider, RN

The Highs and Lows of Thyroid Disease—1.25 Contact Hour

This study was developed for nurses to better understand thyroid diseases and related nursing implications. Developed by Barbara Walton, MS, RN

The Ten Steps to Making a Successful Job Change—0.77 Contact Hours

This study has been developed for nurses who wish to learn more about the steps involved in successfully changing jobs. Developed by Deborah A. Hague, MS, RN, C.

Tips for Managing Anger Constructively 0.86 Contact Hours

This independent study has been developed for nurses who wish to increase understanding about anger management in general. Developed by Deborah A. Hague, MS, RN, C

Understanding Fluid Shifts—1.58 Contact Hours

This study has been developed for nurses who wish to increase their knowledge about fluid shifts. Developed by Barbara Walton, MS, RN.

Violence Against Nurses: The Silent Epidemic—1.16 Contact Hours

This study has been developed for nurses who wish to learn more about violence against nurses. Developed by Donna M. Gates, EdD, MSPH, MSN, RN and Darcy Kroeger, BS, BSN, RN

Whose Job Is It, Anyway? The Nurse's Role in Advocacy and Accountability—0.80 Contact Hours

This study has been developed to assist nurses with their role in accountability and advocacy. Developed by Pam Dickerson, PhD, RN-BC

ORDER FORM

All independent studies listed below are available to interested nurses at a nominal fee of $12.00 per study (plus shipping and handling). **The fee applies to both ONA members and non-members.** After completion of the packet, learners return their completed post-test and registration information to earn contact hours. To order any of these independent studies, please mark your choices, fill out the form, and return to ONF.

ALL STUDIES MUST BE PRE-PAID

- ❑ A Nursing Malpractice Primer—0.87 Contact Hours.
- ❑ A Profile of Nursing Abuse: What Can Be Done?—1.16 Contact Hours
- ❑ Alzheimer's Disease—1.08 Contact Hours
- ❑ An Introduction to Peripherally Inserted Central Venous Catheters (PICC)—1.5 Contact Hours
- ❑ Anxiety and Depression in Older Adults—1.16 Contact Hours
- ❑ Are You in Congestive Nursing Failure? Legal Issues, Critical Thinking and the Impact on Practice—0.91 Contact Hours
- ❑ Arthritis—Rheumatoid and Osteo—1.26 Contact Hours
- ❑ Assessment and Management of Neuropathic Pain—1.2 Contact Hour
- ❑ Asthma—1.13 Contact Hour
- ❑ Balancing the Demands in Your Life Through Humor—0.91 Contact Hour
- ❑ Becoming Politically Active—1.08 Contact Hours
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- ❑ The Challenge of Critical Thinking—1.0 Contact Hours
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- ❑ Identification and Treatment of Alcohol Abuse, Dependence and Withdrawal—1.16 Contact Hour
- ❑ Individual Health Care Plans: A Guide to School Nurses—1.66 Contact Hours
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- ❑ Nurturing Workers Using Performance Reviews—1.66 Contact Hours
- ❑ Pain Management—An Overview—1.33 Contact Hours
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- ❑ Whitstleblowing—How to Ensure That the Law Protects You—1.0 Contact Hour
- ❑ Whose Job Is It, Anyway? The Nurse's Role in Advocacy and Accountability—0.80 Contact Hours

HOW TO ORDER

Each individual Independent Study is $12.00 plus shipping and handling. All studies must be pre-paid. **The fee applies to both ONA members and non-members.**

Shipping/Handling:
1 Study—$3.00
2–4 Studies—$5.00
5 or more Studies—$10.00

Please send me the studies checked on this page. I am enclosing $12.00 per study, including shipping and handling. **The fee applies to both ONA members and non-members.**

_____ Studies X $12.00

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_____ $5.00 S&H (2–4 studies)
_____ $10.00 S&H (5 or more)

_____ Total Enclosed

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Please mail to: The Ohio Nurses Foundation, Dept. LB-12, PO Box 183134, Columbus, OH 43218-3134 or request via email at sswearingen@ohnurses.org or phone (614-448-1030).

Becoming an Approved Provider - 2008

Objectives:

1. Identify the background for the continuing education process.
2. Discuss the rules and criteria to be used to develop an approved provider unit.
3. Describe the process in becoming approved as a provider.

The Ohio Nurses Foundation, the foundation of the Ohio Nurses Association, is offering a special class for individuals who wish to become an Approved Provider of continuing education or are new into an existing Provider Unit. This class will discuss the reasons for developing an approved provider unit, how to establish a unit, and how to obtain approval as a provider unit. A prerequisite is for the learner to have submitted at least one individual CE event application to ONA for approval.

Dates: March 5, 2008; July 16, 2008; October 8, 2008. The classes will be held from 10:00 a.m. to 2:30 p.m. The program will be held at the Ohio Nurses Association headquarters building, 4000 East Main Street, Columbus, Ohio. The fee for the class is $55 ($50 for second person from same organization). The speaker will be Zandra Ohri, MA, MS, RN, Director, Nursing Education, Ohio Nurses Association.

If you have any questions, please contact Zandra Ohri at 614-448-1027 or Zohri@ohnurses.org or Sandy Dale-Swearingen at 614-448-1030 or Sswearingen@ohnurses.org

4.2 contact hours will be awarded including 1 contact hour of Category A (law and rules). Criteria for successful completion includes attendance at the entire event and submission of a completed evaluation form.

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

Registration Form

Name _____

Address _____ City _____ State_____ Zip_____

Daytime telephone: _____ E-mail: _____

Employer:_____

I would like to attend:
____ March 5, 2008
____ July 16, 2008
____ October 8, 2008

____ I would like a Vegetarian Lunch
Registration Fee: $55 ($50 for second person from same organization). Fee includes contact hours, handouts and lunch.
_____ Check Enclosed _____ Visa _____ Mastercard _____ Discover _____ American Express

Card #: _____ Expiration Date (mm/yyyy) _____

Verification # _____ Signature_____
Please return form one week prior to the event to the Ohio Nurses Foundation, Dept. LB-12, PO Box 183134, Columbus, OH 43218-3134.

Office Use: Date Rec: ____ Amt.: _____ Check #: _____