Is structured visitation in the ICU more effective than open visitation in promoting patient safety and rest, and nurse, patient, and family satisfaction?

Theresa Tomlinson, RN, BSN

**Practice Question:** Is structured visitation in the ICU more effective than open visitation in promoting patient safety and rest, and nurse, patient, and family satisfaction?

**Background:** Family may visit the patient for extended periods of time. ICU patients may have infrequent rest periods due to the constant influx of visitors and staff. Nurses may be distracted by visitors, which can affect patient safety. York Hospital’s visiting policy is implemented to varying degrees among the units. Patients, family and staff become frustrated when visiting policies are inconsistent.

**EBP Model:** The Johns Hopkins Nursing Evidence-Based Practice Model was used as the framework for this project.

**Evidence:** Thirty-four articles were included in the individual evidence summary. No level-I evidence was found. A quasi-experimental study with a quality rating of “A” was the only level-II evidence. Eight level-III studies were reviewed. Three were rated “A” and five were rated “B”. Two level-IV articles, with a rating of “A” were included. Sixteen articles were categorized as level-V evidence, with half “A” and half “B”. Level-V evidence included quality improvement, case studies and literature reviews. Eight articles were assigned a quality rating of “C” and were not included in the overall evidence summary.

**Practice Recommendations:** Open visitation in the ICU is recommended over structured visitation. Open visitation has been found to be safe and beneficial to the patient, and promotes patient and family satisfaction. Thorough communication and education to staff, patients and visitors is integral for successful implementation. Patient, family and staff input should be used in the development of the visitation policy. An individualized visiting plan should be used whenever possible. A trial period will allow issues to be addressed as they occur. Patient privacy and staff /patent safety should never be compromised when implementing open visiting.

**References**


The CNS Role in Translation of an Insulin Pump Policy into Bedside Practice
Susan Dayhoff, RN, MS, CNS

Introduction: Within a 558-bed community-based teaching hospital, there has been an increase of patients with insulin pumps being admitted to the medical/surgical areas. There are inconsistencies in physician orders and nursing documentation. The CNS is pivotal within an organization to collaborate with the health care team and patient to promote outcomes that will incorporate best practices. A CNS-led team has been instrumental in identifying the problem, coordinating a team, and initiating a process to improve patient safety and self management.

Purpose: The purpose is to incorporate a safe and effective insulin pump algorithm of care for use by the health care team and the patient while in the hospital.

Methods:
· Step 1: A clinical effectiveness interdisciplinary team designed an algorithm of care to assist nurses and physicians to safely care for patients with insulin pumps.
· Step 2: The CNSs looked retrospectively at 24 charts of patients with an insulin pump on the medical-surgical acute care areas from January 2009 to June 2010. Data were collected regarding appropriate physician orders and appropriate nursing documentation. The outcomes were sub-optimal.
· Step 3: An educational plan was developed and implemented that included computer-based training and oral presentations to nurses and physicians.

Results: A quasi-experimental design will be used to evaluate physician and nurse documentation pre and post-education. Prospective data collection began July 2010. Data analysis will be completed prior to the conference.

Conclusions: By incorporating evidence-based practice through an interdisciplinary clinical effectiveness team, the CNS has improved staff knowledge, staff performance and instituted a valuable practice model. Results of this study will establish the appropriateness of documentation and the safe and effective care of the patient with an insulin pump.

References:
Identification of Barriers to Patient Education Regarding Sexuality by Nurses Among Oncology Patients
Donna Fitz, RN, MS, ONC and Rod Grim, MA
York Hospital

Introduction: As early as 1972, the World Health Organization (WHO) issued statements in their Progress newsletter defining sexual health and how it is intertwined with many aspects of the human being. WHO defines sexual health as “…a state of physical, emotional, mental, and social well being in relation to sexuality: it is not merely the absence of disease, dysfunction or infirmity.” The oncology nursing literature has for years been addressing sexual health related to an oncology patients’ general health. The literature suggests that nurses have their own beliefs, values, and issues regarding sexuality, which affect how comfortable they are with discussing this topic.

Purpose: This study was conducted to determine if the nurses from designated areas are comfortable with discussing sexual health with oncology patients and to identify barriers that may exist that prevent this discussion from occurring.

Methods: The Sexuality Attitudes and Beliefs Survey (SABS) (Reynolds & Magnan, 2005) and an open-ended question assessing barriers were given to all nurses in the Oncology Service Line. Nurses could choose not to fill out the survey.

Results: Twenty-nine of 57 (51%) staff nurses voluntarily participated in the study. SABS identified four specific barriers: lack of comfort with the topic, time, education on the issue, and questioning who should be doing the teaching. The open-ended question yielded 6 categories: privacy, comfort with discussing the topic, time, education/knowledge deficit, who should do the teaching, and “other” (i.e., patient fatigue).

Conclusions: The study uncovered a substantial gap in discussing sexuality with cancer patients. A team has been designated to address the barriers uncovered in this study. Future research will review charts to determine if nurses are improving with sexuality discussions. In the end, it is our hope that patient quality of life will improve.

References
Student Nurse Dyads Create a Community of Learning: Proposing a Holistic Clinical Education Theory
Lisa Ruth Sahd, RN, EdD, CEN, CCRN

Introduction. Although cooperative learning is often used successfully in the classroom, it has not been documented in the clinical setting with sophomore nursing students being paired with other sophomore nursing students.

Purpose. This paper is a report of a qualitative study of students' experiences of cooperative learning in the clinical setting.

Methods. Using a grounded theory methodology a sample of 64 participants (32 student nurse dyads, 8 clinical groups, in 2 different acute care institutions) were observed on their first day in the clinical setting while working as cooperative partners. Interviews also were conducted with students, patients and staff preceptors. Data were collected in the fall 2008, spring and fall 2009 and spring 2010 using semi-structured interviews and reflective surveys. Data were analyzed using the constant comparative method.

Results/Findings. A holistic clinical education theory for student nurses emerged from the data. This theory includes a reciprocal relationship between five categories relevant to a community of learning: supportive clinical experience; improved transition into practice; enhanced socialization into the profession; increased accountability and responsibility; and emergence of self-confidence as a beginning student nurse.

Conclusion/Implications. The use of student dyads creates a supportive learning environment while students were able to meet the clinical learning objectives. Cooperative learning in the clinical setting creates a community of learning while instilling very early in the education process the importance of teamwork. Nurse educators should consider using cooperative dyads in the clinical environment to enhance student learning. Current clinical education strategies must be reevaluated to determine the best approach for students to create a positive clinical learning environment. This approach to clinical instruction eases the transition from the classroom to the clinical learning environment, and improves patient outcomes.

References
Intrahospital transport: Safe passage or potential for disaster
Cynthia Stermer, RN, MS, CNS

Practice Question: What are the best practices for intrahospital transport of acutely ill patients?

Background: Transport of acutely ill patients through the hospital can be potentially unsafe and place the patient at an increased risk for complications, morbidity, and mortality. Acutely ill patients are defined as any patient on continuous monitoring being transported to a treatment, procedure or a higher level of care within the hospital setting. Limited resources such as expertise of transport staff and equipment also add to the potential for complications during transport. Currently there are no best practices for transport of the non-ICU patient.

EBP Model/Evidence: An interdisciplinary team was formed to address the issue of acute patient transport. An EBP project was conducted using the Johns Hopkins Evidence-Based Practice Model. After formulating the practice question, 100 articles were reviewed with 27 having relevant content. Appraisal revealed that five articles were of poor quality and were eliminated. The remaining 22 articles were graded as follows: Level I – 0; Level II – 0; Level III – 3 A/2B; Level IV – 5A/1B; Level V – 5A/6B

Practice Recommendations and Action Plan:

- Increase awareness that intrahospital transport poses many risks; the decision to transport should be balanced between benefit and risk.
- Patients being transported are still acutely ill and should receive the same physiologic monitoring.
- Evidence-based policies and protocols should be strictly followed and include specific details regarding pre-transport coordination, transport personnel, transport equipment, monitoring during transport, communication, and documentation.
- Encourage use of checklists, algorithms, or scorecards to ensure appropriate resources are provided for transport.
- Translation will begin by revising current policies and procedures, developing a patient transport scorecard, and conducting a patient transport trial.

References
Assigning a Code Team: Is it Needed?
Mindy Guinard RN, MS, CEN and Annette Gillespie RN, BSN, CEN
Memorial Hospital, York PA

Practice Question: Should a specific “code team” be designated during each shift?

Background: Current practice within the hospital is that a nurse from ICU and a respiratory therapist is assigned at the beginning of each shift as well as the on call resident and hospitalist respond to the code. All those responding are ACLS certified, but the members may change day to day. This has created a concern that the facility may need to consider changing the policy to include a specific code team. A literature search was conducted and practice recommendations were considered.

EBP model used for reviewing literature was the Johns Hopkins module. Key words used in searching the CINAHL and PubMed data bases included: cardiac arrest teams, code teams, cardiac resuscitation teams.

Evidence: A total of 43 articles were found, only 6 were relevant to the topic. Of those six, four were level V/B, one was a level III/A, and one was II/A. Additional evidence may be needed since the article sampling was small; however one practice recommendation can be made: assigning a specific code team has not been determined to be the best practice at this time, but assigning roles/duties early at the onset of a cardiac arrest is needed.

Action Plan: The action plan consists of all ACLS and PALs classes will continue to have a renewed effort in using the principle of team dynamics as outlined by the American Heart Association. In addition, mock codes will continue to occur with each participant receiving a card assigning their role such as chest compressor, med nurse, air management, recorder, etc. Furthermore, a diagram has been developed and will be posted on every code cart reminding staff of the code team’s role. It will be printed on bright colored paper and laminated as a visual cue of roles during a cardiac resuscitation. Another use of this visual diagram will be to assist with crowd control when too many staff are present only as onlookers impeding the work of the cardiac arrest team.

References
Balancing Act: Infection vs Skin Breakdown
Jeanine Albin, RN, BSN and Sharon Brady RN, BSN, CWOCN
Hanover Hospital

Practice question: Will patients with urinary incontinence after Foley catheter removal have fewer incidences of incontinence-associated dermatitis by using incontinence management guidelines?

Background: Catheter-associated urinary tract infections are the most common hospital-acquired infections (HAI) in the nation. As the elderly population increases, the incidence of urinary incontinence also will grow. Research has shown that by removing catheters as quick as possible we could significantly reduce urinary tract infection rates. Nurse driven urinary catheter protocols are raising concerns of how to manage increased urinary incontinence and subsequent skin breakdown. This same population already compromised due to medications, delirium, fecal impactions, dehydration, impaired mobility, and infection. There is a need to establish incontinence management guidelines to ensure that it is consistent with evidence-based practice recommendations. New technology has provided improved products and equipment to provide comfort and protection.

EBP model: The Iowa Model of Evidence-Based Practice to promote quality care

Evidence: Using a systematic review of research on urinary incontinence management, we were able to formulate management guidelines.
12 references reviewed.
There was one Level II, four level V and seven level VI articles

Practice Recommendations:
- Develop urinary incontinence guidelines
- Staff education
- Revise electronic medical documentation
- Institute urinary incontinence care plan

Conclusion:
Implementation of urinary incontinence guidelines will decrease incontinence associated dermatitis and prevent urinary tract infections by earlier Foley catheter removal

References:
WOCN Professional Practice Committee, Reversible causes of urinary incontinence: A guide for clinicians. 2007
Bedside Reporting and Patient Satisfaction
Ann K. Fiala, RN, and Cassie Craven, RN
Gettysburg Hospital

**Purpose:** To determine if nurse-to-nurse bedside reporting improves patients’ understanding of care they are receiving. This promotes the goal of patient centeredness, increased communication among nurses, patients, and families, and overall patient satisfaction.

**Method:** Staff members were educated on the concept of nursing shift report being conducted at the patient’s bedside. Bedside reporting was initiated and considered successful for the nurses; however, the literature shows that patient involvement during these rounds increases patient satisfaction. The next intervention was to include the patient and family during the rounds.

**Results:** Patient satisfaction has increased since bedside report commenced on B1. Patients are being educated on bedside report. Nurses agree that bedside report is occurring regularly and is an integral part of patient care.

**Conclusion:** The process of implementing bedside reporting has generated a new appreciation from patients and family regarding their plan of care and connection to the healthcare team.

**References:**
http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/
TCABHowToGuideIncreasingNursesTimeinDirectPatientCare.htm
http://bphc.hrsa.gov/patientsurvey/data.htm
Question: What are the best practices for the nursing care of acute traumatic brain injury?

Background: Patients who sustain acute traumatic brain injuries require intense monitoring and specialized care that directly affects the outcome of the patient’s well-being for the remainder of his/her life. According to the CDC, 1.4 million people in United States sustain a traumatic brain injury annually, which puts these patients at an increased risk of developing other life-threatening complications (Olson, Bader, Dennis, Mahanes, & Riemen, 2010). The purpose of this project was to summarize current best practices for acute traumatic brain injury. Evidence-based practice provides the best opportunity for improving the patient’s health status in a timely manner in order to prevent secondary brain injury and to improve overall patient outcomes.

EBP model: The Johns Hopkins Nursing Evidence-Based Practice model was used to guide the process of investigating this clinical issue.

Evidence: Evidence from levels I, II, IV, and V provided insight into evidence-based practices that improve patient outcomes for those who have suffered acute traumatic brain injury. A total of 10 articles were found: 2 were level I-A, 1 was level II-B, 1 was level IV-A, and 6 were level V-A/B.

Practice Recommendations: Experts recommend the following invasive and therapeutic interventions to improve patient outcomes: brain oxygen monitoring, intracranial pressure monitoring, chest percussion, nutritional support, proper medication administration, and therapeutic positioning. By following and understanding these interventions, as well as performing constant neurological assessments, the professional nurse will aid in the recovery and increased quality of life for patients who sustain acute traumatic brain injuries.

References
EBP: Are chronic pain and depression related to unresolved grief?

Ivandra Adams, BSN, RN
York Hospital

**Practice Question:** What is the evidence related to the relationship between unresolved grief and chronic pain and depression.

**Background:** Many patients who have multiple hospitalizations on our inpatient behavioral health unit have chronic pain and depression. On interview, they often reveal at least one experience of significant loss that preceded their chronic illness. The purpose of this study is to identify the relationship between unresolved grief and chronic pain and depression and ultimately determine if there are better methods to identify persons who are more at risk. This may enable the nurse to better identify strategies for prediction, prevention and management of unresolved grief.

**EBP Model:** The Johns Hopkins Nursing Evidence-based Practice Model was used for this project.

**Evidence:** Fifty-five articles were selected for analysis after using the key words of depression, grief, unresolved grief and chronic pain. Twenty-one of these articles were selected based upon quality and relevance: one Level 1 article, one Level 2, thirteen Level 3, two Level 4, and three Level 5 articles that were used. All final articles were either high (A) or good (B) quality. The evidence revealed three types of losses and grieving processes which required predictable interventions.

**Practice recommendations:** Using the evidence, a pilot research project would be designed to evaluate the efficacy of the current assessment, and to determine if there are other tools which could be better suited to identify the high risk grievers early in the grieving process.

**References**


Getting the Right Mix: Measuring Patient Acuity for Nursing Staffing

Bill Siler, RN, BSN
Memorial Hospital

Practice Question: Is there a current tool to measure nursing acuity on a telemetry unit?

Background: Making patient assignments can be difficult when there is no standard of practice in considering patient acuity/staffing levels and work load. Staff on a telemetry floor have become more concerned about the ability to provide the safest care possible to a changing patient acuity level but are unsure how best to measure the acuity of their patient population. Several States have instated nurse to patient ratios but many of them do not take into account patient acuity.

EBP model: Johns Hopkins module was used to evaluate current literature where a rating scale of I-V and a grading scale of A-C is used. Evidence was found using the key terms of patient acuity and nurse to patient ratio through searches of CINAHL, PubMed, and Google. A total of 27 articles were found and 7 were deemed relevant to the practice question. Of the articles reviewed, a rating of III with a grade of B was most frequently given.

Practice recommendations are to review all patient needs in calculating an acuity score for a patient and use the available research to create an acuity tool which will be trialed on the telemetry unit. The acuity tool considers five main topics of medications, complicated procedures, education, psychosocial, IV medications, and ADLs.

References
Helping to Overcome Mental Illness Stigma through Research
Nancy Mann, MS, RN, PMHCNS-BC
York Hospital

Introduction: The literature on mental illness stigma demonstrates that individuals diagnosed with psychological disorders are subjected to a range of negative thoughts, feelings and behaviors by others, including nurses. These views of mental illness and the patients who are so diagnosed have implications for treatment and health care.

Purpose: The purpose of this research study was to investigate the prevalence of mental illness stigma among different nursing specialties in order to identify the potential ways Psychiatrist Mental Health Clinical Nurse Specialists (PMHCNS) can impact clients, staff and system.

Methods: The Mental Illness Stigma Scale (MISS, Day, 2003; Day, Edgren, & Eshleman, 2007) was sent electronically to 3,480 health care providers and staff of a community health system as part of a larger data collection project. ANOVAs were conducted on 7 dependent variables from MISS: Relationship Disruption, Hygiene, Treatability, Anxiety, Visibility, Recovery and Professional Efficacy. The independent variable of nursing specialty had 11 levels: Behavioral Health, Cardiovascular, Care Management, Emergency, Medical, Neurosciences, Oncology, Surgical, Women Children, Outpatient, and “Other.”

Results: 685 (48%) nurses responded to the survey. Behavioral health nurses reported significantly less anxiety around people with mental illness than nurses from all other specialties except care management. Behavioral health nurses reported significantly more positive views about treating mental illness than surgical nurses, but less positive views than oncology nurses. There were no significant differences between specialties for the remaining MISS scales.

Conclusions/Implications: Although some nursing lines show differences in certain types of mental illness stigma, no specialty is without stigma. Given the results of this study, the availability of a PMHCNS as a consultant within Behavioral Health as well as other specialties can help to reduce stigma, assure proper treatment and facilitate appropriate follow-up.

References
Home based education to heart failure patients: A proactive approach to decrease hospital re-admissions

Julie Mosebrook, RN, BSN, CEN; Cheryl A. Tull, RN
Hanover Hospital

Practice question: Do home based educational visits by a cardiac nurse reduce the number of hospital re-admissions for heart failure patients when compared to the current practice of giving patients written instructions at discharge?

Background: Chronic heart failure is a growing concern in health care, both from the economic impact it creates for hospitals and the quality of life impact on patients and their families. Providing the most complete information while patients are confined to a hospital is not always enough to prevent unplanned re-admissions. Medicare cut-backs for heart failure re-admissions are causing facilities to examine strategies to curtail these additional costs.

EPB model: The Iowa Model was chosen for this research project. Evidence: A literature search of PubMed, Evidence Based Nursing Journal and the American Heart Association Journal led to nine articles. These articles were narrowed to four. The evidence was rated as Level 2 Grade B. The evidence supports the creation of an outpatient educational intervention.

Practice recommendations: Consider the implementation of a cardiac nurse-led home-based educational intervention for heart failure patients within 2 weeks of discharge from the hospital. The cardiac nurse will be in direct contact with the primary care physician. Education will include medication, diet and chronic disease process. The patient, family and caregivers will be instructed on the signs and symptoms of heart failure exacerbation and home intervention before seeking emergency care.

References


Implementing Strategies to Shield Nurses Against Lateral Violence
Penelope Kelly, RN, MSN
Hanover Hospital

Practice Problem: Without standard guidelines of expected professional behaviors, lateral violence (LV) will continue to affect nurses and healthcare organizations negatively. How do healthcare organizations acknowledge LV and provide nurses with strategies to shield themselves against it?

Background: LV among nurses is an increasing problem. Excessive criticism, bullying, exclusion, and backstabbing are examples. LV is responsible for high turnover rates, increased use of sick time, low self-esteem, nurses leaving the profession, and endangerment of patients. Concerned about the effects of LV, The Joint Commission, the American Association of Critical Care Nurses, and the American Nurses Association have issued guidelines for professional behaviors and adopting a zero-tolerance policy of LV.

EBP Model and Evidence: A literature search of EBSCO, CINAHL, and the University of Phoenix library databases resulted in 18 articles. Five articles focused on educating nurses about LV and strategies to shield against LV. Cognitive rehearsal techniques and the DESC model of communication provide nurses with tools to face LV. In a study by Martha Griffin, RN, CS, PhD, newly licensed nurses trained in the use of cognitive rehearsal were able to confront LV. All the newly licensed RNs in Griffin’s study used the cognitive rehearsal techniques to confront the responsible individual. The LV stopped 100% of the time when new RNs addressed their concerns with the perpetrator. Guidelines by professional organizations provide a framework to deal with LV.

Practice Recommendations: Administrations must adopt guidelines of expected professional behaviors along with consequences for unprofessional, disruptive behaviors. Practical everyday strategies, such as the use of cognitive rehearsal techniques and the DESC model of communication, must be incorporated into organization-wide orientation programs and competencies, holding nurses accountable for their actions.

References
Inpatient HiROC (High Risk Osteoporosis Clinic): Improving Osteoporosis Care Post Fracture

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Purpose: Ineffective care pathways and process flows hinder post fracture care. To enhance the care of high risk osteoporosis patients across our health system, the rheumatology department created HiROC. Success was achieved by partnering with fellow stakeholders (orthopedists, hospitalists) to provide comprehensive post-fracture care to this high risk group.

Method: HiROC utilizes rheumatology physician experts, clinical nurse specialists, electronic tools, and redesigned care processes to provide comprehensive osteoporotic care in an efficient manner to patients after fracture. HiROC has both inpatient and outpatient components. Inpatient HiROC involves an auto-consult to the Inpatient HiROC Team on all patients admitted with a low-impact fracture. At 6-weeks post-fracture, all Inpatient HiROC patients are contacted to re-assess their status. They are then seen in the Outpatient HiROC, or their treating physician is contacted and given a consultative osteoporosis management plan, if they decline outpatient HiROC followup. We report on the first 200 Inpatient HiROC patients, including baseline demographics, risk assessment, and treatment. High risk for future fracture was assessed by fracture type (vertebral or hip) and/or DXA results.

Results: Inpatient HiROC admission fracture types included hip (50.5%), vertebral (13%), other (38%). All 200 patients reached their 6-week assessment point with 48% of patients transitioning to Outpatient HiROC. Significantly more high risk patients received treatment in the Outpatient HiROC group (83%) than the in-system PCP group (25%), (p<.0001).

Conclusion: By combining inpatient and outpatient components, organized task management, and electronic tools, the HiROC program demonstrates significant treatment success. Quality of care was greatest when an inpatient HiROC visit was paired with an outpatient HiROC visit. We are exploring ways to increase this connectivity by expanding Outpatient HiROC site availability and assessing patient motivation.

References


Peg Tubes: To Dress or Not to Dress!
Luz Sebesta RN, Deb Hare RN, K. Chapman RN
Memorial Hospital

Practice Question: Should the care of a peg tube include a dressing?
Background: Multiple patients presented to the hospital for peg tube replacement due to leaking issues or severe peg site infection, with a few skin infections requiring a referral to wound care specialist. Attempts were made to speak with the caregivers regarding underlying causes of the infection. Family members mentioned the use of gauze underneath and on top of the bumper and pulling of the tube to clean underneath with peroxide. All these treatments seem contrary to our teaching materials and peg tube manufacturer instructions which states, “no dressing is necessary unless there is drainage.”

EBP Model: We used the Johns Hopkins model and articles were found using the key search words: “care of peg site,” “skin complications of peg site,” and “peg tube and dressings”. The search was narrowed to articles and studies that were done within the last 20 years.

Evidence: The articles were evaluated and only the articles that had an average rating of IIIB and above were included in the final recommendation.

Practice Recommendation: The evaluation of these articles did not provide a clear answer in identifying best practice for the care of peg site. We would like to collect data on the skin condition of patient day after peg tube insertion, 1 week, 1 month, 3 months with no dressing on the peg site. This would require us to obtain IRB approval moving forward.

References
Practice question: Would the prevalence of heel pressure ulcers in the acute care setting decrease if clinicians were electronically prompted to implement use of heel off-loading devices?

Background: Numerous articles have indicated that heel pressure ulcers are the second most common type of facility acquired pressure ulcers. Medicare will no longer pay for treatment associated with the care of hospital-acquired pressure ulcers. As a result, millions of dollars in revenue could be lost for the hospital. Additionally, the presence of a heel pressure ulcer(s) could negatively impact the patient’s physical rehabilitation.

EBP Model: The Iowa Model of Evidence-Based Practice to Promote Quality Care

Evidence: Using the Institute for Clinical Systems Improvement Evidence Grading System, the following grades were assigned to those articles utilized: (1) article-Grade I, (3) articles-Grade II, (7) articles-Grade III, and (1) article-Grade Not Assignable. A review of data from three different hospital-wide prevalence studies conducted from June 2009 to August of 2010 at Hanover Hospital indicated that heel pressure ulcers were occurring in the acute care setting despite the common nursing interventions often taught to prevent such breakdown. Supporting evidence from numerous related articles has proven that implementation of heel off-loading devices is effective in preventing heel pressure ulcers.

Practice recommendations: All patients would be screened to determine if they are at an increased risk for heel pressure ulcers. Patients at risk are (1) unable to lift either or both of their feet off of the bed, and/or (2) have an impaired degree of sensory perception in their lower extremities. Anytime staff documents that a patient possesses either one or both of these risk factors in the electronic medical record, an instant prompt will appear on the clinician’s screen that heel off-loading devices must be implemented until that patient is no longer considered at an increased risk.

References


Practice Question: What is the most effective agent for skin care in the hospitalized patient to prevent or treat skin breakdown especially in those patients with respiratory compromise.

Background: Cornstarch powder has been used in the medical/surgical areas throughout the institution to decrease moisture in skin folds, to reduce friction, and for patient and family comfort. Several nursing areas, including the operating room (OR), brought up the question on the use of powder in the hospitalized patient. Some safety concerns raised against powder were contamination of the surgical site, patients and staff fall risk, and patients and staff respiratory compromise.

EBP Model/Evidence: Review of the literature was based on the “John Hopkins Model for Appraising the Evidence.” Based on potential clinical significance, the Evidence Based Practice/Research Council initiated a formalized EBP project. MEDLINE, CINAHL, Google Scholar and the Cochrane Database of Systemic Reviews were searched comprehensively. Twenty-one articles were initially reviewed and 12 articles of good quality were used to answer our practice question.

Practice Recommendations/Action Plan: Recommendations for staff education included important information on:
· Elimination of powder on all patients going to the OR
· Factors causing skin breakdown
· Avoidance of cornstarch products especially in warm moist environments such as groin, perineum and axilla
· Keeping patients skin clean and dry
· Minimize or decrease use of cornstarch powder throughout the hospital

Our action plan included revising policies specific to skin care. Monitoring powder use throughout the organization, monitoring surgical site infection due to powder use and monitoring fall rates caused by powder.

References
Pre-Operative Fasting: When is it too long?  
Joyce A. Yeager, RN, MSN/Ed, CNOR, Brandy Snell, RN  
Memorial Hospital

Practice question: Are the American Society of Anesthesiologists’ (ASA) Guidelines for pre-operative fasting as safe as NPO after midnight while also promoting improved patient outcomes and satisfaction?

Background: For decades nothing to eat or drink after midnight has been the foundation anesthesia practice to reduce the risk of pulmonary aspiration. However, studies have demonstrated that prolonged fasting is unnecessary, which led the ASA to published new, less stringent guidelines in 1999. Prolonged fasting has been shown to be more than uncomfortable for surgical patients; it can have detrimental pre-operative and post-operative effects. As with many institutions in this country, Memorial Hospital’s Short Procedure Unit (SPU) has continued to instruct patients: “nothing to eat or drink after midnight” These instructions are contrary to the pre-operative instructions listed on Memorial Hospital, Department of Anesthesiology’s webpage, which mirror ASA recommended guidelines.

EBP model: The Johns Hopkins Nursing Evidence Based Practice Model was used to conduct a literature review examining the effects of prolonged fasting versus the ASA Guidelines. In addition, a retrospective review of actual fasting times of Memorial Hospital pre-operative patients entering through SPU over a 60-day period was conducted after receiving IRB approval. Evidence:

Level IA – 5 articles; Level IB – 2 articles; Level 3A – 1 article; Level 4A – 1 article; Level 5A – 3 articles; Level 5B – 2 articles

Practice Recommendations: Based on the results of this project, the ASA Guidelines for pre-operative fasting has been confirmed as safe and effective and should be instituted for healthy pre-operative patients.

Action Plan: Revised Pre-operative fasting guidelines

- Clear liquids until 2 hours before scheduled arrival time at hospital:
  - Water, carbonated beverages, clear juices or fruit drinks without pulp
  - Black coffee or tea- sugar allowed, No milk or creamer
- Patients with arrival times after 12:00 PM may add:
  - Light breakfast at 6:00 AM
    - Clear liquids
    - 2 pieces of toast with jelly or jam, No butter
    - Or 5 plain graham or saltine crackers

References
Prescreening to Identify the Perioperative Patient on Chronic Opioid Therapy Using Sustained-Release Opioids
Karen M. Dykstra, BSN, RN, CPAN
York Hospital

**Practice Question:** Identify if prescreening the chronic pain patient before the day of surgery is safer and would increase patient satisfaction with pain control

**Background:** There is no standardized approach to managing perioperative pain in the chronic pain patient on sustained-release opioids. A pre-anesthetic interview is done by telephone before surgery to verify the patient’s health history and identify medications. The anesthesiologist reviews the assessment on the day of surgery and provides analgesics according to their preferences. Analgesic gaps are created if the patient omits their morning pain medicine, the anesthesia provider doesn’t compensate for the missed doses, and the surgeon writes a postoperative analgesia order that doesn’t consider their patient’s chronic pain condition. The patient may be dissatisfied with the pain management received during the surgical visit and is at risk for withdrawal symptoms if treated the same as an opioid-naïve patient.

**EBP Model/Evidence:** The Johns Hopkins Nursing EBP Model. A literature search produced 42 articles which were narrowed to 2 (Level 4 A/B) clinical practice guidelines and 10 (Level 5 A/B) reviews. Results: Identifying chronically opioid-consuming patients is the responsibility of the entire perioperative team. Preoperative evaluation is necessary to document daily opioid use and plan perioperative pain medicine management.

**Practice Recommendations:** Pre-hospital nurses can identify surgical patients on chronic opioid therapy using sustained-release opioids. A sticker placed on the inside cover of the patient’s chart will remind the anesthesia provider and surgeon that the patient is on chronic opioid therapy, to expect higher perioperative opioid usage, and to take the patient’s baseline requirements into consideration as well as acute pain. A pain management reference guide and pain team consult form can be included in the chart to assist the surgeon in writing appropriate and safe postoperative orders. Recommendations went into effect in October 2010.

**References**


Promoting patient and staff safety
Nicole Edwards BS, RN, CEN and Kandice Geiple BS, RN
Memorial Hospital

Practice Question: What interventions are needed to promote a safe environment for both Emergency Department staff and the crisis patient?

Background: Patient tracking revealed a large increase in the number of crisis patients seen each month and an increase in staff injuries while caring for these patients. Staff verbalized concerns for their own safety, as well as that of the crisis patients. Staff asked for education and tools to improve patient safety, decrease patient agitation, increase patient well-being, and decrease staff, patient, and organizational risk.

EBP model/Evidence: The Johns Hopkins Evidence-Based Practice model of was used for this project. A literature search was conducted using the key phrases of “violence in the emergency department”, “restraint use in the emergency department”, and “patient in crisis in the emergency department”. Several hundred articles were narrowed to a selection of 30. Five key articles were chosen with an overall rating of “4” with a grade of “A”.

Practice Recommendations/Action Plan:

- Enhance crisis patients’ safety by minimizing restraint use and implementing early and frequent assessment and intervention. Staff will be educated about the appropriate use of behavioral restraints, alternate methods, discontinuing restraints as soon as possible, and safe take-down methods for a violent patient.
- Create and implement the Clinical Opiate Withdrawal Scale and Alcohol Assessment Severity Scale in the department. Educate nurses to use the scales to assess all crisis patients initially for symptoms and to re-assess frequently so that escalation is recognized early and addressed.
- Create and implement standard order sets for alcohol and opiate withdrawal with “prn” medications that be given based on patient’s level of agitation based on the assessment scales.

References
**Should patients take an antiseptic shower prior to outpatient surgery?**

Jessica Daniels, RN, BSN
Surgical Center of York, Memorial Hospital

**Practice Question:** Should surgical outpatients be advised to take an antiseptic bath prior to surgery to decrease the risk of infection?

**Background:** Surgical site infections (SSIs) are among the top three health care-associated infections (HAIs), in the United States with approximately 750,000 to 1,000,000 per year. Hospitals are now responsible for the cost of HAIs since Medicare will no longer pay. Hospitals need to be proactive by developing protocols and policies to prevent post-operative infections. SSIs can cause increased recovery time as well as, an increased cost to both the patient and the insurance company. Currently, there are no policies or procedure for outpatient baths in the pre-operative packets or calls given to patients prior to surgery.

Model: Johns Hopkins Nursing Evidence Based Practice Model was used

**Evidence** was collected by researching databases such as CINAL and PubMed using the key terms of antiseptic, bath, shower, chlorhexadine, and pre-operatively. A total of 37 articles were found, with 8 articles relating to the topic. Overall the evidence level was II with a grade of A.

**Practice Recommendations:** The standard use of 2% CHG coated cloths with written instructions should be used by surgical outpatients was indicated after reviewing the research.

Further recommendations include additional education for the pre-operative nurse who call patients, review the current recommendations with physicians, and develop a new policy.

**References**


Strategies to Reduce the Incidence of Symptomatic Catheter Associated Urinary Tract Infection (CAUTI)
Jo Ann Scheu, RN, BSN, M.Ed, Renee Comrey RN, BSN, Caroline Duncan RN, Jennifer Laughman BS, MT(ASCP), CIC, Linda Martin RN, BSN, Cynthia McCoy RN, BSN, Annie Wilt RN, BSN
Hanover Hospital

Practice Question: What strategies can be implemented to reduce the incidence of symptomatic CAUTIs in a community hospital setting?

Background: The urinary tract is the most common site of healthcare associated infections. Most of these infections follow urinary catheterization. The overwhelming majority of urinary tract infections are associated with indwelling urinary catheters. There were no consistent practices in place across the nursing units for the management of the patient with an indwelling catheter. The UTI team, a multidisciplinary committee, was challenged to develop a standard of care to reduce the incidence of symptomatic CAUTIs, of 3.15/1000 patient days, which was well above the national benchmark.

EBP Model: The Johns Hopkins Evidence-Based Practice Model was used for this project.

Evidence: 36 articles were narrowed to a selection of 7. Five key articles were chosen. Level 1 – 1 article, Level 3 – 2 articles, Level 4 – 1 article and Level 5 – 1 article.

Practice Recommendations with Action Plan: A standard of care (SOC) was developed and approved for use. Extensive education was provided to nursing staff, ancillary staff (radiology, rehab medicine, respiratory and laboratory), and the volunteers who transport patients. A sticker system was implemented that required (and reminded) physicians to renew or discontinue catheters every 48 hours. Monthly auditing was performed on each nursing unit.

Results: There was a 30% reduction in the symptomatic CAUTI rate during the year the strategies were implemented. There was an overall CAUTI rate reduction of 83% in the first full year following implementation. During this time period the hospital received a Pennsylvania VHA award for 3 consecutive months for zero CAUTIs. Based on auditing results, compliance with the SOC improved.

References
Translation of Evidence-Based Practices for Preventing Methicillin-Sensitive *Staphylococcus aureus* (MSSA) and Methicillin-Resistant *Staphylococcus aureus* (MRSA) Infections in Patients Undergoing Elective Orthopaedic Surgery

Patricia A. Krieger, MSN, RN, CNOR, ONC, Jennifer Laughman, BS, MT (ASC), CIC, Michelle Baker, MHA, MT (ASCP)
Hanover Hospital

**Practice Question:** What are best practices for preventing MSSA and MRSA post-operative infections in patients having elective total hip and total knee replacements, laminectomies, and spinal fusions?

**Background:** Surgical site infections (SSIs) in orthopaedic patients having implant surgery can be devastating to the patient and costly to the facility. Infection prevention statistics for the first 9 months of 2010 demonstrated 9 SSIs for orthopaedic patients that included one MRSA and 7 MSSA infections.

**EPB Model:** The Johns Hopkins Evidence-Based Practice Model was used.

**Evidence:** A search of the literature was conducted using the search terms MSSA, MRSA, surgical site infection, preoperative nasal screening, and postoperative infection. From these 690 articles, 35 were selected for formal review, and 12 were of adequate quality to be included in the evidence summary.

**Practice Recommendations:** Preoperative nasal screening during preadmission testing for MSSA and MRSA in patients undergoing elective orthopaedic surgery including total knee and total hip replacements, laminectomies, and spinal fusions is the first step in identifying colonized patients. Patients who test positive receive prescriptions for 2% intranasal mupirocin ointment to be used twice daily for 5 days prior to surgery. In addition, all tested patients (both positive and negative) receive educational material, and 4% chlorhexidine gluconate to be used in a daily shower for 5 days prior to surgery. The program was implemented November 15, 2010, and will be evaluated at 6 months and 1 year. Based on the success of the initial population of patients, the implementation may be extended to all surgeries.

**References**


Transforming Care at the Bedside Improves Patient Satisfaction  
Kay Slothour, RB, BSN, FCN; Carol Hopkins, RNC-OB, BSN  
Hanover Hospital

**Practice Question:** Do nursing rounds improve patient satisfaction?  

**Background:** Due to budget crunch, staff numbers and supplies kept at the bedside were decreased, which led to a decline in staff morale. Would this decline in morale affect patient satisfaction? The hospital engages in NRC Picker to conduct quarterly surveys to help assess hospital performance. During 2009, our scores started dropping. The hospital decided to initiate Transforming Care at the Bedside (TCAB), a national program of the Robert Johnson Foundation and the Institute of Health Care Improvement, to see if it would improve ratings.

**EBP Model:** Johns Hopkins Nursing Evidence-Based Practice Model.

**Evidence:** OJIN, AJN, IHI, AJCC, Nursing Center.com. Ten articles were reviewed and evaluated for strength and quality of evidence. Five articles were selected as follows: Level 1 – no articles; Level 2 – one article; Level 3 – one article; Level 4 – one article; Level 5 – two articles.

**Practice Recommendations:** The recommendations included forming an hourly rounding sheet to be placed in the patient’s room and placing a white board in the patient’s room including information on patient’s doctor, nurse, and pain medication last given.

**References**

What is best practice for creating patient education material?
Samantha Obeck, MS, RN
Memorial Hospital

Practice Question: What is the best practice for developing education for heart failure patients to prevent readmissions?

Background: Heart failure (HF) readmissions are a concern for everyone. Readmissions are costly and possibly preventable. Self-management along with medication adherence can improve patient outcomes. A session presented by the Institute of Healthcare Improvement addressed some of the issues surrounding HF readmissions. Health literacy affects a patient’s ability to follow the plan of care. Techniques to enhance understanding of discharge instructions help a patient succeed and prevent readmissions. Our organization has patient education from multiple sources and without a standardized process. As an organization, are we providing the best patient education? Literature reviewing the effectiveness of HF patient education was identified from the following data bases: CINAHL and PubMed.

EBP Model Using the Johns Hopkins Model, 48 articles were found using key search words of HF prevention and control, HF patient education or discharge instructions and patient HF readmissions. 22 articles were selected.

Evidence: The overall evidence rating was IV/V and B quality.

Recommendations: Based on the literature review and lessons from the IHI Expedition: Reducing HF readmissions a HF task force was created. This group developed a HF packet which was presented to the Director of the cardiovascular service line and cardiology. In January a patient focus group will review the packet. Upon approval from the Medical executive group and forms team, the nurses will receive a short in-service. The packet will be distributed to patients admitted with HF. A simple pre and post test will assess patient knowledge level to those who receive the HF packet.

References