

The Essence of Nursing

**Advancing the
Art and Science
of Patient Care,
Quality, and Safety**

PART 2

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Responding to the demand for more “Essence of Nursing”

Your positive feedback to May’s “Essence” supplement inspired us to offer a sequel.

By Melissa A. Fitzpatrick, MSN, RN, FAAN



It’s a pleasure to bring you part 2 of “The Essence of Nursing: Advancing the Art and Science of Patient Care, Quality, and Safety.” We’ve had an overwhelming response to part 1, published in May. It obviously struck a deep chord with our 175,000+ print readers, as well as those accessing the supplement online at AmericanNurseToday.com/the-essence-nursing. In our online surveys, response to this supplement has been plentiful and positive. Thank you for taking time out of your busy day to tell us what you thought of it.

As we all know, nurses are passionate, opinionated, and articulate when it comes to our top priority—meeting the needs of patients, families, and communities. Readers of our May

“Essence” supplement expressed unwavering dedication to enhancing patient outcomes and told us that despite the many challenges they face, they always strive to do what’s right for their patients with compassion, vigilance, and diligence. Several stressed that we need to go beyond simply being present for patients to making them aware of our intentions and always providing the “nurse’s touch.” Some of you said the supplement validated your beliefs, advocacy efforts, and reasons for becoming a nurse in the first place. Your expressions of what the essence of nursing means to you and how it comes through in your daily work were inspirational and heartwarming.

Some readers worried that the increasing focus on computers, technology, and documentation could be imperiling our ability to provide the essence of nursing. Many of you shared the concern that we’re at risk of losing that essence unless we commit every day to manifesting and emphasizing it in our care delivery systems. You validated that the articles in “Essence, Part 1” provided many of the tools, solutions, and evidence you’ve been looking for to accomplish these goals and ensure patients’ safe passage through the care process. Your

feedback was unanimous: You wanted more “Essence.”

Introducing “Essence, Part 2”

“Essence, Part 2” is our response to your request. It covers topics suggested by readers—topics that represent areas of focus and priority for their units and organizations. In your feedback to “Essence, Part 1,” you told us that creating a culture of caring, intentional rounding, preventing falls, promoting mobility, optimizing nutrition, and enhancing the patient experience are top of mind. Working toward these goals enables the essence of nursing to shine through.

Many nurses have been working on these issues for decades. What’s more, these topics have been gaining increasing attention from accrediting bodies, Magnet® Recognition Program appraisers, and the media. Doesn’t it seem that not a day goes by without a news report on infections and communicable diseases? Are you dismayed when you see a coworker go in and out of a patient’s room without washing his or her hands? How often does a neighbor or family member tell you a loved one sustained a fall or acquired an infection or pressure ulcer in your hospital? Who can walk

through a supermarket, go to a movie, or visit a school without noticing the epidemic of morbid obesity in our country—and realizing the pressing need to increase our efforts to optimize nutrition and healthful living?

We asked the authors for “Essence, Part 2” not only to share the evidence and science pertaining to these key issues, but also to describe nurses’ real-world efforts to keep patients safe while managing care within our complex workplace. You asked for specifics on process, collaboration, and results—and our authors have fulfilled your request.

You also asked for examples of real-world conversations on these topics. We know dialogue is the key to reaching consensus on clinical solutions. Here are a few examples from my own experiences talking to nurses about preventing patient falls:

- After a spirited discussion with a group of dedicated falls champions at a large academic medical center, I reviewed the minutes from the past 6 months of their meetings. I saw they’d spent a tremendous amount of time discussing how to designate patients who were at risk of falling. They’d debated whether to use booties, blankets, wristbands, or signs over the heads of these patients’ beds. After months of deliberation, they decided to place a picture of Humpty Dumpty over the head of the bed of every patient deemed at risk (nearly every patient on some units). The decision

left me wondering: Is this a reasonable solution or does it just make these nurses feel as if they’re doing something? How would family members feel when visiting a loved one in the hospital and seeing Humpty Dumpty above his or her head? The nurses’ intentions were good, but the Humpty Dumpty solution leaves much to be desired.

- A group of more than 300 critical care nurses from a hospital in a large Northeast city told me they’d spent more than \$1 million last year on “sitters” for critical care units. Yet their nurse-to-patient ratio was 1:1 or 1:2—which is excellent. In my best Dr. Phil imitation, I asked how the sitters were working out for them. “They just sit there and watch the patient fall,” one nurse replied. We discussed how that \$1 million could have been put to much better use by investing in better nurse communication tools, sensor technology, and more staff.
- Of course, many teams are having conversations that are yielding positive results in falls reduction. I recently made the rounds on a busy med-surg unit with a charge nurse who exuded the essence of nursing. He and his colleagues had taken a data-driven approach to falls reduction. Based on data reported from their connected smart technologies (beds, nurse call and locating system, electronic

signage, and electronic health record), they found patients were falling as they tried to get out of bed to go to the bathroom 1 hour after receiving a diuretic. Once he and his team put all the pieces together, they were able to avert patients’ unassisted attempts to get out of bed, assisting them to the bathroom safely and before it was too late.

Do some of these stories sound familiar? Of course, preventing falls is just one of the many challenges nurses face on every shift, every day. I’m sure each of you has opinions and ideas about what’s working and what isn’t working in your workplace as we strive to decrease all adverse events. I hope you’ll share these with us by providing feedback to “Essence, Part 2,” which describes multidisciplinary, evidence-based solutions to help nurses deliver the essence of nursing. Our authors are nationally renowned experts, frontline caregivers, advanced practice nurses, educators, and consultants who’ve studied these challenges, developed best practices, and collaborated across disciplines to create meaningful changes in their care environments. Never have we needed their expertise more.

Enjoy “Essence, Part 2”—and by all means, let us know what you think by contacting us at AmericanNurseToday.com/send-letter-editor/. 

Melissa A. Fitzpatrick is a member of the Editorial Advisory Board of *American Nurse Today*. At the time this article was written, she was vice-president and chief clinical officer at Hill-Rom.

A culture of caring is a culture of curing

The essence of nursing depends on a healthy, ethical work environment that embraces change.

By Lillie Gelinas, MSN, RN, FAAN

Nursing has a powerful positive impact on patients' lives. Because of its intimate nature, as exemplified by the essence of nursing, nurses can make the most significant contribution to patients' experiences, safety, and healing.

The spirit and spirituality we express through our nursing care reflects the very core of organizational culture. A culture of caring is marked by a sound professional practice functioning within an innovative environment to improve patient and community health. Today, with such a strong evidence base in place to demonstrate the correlation between nursing and outcomes, a caring culture also can be described as a culture of curing—

but not curing in the most obvious clinical sense. High-quality nursing care thriving in a healthy work environment can cure healthcare-related economic woes through better outcomes achieved at lower cost. With this type of caring—and curing—culture, nurses, and nursing practice thrive.

“We’ve never done it that way before”

How do we ensure that a caring, curing culture that nurtures both nurses and nursing practice survives the current winds of change while preserving the essence of nursing? It starts with understanding the type of culture that’s driving the work environment and the staff working in it.

Frequently, culture is described as “what happens when no one is watching,” where the strongest forces that drive nursing practice reflect the attitude that “We’ve *always* done it that way.” In reality, nursing evolves continuously. Some changes occur gradually and may not be readily apparent. These changes are similar to updates for smartphone apps: We accept the update, install it, and don’t need a lot of training to use the new version. In other words, the same work environment and culture that was in place before the change stays in place.

But other changes are more obvious and abrupt, causing the evolution to feel more like a revolution. The resulting transformation can be dramatic, redesigning the work environment as a place nurses and patients might not recognize. Examples include eliminating the centralized nursing station and implementing new technology that changes the world at warp speed, such as robotics. Such dramatic changes can be good, and many come about through innovation. These changes take us from “We’ve *always* done it that way” to “We’ve *never* done it that way.” They can be exciting, igniting the spirit of caring and fanning the flame even more.



George Bernard Shaw said, “You see things; and you say ‘Why?’ But I dream things that never were; and I say ‘Why not?’” When it comes to today’s consumers and the economic demands on healthcare organizations, we obviously need to design new ways of caring, including new ways of caring for both patients and caregivers. This change must take place within the context of high-performance work environments with inspirational cultures. The need for speed and an open mind to create and achieve new ways is crucial. So the next time someone says, “We’ve never done it that way,” you might want to ask, “Why not?”

Ethics, work environment, and impact on caring

Change is all around us, and our response to it determines the level of success we can achieve. Understanding the impact of change and innovation on care and the caregiver is important. Lack of understanding or inability to address the challenges can undermine even the healthiest work culture.

The links between ethics and caring are well-known. However, we’re often hesitant to address moral and ethical issues as soon as the need arises. The result is a drain on both staff and the caring culture. The American Nurses Association’s (ANA’s) Ethics Advisory Board believes an ethical environment or climate is necessary for a healthy work environment: You can’t have one without the other. ANA’s Code of Ethics for Nurses with Interpretive Statements (2015) reflects the nursing pro-

Five types of moral issues

Consider these five categories of moral issues, as described by Rushton and Kurtz (2015):

- **Moral uncertainty** occurs when a nurse is unsure whether an ethical conflict or dilemma is present or what principles to apply to resolve it.
- A **moral dilemma** arises when two or more ethical values or principles conflict, making it hard to choose among them.
- A **moral conflict** happens when two or more stakeholders hold different opinions on how a moral dilemma should be resolved.
- **Moral distress** involves the perception that one’s core values are being violated, as well as a feeling of constraint from taking the course of action that’s perceived to be ethically appropriate.
- **Moral residue** is the lingering feeling that remains after a morally problematic situation has passed.

profession’s ethical values and obligations. A nonnegotiable ethical standard, it serves as an expression of nursing’s commitment to society.

Two provisions in the Code of Ethics offer important guidance related to the need for an ethical environment and a safe, healthy culture:

- **Provision 5:** The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.
- **Provision 6:** The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

This guidance is particularly important when dealing with ethical and moral issues that may arise at any time while delivering nursing care. (See *Five types*

of moral issues.)

ANA defines a healthy work environment as one that is safe, empowering, and satisfying. It’s not just the absence of real and perceived threats to health but a place of physical, mental, and social well-being, supporting optimal health and safety. In healthy workplaces, moral and ethical issues are understood and addressed, and the health and safety of patients and healthcare workers are respected and continuously promoted. In these workplaces, the essence of nursing emerges, reflecting the art of caring, the science of curing, and the soul of our profession.



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The value of purposeful rounding

The authors describe how to customize purposeful rounding to each unit.

By Jane McLeod, MSN, RN, and Sue Tetzlaff, MHA, RN, FACHE, RHIA

Purposeful rounding is a proactive, systematic, nurse-driven, evidence-based intervention that helps us anticipate and address patient needs. When applied to nursing, rounding often is described as “hourly” or “purposeful.” We prefer the latter term, because on some units or at certain times of day, rounding doesn’t take place at hourly intervals.

As we travel around the country and interact with nursing staff and leaders in units and organizations of all sizes, we often encounter nurses’ frustration with purposeful rounding. It’s not that they don’t believe in it; rather, they don’t know how to get purposeful rounding to “stick” because it entails asking staff to reorganize and approach their work in a completely new way to accommodate the rounding schedule. Some caregivers have been organizing their shift the same way for more than 30 years. Rounding forces nurses to change their habits—and as we all know, changing habits is hard. If we expect them to make this change, we have to present them with extremely compelling evidence that rounding works.

Fortunately, the evidence is compelling. A growing body of research suggests effective purposeful rounding can promote patient safety, encourage team

communication, and improve staff ability to provide efficient patient care.

Purpose and intent

Purpose and intent—the forces that make rounding effective—go beyond quickly eyeballing the patient and asking “How are you doing?”, followed by a hasty checkmark on a whiteboard or rounding sheet. Purposeful rounding with intent is a work process that structures the time staff spends with the patient by using an actual or mental checklist of procedures meant to promote optimal outcomes in a clean, comfortable, safe environment. (See *Common elements of purposeful rounding*.)

Making rounding a common practice

The systematic process of rounding is an intentional act conducted with clear purpose for the patient’s benefit. It has significant value for the patient. In light of its value, how can we make it common practice on nursing units?

One way is to organize rounding as a process-improvement initiative. It’s not enough to simply write a new policy, create a new documentation process, and run it by staff at the next department meeting. To succeed, purposeful rounding must be implemented through a formal change-management process, such as the Plan-Do-Study-Adjust cycle.

Also, the change process must involve staff, not just leaders. Recently, a large tertiary-care hospital asked our company to reimplement purposeful rounding 2 years after its initial attempt failed. When we went on-site to meet with the team responsible for reimplementation, we saw it consisted solely of leaders (as it had 2 years earlier). But rounding requires a change in the work of *staff*, not leaders. Our advice to these leaders: “Do it *with* staff, not *to* staff.”

As the process improvement proceeds, the organization should evaluate options related to technology’s role. Emerging technologies similar to call-light systems can assist the new workflow by alerting caregivers when rounding is due. They also can simplify documentation, monitoring, and reporting. Yet while such technologies exist, we’ve also seen successful implementation that didn’t involve technology.

Approaches to purposeful rounding

The implementation team also needs to grapple with how to customize purposeful rounding to each unit. For instance, they need to consider how purposeful rounding will meld with the organization’s nursing model. To accomplish purposeful rounding, facilities can take one of three approaches: primary, team, and functional. (For a description of

these approaches, see the online version of this article.) The team must determine which approach would work best for each unit, develop a checklist of tasks to perform during purposeful rounding, and determine rounding frequency.

Implementing rounding

Once planning is complete, implementation can take place. However, we've often seen change efforts stop at this step. In units that need to tackle multiple improvements or changes, the "Plan-Do" steps for one project may be followed quickly by the "Plan-Do" steps for the next. For the best chance of success in process improvement, each change must be followed by "Study" and "Adjust" activities. The team must make sure to study even the best-planned changes to determine if they're accomplishing their aim and if each change has taken hold. In many cases, adjustments are needed.

Don't skimp on the step of validating that the change really is happening. With purposeful rounding, validation can be both subjective and objective. Subjectively, a leader can round on some or all patients in the unit daily; we call this *validation rounding*. Say to the patient, "I want to make sure that when you need anything at all, your call light is being answered promptly. Is this happening for you?" It's music to the leader's ears when the patient says, "Actually, I never have to ring my call light. My nurse is always right here when I need her."

When following up on findings from validation rounding, leaders can seek out the care-

Common elements of purposeful rounding

As we speak to nurse leaders around the country about improving patient care, several audience members invariably raise their hands to ask, "How do I make purposeful rounding succeed in my department? We've tried and failed several times." To help make rounding stick, we recommend nurses use the checklist below with each patient.

- ☑ **Open your rounding visits with key words and phrases.** Example: "Hello, Mrs. Jones. I'm back for my rounds. May I start with your medications that are due now?" Or: "Good morning. I'm back for my rounds as promised. Last time I was in, you told me you wanted to wait to get in the chair today. May I help you get up now?"
- ☑ **Complete scheduled tasks.**
- ☑ **Ask the patient about and assess pain level, position, and other comfort needs.**
- ☑ **Assist the patient with toileting needs.**
- ☑ **Scan the environment, checking the patient's access to personal items, as well as cleanliness and safety.**
- ☑ **Close with key words and phrases.** Example: "Is there anything else I can do to make you comfortable before I go? I will be back in 1 hour, but please ring your call light if you need me before that."
- ☑ **Explain when you or another caregiver will be back.** Example: "Is there anything else I can do for you? I have time."

giver assigned to the patient to recognize her or him for purposeful rounding. Or, in some cases, the leader may need to ask, "What's getting in your way of purposeful rounding with every patient every hour?" Some of the best ideas for adjustments to rounding can come from conversations between leaders and caregivers.

For objective validation, use data. Are call-light volumes going down? What's happening to patient satisfaction scores for such items as pain and responsiveness of staff? What trends do you see in your unit's patient falls and pressure ulcer rates?

Call to action

For our patients' sake, we need to get beyond our frustrations with purposeful rounding efforts and beyond the perception that

rounding is just another daily task in a seemingly endless list. Remember—purposeful rounding is purposeful work. Patients aren't interruptions in our work; they *are* our work. Purposeful rounding is a proactive strategy that helps us manage our work.

A formal process-improvement initiative driven by frontline caregivers is the vehicle that makes purposeful rounding happen—and makes it stick. If you've tried it and it's not working, try again. If you're about to make that first attempt, just start. 

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Tailoring falls-prevention interventions to each patient

Instead of relying on universal fall precautions, customize care to each patient's unique fall risk.

By Patricia Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP

Falls result from an unsafe environment or known risk factors that haven't been addressed. Although most patient falls are preventable, falls are the top-reported adverse events in hospitals. A leading cause of injury in adults aged 65 and older, falls are the number-one cause of unintentional injury deaths in persons aged 85 and older. In 2010, 45% of the U.S. inpatient hospital population was aged 65 and older. Among these patients, 19% were ages 75 to 84, and 9% were ages 85 and older.

Obviously, preventing falls is a high patient-safety priority. As a nurse, your knowledge, skills,

and expertise are vital to protecting patients from falls and preventing or minimizing injuries caused by falls. Changing our practices and focusing on reversible risk factors can make a big difference.

However, while preventing a fall avoids patient harm, not all falls can be prevented. Protecting patients from falls and resulting injuries requires a population-based approach. That means we can't assume all patients have the same fall risk. As you reexamine your approach to core interventions for falls prevention and surveillance, consider the following do's and don'ts.

Fall risk assessment

DO design and implement an individualized plan of care for preventing falls. Screen patients for risk factors using a valid and reliable risk tool. Follow up with comprehensive nursing and interdisciplinary assessment (such as medical record review, fall and injury history, and cognitive, physical, and function evaluation) and care planning based on fall and injury risk factors.

DO use a team approach. Strong, sustained evidence supports falls prevention based on an interdisciplinary, multifactorial approach to assessment, intervention, and evaluation.

DO evaluate the types of risk factors found. Some individual fall risk factors can be modified; with others, the patient and family or home caregiver must learn to compensate. Defined fall risk factors serve as the patient's "diagnosis list." For each fall risk factor, list specific interventions linked directly to the risk. Then engage the patient and family or home caregiver in care planning.

DO schedule time with the patient and family to review re-



sults of the nursing and interdisciplinary fall risk assessment and defined fall risk factors. Besides engaging them, this educates them about why the patient is at risk for falls and about interventions to mitigate, eliminate, or compensate for each risk factor.

DO provide time for patients to discuss their concerns about falling, identify fall risk factors not on the list, confirm their understanding of their risk factors and interventions, and ask if they have concerns or questions. Make sure all communications with the patient, nurse colleagues, and other team members address *actual* fall risk, not the level of fall risk or a score.

DON'T simply tell a patient he or she is at risk for falls, apply an armband, post a no-falls sign, and report to the next shift that a patient is a high fall risk. These actions alone are inadequate.

DON'T rely only on universal fall precautions. Although these standard strategies help create a safe environment that reduces accidental falls and delineates core preventive measures for all patients, each patient has a unique fall risk based on individual assessment. No evidence supports implementing universal fall precautions alone as the key best practice for reducing fall risk. You must evaluate interventions listed in universal fall precautions for each patient. For instance, not all patients

When to use a low bed

Low beds are designed to reduce the distance a patient falls after rolling out of bed. Although these beds don't prevent a fall, they reduce the distance of a fall, helping to decrease trauma and injury. (Haines et al. found low beds don't reduce falls or injuries from falls compared to matched controls. However, larger studies are needed to determine the effect of these beds on fall-related fractures.)

Keep these do's and don'ts in mind for patients with low beds.

DO place the bed in a low position when the patient is resting in bed or if you're concerned the patient might roll out of bed.

DO use a floor mat at the bedside to reduce impact from a fall.

DO raise the bed to the proper height for the patient to transfer or stand up from the bed.

DON'T leave the bed in a low position at all times. A patient who is 6' tall with weak leg muscles who tries to sit on the bed from a standing position is likely to fall onto the bed, because it's too low for him to lower himself safely. Similarly, if he tries to get up from a low bed without assistance, he's likely to fall back down onto the bed or miss the bed and fall onto the floor.

should be placed in a low bed. (See *When to use a low bed*.)

Proper footwear

Nonskid socks are meant to prevent the feet from sliding. They're used in many clinical settings, probably because going barefoot or wearing standard socks is linked to a much higher fall risk. However, Chari et al. compared slip resistance during mobilization, incline, and descent in patients with bare feet to patients wearing nonskid socks or compression stockings. They found bare feet provide better slip resistance than nonskid socks during mobilization and incline.

DO have patients wear proper footwear. Use nonskid socks to prevent from the feet sliding upon standing. How-

ever, for ambulation, encourage patients to wear appropriate, well-fitting shoes—not nonskid socks.

DO teach patients, families, and home caregivers about footwear recommendations, because financial and comfort aspects are likely to outweigh safety considerations for older patients' footwear.

DON'T put nonskid socks on a patient with a shuffling gait or on a foot with foot drop (impaired dorsiflexion).

Fall surveillance methods

Surveillance systems enable staff to monitor patients before a fall through direct or indirect observation or notification.

DO observe. Rounding allows direct visual observation; cam-

eras provide remote observation. Alarm features on beds and chairs also provide notification. Many hospitals use movement alarms, although evidence on their effectiveness is still emerging.

DO measure the effectiveness of fall surveillance by timeliness of response to a patient's attempts to get up without assistance—*not* by reduction of overall fall rates.

Bed alarms

Bed alarms act as early-warning systems to alert nursing staff that a patient is starting to get up from bed without assistance. They're designed to promote timely rescue, not to prevent falls from bed. Shorr et al. found no statistical difference in fall reduction between units with bed alarms and control units. Bed alarms may even cause harm stemming from false alarms, alarm fatigue, and placing alarms on the wrong patient, so they must be used appropriately. Also, we need more research on bed alarms, in addition to well-designed evaluation of their implementation and effectiveness.

DO consider using bed alarms for patients who are unable to use the call light to call for help, fail teach-back strategies, can't participate in fall-prevention care, or are mobile enough to get up from bed. However, evaluate whether sound from the alarm may cause more harm than benefit.

DO orient patients and family

members to the alarm sound, how it's triggered, and alarm alternatives that could agitate or scare the patient. Alternatives include alarms with voice-over recordings by a family member, integration into a call light or smartphone app to eliminate alarm sounds, and real-time surveillance camera technology that is alarm free but features continuous observation.

DON'T place bed alarms on patients who are immobile, unable to get out of bed, or deemed at high fall risk based on assessment or fall risk score.

DON'T assume one type of alarm technology works for all patients.

Nurses can lead interdisciplinary efforts

As nurses, we must advance falls-prevention practices beyond universal fall precautions based on each patient's score or a level of risk. Use your clinical judgment and expertise when selecting core interventions to protect patients from falling.

As nurses, we're called on to lead nursing and interdisciplinary approaches that individualize plans of care based on actual fall and injury risk factors. Doing this requires nursing leadership within an interdisciplinary approach to care. 

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Boosting the success of a hand-hygiene campaign

Tailoring the campaign to each unit can be the best approach.

By Megan Read, MPH, MLS, CIC, and Karen Chandler, MSN, RN

For nearly two centuries, we've had evidence that hand hygiene reduces healthcare-associated infections. Yet many healthcare organizations still struggle to improve compliance with hand-hygiene guidelines. Like many other facilities, Dartmouth-Hitchcock Medical Center (DHMC) in Lebanon, New Hampshire has launched a series of hand-hygiene campaigns over the years. Although each one yielded some improvements, these weren't sustained.

The Centers for Disease Control and Prevention, World Health Organization, and Association for Professionals in Infection Control and Epidemiology recommend multimodal hand-hygiene improvement programs, because single strategies are unlikely to sustain improvements. Improvement strategies should focus on cultural change, leadership support, education and training, evaluation and feedback, multidisciplinary teams, readily accessible hand-hygiene products, workplace reminders, and monitoring of healthcare-associated infections. Although much progress in hand-hygiene compliance has been made over the last few years, no off-the-shelf, one-size-fits-all improvement program exists.

"Hand Hygiene, A Contact



Sport" is the slogan of our most recent campaign at DHMC. Called Team Care, it emphasizes the importance of performing hand hygiene before and after contact with every patient or with the patient environment. Team Care features the "Triple E" approach:

- **Education**—ensuring staff know why, how, and when to perform hand hygiene
- **Environment**—ensuring hand-hygiene products are available at the point of care
- **Encouragement**—creating

a culture where everyone feels enabled to give a friendly reminder to a colleague who's about to miss a hand-hygiene opportunity. This aspect of the campaign hinges on the concept that sustained improvement comes only by creating a culture where everyone is invested in patient safety.

How Team Care began

At DHMC, each inpatient unit is responsible for initiating hourly purposeful rounding, interdisciplinary rounding, leadership

rounding, and nurse knowledge exchange at the bedside. Units receive a toolkit on minimal expectations for each initiative, which they can tailor to their own unit. Then they share success stories with each other at quarterly meetings. Even though ideas may spread from unit to unit, they're customized to meet each unit's needs.

In 2014, DHMC created the Team Care concept at a safety summit to address healthcare-acquired conditions, such as falls, catheter-associated urinary tract infections, and central line-associated bloodstream infections. We decided Team Care was the perfect platform from which to launch our hand-hygiene campaign.

Electronic hand-hygiene monitoring

Electronic monitoring systems, which monitor hand-hygiene events 24/7, have great potential. At DHMC, we've been trialing an electronic hand-hygiene monitoring system in two units since February 2015. Although the system provides invaluable data, it entails significant work. For instance, staff members must wear a badge that tracks their movements on the unit. They must wear the badge on a visible location on their chest, because the system may record compliance inaccurately if employees keep it in their pocket or cover it with a lab coat. Also, low batteries in the badges or monitors can affect recording.

The manufacturer's representative and facility staff can help identify and troubleshoot problems to ensure the software works properly. Although maintaining

and troubleshooting the system can take time, it's far faster than performing direct observations. Also, the data aren't subject to many of the other limitations inherent to direct observation, such as a small, nonrepresentative sample size, inter-observer variation, and the Hawthorne effect.

All components needed for a successful hand-hygiene campaign still apply when using an electronic monitoring system—leadership, culture change, education and training, product accessibility, and workplace reminders. Based on our experience at DHMC, change management, unit culture, and local leadership can significantly affect campaign success.

Unit variations

During our trial, we quickly saw a dramatic improvement in hand hygiene on a unit we'll call Unit A. Based on manufacturer recommendations, unit leaders started posting their top 10 performers. Staff received this well, even competing to see who could achieve the best hand-hygiene compliance.

Unit B, the other unit that tested the software, also posted its top performers. But unlike Unit A, a competitive strategy didn't motivate all staff members; in fact, it upset some. After some trial and error, the unit eventually achieved success. We believe that success stemmed largely from an automatic report e-mailed to Unit B staff members each morning that showed their individual compliance rate for the previous day. (Unit A chose not to have compliance reports automatically e-mailed each morning.)

Successful trial

Based on our goal of 100% hand-hygiene compliance before and after every patient encounter, we consider our trial with electronic monitoring a success. During the baseline period, registered nurses' in-and-out of the room compliance averaged 50%. (Initially, we found this low rate shocking because direct observation from our infection prevention team typically showed average compliance for nurses exceeding 90%.) As of September 2015, the average compliance for nursing exceeded 80%.

We believe the electronic monitoring system shows great promise in helping us sustain hand-hygiene improvements. Past DHMC campaigns have lost momentum as staff struggled to continue collecting hand-hygiene data through direct observation. In contrast, the electronic system collects enormous amounts of data continually and distributes them to leadership throughout the hospital. With adoption of this software, we believe we will finally sustain improvements in compliance.

We've found that locally owned and driven changes are more likely to succeed. We've seen this both with hand-hygiene priorities and process improvement work. At times, we may feel as though we're reinventing the wheel, but the additional effort pays off when we see sustainable improvements. 

Visit AmericanNurseToday.com/?p=21649 for a list of selected references and a sidebar on frontline ownership.

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Choosing a support surface to prevent pressure ulcers

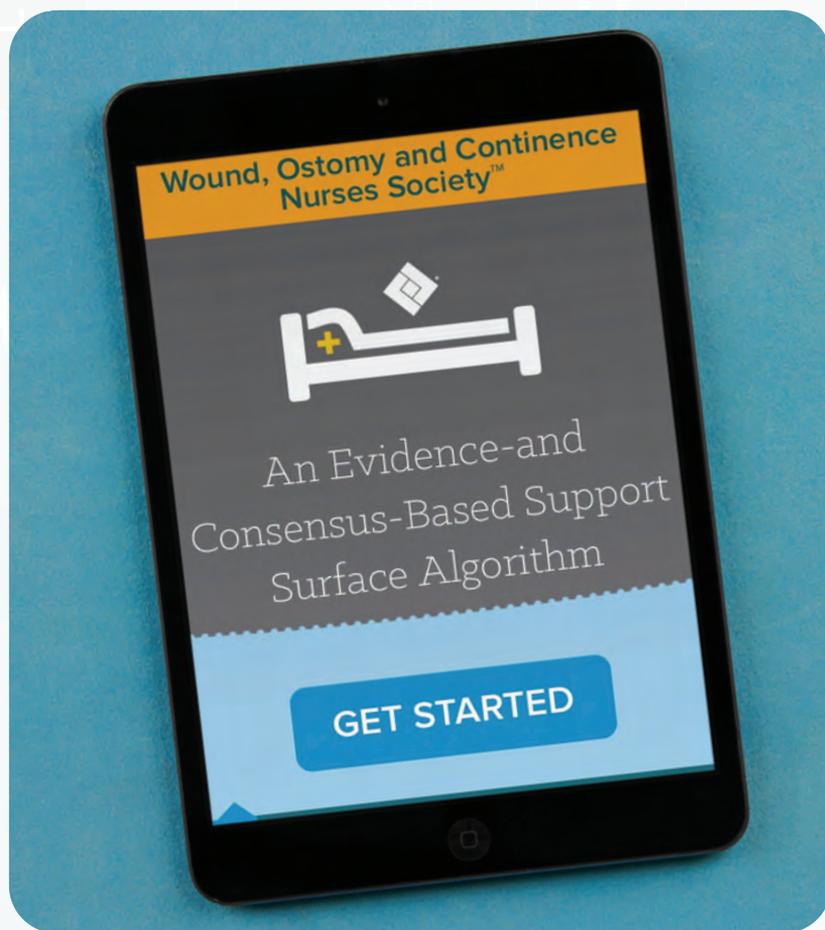
An evidence-based algorithm aids selection.

By Laurie McNichol, MSN, RN, GNP, CWOCN, CWON-AP; Carolyn Watts, MSN, RN, CWON, CBPN-IC; Dianne Mackey, MSN, RN, CWOCN; Mikel Gray, PhD, RN, PNP, FNP, CUNP, CCCN, FAANP, FAAN; and Christopher Carchidi, BA

Nurses in various settings and practices must navigate the complex process of preventing and treating pressure ulcers. Support surfaces play a pivotal role in this process; clinicians use them to redistribute pressure, reduce shearing forces, and control heat and humidity. But with the variety of support surfaces available, ranging from basic to advanced pressure-management systems, how can we determine the best prevention or treatment option for each patient?

Empowering bedside staff with readily accessible tools reduces care delays and increases patient, nurse, and physician satisfaction. Although many wound, ostomy and continence (WOC) nurses leverage their knowledge and experience to select an appropriate support surface, until recently no tool existed to validate their decisions or to guide nonspecialty nurses in their selection. Without national guidelines for choosing support surfaces, reimbursement policies, local factors, or tradition have guided clinicians' decisions.

Recognizing the need for standard guidelines, the Wound, Ostomy and Continence Nurses Society™ (WOCN®) set out to



develop a system that enables nurses and other clinicians to easily determine the right surface for the right patient at the right time. Society leaders discussed several options to address the issue, ultimately opting to create an evidence- and con-

sensus-based algorithm. Once the algorithm was developed, an online version was created for personal computers, tablets, and smartphones, so clinicians can assess patients quickly and easily on both personal and professional devices.

Algorithm development

Creating an algorithm of this type is an intense process. To begin, the WOCN Society identified three experts to serve on a task force devoted solely to algorithm development. Given the vast amount of published academic literature on support

Empowering bedside staff with readily accessible tools reduces care delays and increases patient, nurse, and physician satisfaction.

surfaces (MEDLINE and CINAHL searches returned more than 1,300 references), the task force chose to recruit two methodologic experts to help synthesize existing evidence and link it to decisional steps essential to the algorithm. After a comprehensive review of the evidence, the task force developed a draft version of the algorithm and organized a consensus panel of 20 experts from across multiple practices and geographic locations.

The panel met for a 2-day conference that began with a presentation of task-force activities and a state-of-the-science presentation on support-surface selection. The task force then presented evidence-based statements and the draft algorithm; panel members made recommendations and suggested modifications for clarity. After the

Try it now!

Use the support surface selection algorithm (algorithm.wocn.org) to identify the most appropriate support surface for this patient.

Mrs. M, age 82, is admitted to a medical unit in a large urban hospital with a fractured left hip, caused by a fall in her home.

Previous medical history: heart failure, hypertension, urinary incontinence. She is 5'2" and weighs 145 lb.

Admission lab values: white blood cell count 14,400/mcL, hemoglobin 11 g/dL, hematocrit 23%

Nursing admission notes: Skin intact. Braden score 13 with a mobility subscale score of 2 and a moisture subscale score of 2.

Which support surface would you recommend?

Answer: Reactive/constant low pressure with low-air-loss feature

conference ended, the algorithm underwent a thorough content validation process.

Algorithm publication and online version

The task force published its findings and the final version of the algorithm in the *Journal of Wound, Ostomy and Continence Nursing*. However, the printed algorithm version has limited value to bedside nurses unless they carry a hard copy with them during their shift.

So while awaiting algorithm publication, the task force enlisted WOCN Society staff to translate the algorithm into an easy-to-use, readily accessible tool for clinicians. Staff developed an online version accessible on personal computers, tablets, and smartphones. You can view the algorithm at algorithm.wocn.org; see the box below for a sample.

Launch and reception

The task force presented the algorithm at the WOCN Society's 47th Annual Conference, and

through various simulations gave conference attendees guidance on how to incorporate it directly into several practice settings. The WOC community already has embraced the online algorithm and incorporated it into their practices. Several thousand nurses have accessed it since its release in March 2015. The WOCN Society and the algorithm development task force hope the nursing community will benefit from the algorithm and use it to provide optimal patient care.

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Implementing a mobility program for ICU patients

The author describes five strategies to promote early mobility.

By Darla Topley, DNP, RN, APRN, CCNS

More than 5 million patients are admitted to intensive care units (ICUs) every year, with survival rates approaching 80%. But when they leave the ICU, many patients experience muscle weakness from bed rest and immobility. Some also suffer immobility complications, such as pneumonia and deep vein thrombosis. Early mobility is essential to preventing complications and enhancing quality of life after discharge.

Unfortunately, evidence-based protocols for early mobility are still being developed and aren't easy to find. In 2013, a literature review was followed by a meeting of ICU experts to seek a consensus on safe mobilization of mechanically ventilated ICU patients. It marked the first time a consensus was reached on safety parameters for mobilizing ICU patients. The authors summarized four safety categories to consider when determining if a patient should be mobilized—respiratory, cardiovascular, neurologic, and other (presence of central and arterial lines and surgical or medical conditions). They determined that endotracheal intubation isn't a valid reason for keeping a patient on bed rest; also, early mobilization (getting in and out of bed) is safe for patients with a fraction of inspired oxygen below

0.6, oxygen saturation above 90%, and respiratory rate less than 30 breaths/minute. However, consensus wasn't reached on safe mobilization of patients receiving vasoactive agents.

Of course, mobilizing ICU patients isn't easy, and something can always go wrong. But mobilization is crucial for avoiding discharge of patients with severe weakness, self-care limitations, and poor quality of life.

So why aren't we mobilizing patients sooner? In some cases, nurse staffing concerns play a role. Many nurses worry that mobilizing patients will increase their workload. Compliance with patient mobilization, repositioning, transferring to a bedside chair, or walking may hinge on staffing, patient acuity, resources, and patient assignments. Also, many ICUs lack protocols, activity orders, and guidelines for patient activity.

Changing the culture

The five strategies described below can help foster an ICU culture that promotes early mobility.

1 Lay the groundwork.

Depending on the facility, work on guideline and protocol development, an interdisciplinary project team, electronic health record documentation, statistical reports, and



pilot programs may be prerequisites for initiating an early-mobility program. Also, mobilization equipment must be purchased.

2 Find mobility champions.

Staff members interested in promoting patient mobility can be identified as mobility champions, who can teach staff how to integrate the mobility protocol into daily nursing care. Goals for mobility champions include:

- modeling how to implement the protocol
- reinforcing the importance of patient mobilization
- assisting other staff to ensure maximal adherence to a

Benefits of mobilizing ICU patients

A recent systematic review identified exercise and physical therapy as the only interventions that improve long-term physical function in critically ill patients. Yet one study found only 27% of ICU patients receive physical therapy, with treatments occurring on only 6% of ICU days.

Current literature shows patients can be mobilized safely even while on mechanical ventilation. According to some studies, initiating physical therapy early during an ICU stay can decrease the ICU and hospital stay, lower medical costs, reduce depression, increase exercise capacity, and decrease protein loss.

mobility protocol.

The charge nurse or shift manager can serve as an additional asset by gathering equipment and personnel for patient mobilization and offering the primary nurse additional help for protocol activities.

3 Provide education.

Committed education time for multidisciplinary staff, patients, and families can help everyone understand mobilization risks and benefits. Educate unit staff (including nurses, nursing assistants, nurse practitioners, residents, attending physicians, physical therapists, and respiratory therapists) about the deconditioning effects of an ICU stay and the benefits of patient mobilization. (See *Benefits of mobilizing ICU patients*.) Education can be provided during staff meetings and physician grand rounds, as well as through newsletters, journal clubs, and one-to-one meetings.

Physical and occupational therapists are important team members who can educate staff on how to:

- assess the patient's mobility level and readiness to progress through the mobility protocol, guidelines, or levels
- provide passive range-of-motion (ROM) exercises

- identify mobilization contraindications.

Also, patient education materials need to be developed and given to each patient or family member on admission to the ICU or acute-care clinic before scheduled surgery. Family members need to understand the importance of patient mobility in the ICU environment.

4 Use staff appropriately.

To increase night staff compliance with patient mobilization, ROM exercises can be accomplished on night shift when baths are given, so staff can incorporate exercises into their nightly nursing routines. During the day, nursing or physical therapy staff can perform mobility activities with the patient. In addition, staff should be educated on how to incorporate ROM exercises during usual nursing care, as well as on ways to enlist family help with those exercises.

5 Offer tools for success.

A mobility whiteboard can be developed to hang on the wall of each patient room. Staff can use this board to identify the patient's mobility progress throughout the week and document the number and types of mobility activities accomplished during a shift.

Other tools to promote suc-

cess include theme celebrations (such as "Let's Move it") and marking the hospital floor or baseboard floor every 10' so the patient, family, and staff can quantify the patient's mobility progress. To encourage implementation, leaders can develop incentives, such as paper "mobility bucks" to be handed out to staff in appreciation for following the protocol. Mobility bucks could be used as money in the hospital cafeteria.

Sustaining the effort

With a major project such as early mobilization, sustainment is an important component of culture change. The TeamSTEPS® program, which consists of six steps needed to sustain a mobility program, can help guide an early-mobility sustainment program. The steps include:

1. providing practice opportunities
2. ensuring that leaders emphasize new skills
3. providing regular feedback
4. celebrating wins
5. measuring success
6. updating current plans.

Audits provide a way to gather statistics on mobility protocol compliance. Statistics can be compiled and posted on a unit's quality indicator or communication board and communicated via email or staff meetings. When mobility protocol compliance increases, the unit can celebrate its success.



Visit AmericanNurseToday.com/?p=21651 for a list of selected references, a mobility protocol, and a sidebar on the dangers of mobility.

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Six steps to optimal nutrition care

From initial screening to transition of care planning, nurses play a crucial role in nutrition care.

By Peggi Guenter, PhD, RN, FAAN; Ainsley Malone, MS, RD, LD, CNSC, FAND, FASPEN; and Rose Ann DiMaria-Ghalili, PhD, RN, CNSC, FASPEN

Did you know:

- one in three hospitalized patients is malnourished?
- patients diagnosed with malnutrition stay in the hospital three times longer than other patients?
- surgical patients with malnutrition are four times more likely to develop pressure ulcers?
- nurses are the healthcare professionals who typically conduct nutrition screening as part of admission assessment?

Today, we know that disease-related malnutrition is prevalent and linked to poor patient outcomes, higher readmission rates, and increased costs. Nurses can and should participate in identifying, preventing, and treating malnutrition. (See *Nurse's role in nutrition care*.) This entails a partnership between registered dietitians (RDs) and registered nurses (RNs), with clear interdisciplinary communication throughout the patient's care trajectory.

To provide optimal nutrition care and ensure each patient is assessed for malnutrition, the multidisciplinary care team (including the RD) should take a logical stepwise approach. The six steps in the American Society for Parenteral and Enteral Nutrition's (A.S.P.E.N.)



Adult Nutrition Care Pathway, described below, require documentation in an electronic health record that's robust enough to allow efficient assessment, intervention, and communication across the entire healthcare team. (See nutrition-care.org/malnutrition.)

Step 1: Nutrition screening

The Joint Commission requires nutrition screening for all hospital patients within 24 hours of admission to identify those who may be malnourished or at risk for malnutrition. Assessment findings determine if the patient requires a detailed nutrition assessment. In most cases, nurses perform this screening as part of the general admission assessment.

Step 2: At-risk determination

Adults with any of the following may be considered to be at risk for malnutrition:

- involuntary loss of 10% or more of usual body weight within 6 months, or involuntary loss of 5% or more of usual body weight in 1 month
- involuntary loss or gain of 10 lb within 6 months
- body mass index below 18.5 kg/m² or above 25 kg/m²
- chronic disease
- increased metabolic requirements
- altered diet or diet schedule
- inadequate nutritional in-

Nurse's role in nutrition care

If you think dietitians alone are responsible for patients' nutrition care, think again. In the early part of nursing's modern era, nurses were responsible for preparing patients' meals and assessing and monitoring the impact of nutrient intake (or lack thereof) on their recovery and well-being.

Today, nurses still play a key role in nutritional care. Although we're no longer responsible for overseeing food preparation and delivery, nutrition continues to be an essential domain of nursing practice.

All nurses who provide patient care are responsible for addressing patients' nutritional needs. This can take the form of:

- conducting nutrition screening
- performing assessment and intervention
- providing mealtime assistance and nutrition support therapy
- monitoring, managing, or evaluating the impact of nutrient and dietary therapies.

take, including not receiving food or nutrition products for more than 7 days.

Once you identify an at-risk patient, be sure to communicate this finding to the RD.

Step 3: Nutrition assessment

A comprehensive approach to diagnosing nutrition problems, nutrition assessment relies on a combination of medical, nutrition, and medication histories; physical examination findings; anthropometric measurements; and laboratory data. When conducting a nutrition assessment, check the patient for:

- trouble chewing
- swallowing disorders
- weight history
- height and weight measurement
- skin integrity
- edema
- electrolyte abnormalities
- hand-grip strength (have the patient squeeze your hand).

Generally, an RD or a member

of the nutrition support service performs a more in-depth nutrition assessment. This assessment delineates the malnutrition diagnosis and serves as the basis for the nutrition plan of care.

Step 4: Malnutrition diagnosis

In 2012, the A.S.P.E.N./Academy of Nutrition and Dietetics Malnutrition workgroup identified six malnutrition characteristics to assess. Two or more of the following findings warrants a malnutrition diagnosis, with severity defined further through specific thresholds or parameters:

- weight loss
- inadequate energy intake
- muscle mass loss
- subcutaneous fat loss
- fluid accumulation
- reduced hand-grip strength.

Step 5: Nutrition care plan

The nutrition care plan is a formal statement of nutritional goals and interventions prescribed for the patient, based on nutrition assessment data. The plan includes statements of

nutritional goals and monitoring and evaluation parameters, the most appropriate administration route for nutrition therapy, nutrition access method, anticipated duration of therapy, and training and counseling goals and methods.

Nutrition interventions may include optimizing the patient's oral intake, providing oral nutrition supplements, and administering enteral and parenteral nutrition. Nurses play a key role in implementing these interventions.

Step 6: Monitoring and transition-of-care planning

The patient's nutritional status, nutrition goals, and safety and efficacy of interventions need to be monitored on a continual basis, particularly with transition-of-care planning. Be sure to communicate the patient's nutrition care plan during care transitions. Too often, nutrition interventions stop when a patient is discharged from the hospital; in many cases, the patient needs to be readmitted with worsening malnutrition. Using a transition-of-care plan by nurses (such the A.S.P.E.N. Nutrition Care Pathway) can help prevent readmission of vulnerable patients.

For a list of selected references and a sidebar on three forms of malnutrition, visit AmericanNurseToday.com/?p=21647.

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Promoting early student engagement and proactive prevention of missed nursing care

Simulation technologies can raise awareness of missed care before students provide actual patient care.

By Pamela Wells, DNP, RN, MSHA, and Amanda Pierce-Anaya, DNP, RN, MSN

The difficult transition from student nurse to new nurse can lead to nursing errors, including missed care and untoward patient consequences. Defined as an error of omission, missed care may go by other names—*nursing care left undone, unfinished care, task in-completion, unmet nursing care needs, and implicit rationing of nursing care*. Whatever it's called, it can jeopardize patient outcomes, especially when it's cumulative over time.

According to Kalisch (2012), certain nursing care elements are missed at a higher frequency rate, including ambulation, turning, oral care, glucose monitoring, and vital sign checks. Research supports the positive impact of these basic nursing interventions on quality of care and patient outcomes. Other reportedly missed or delayed nursing care activities include purposeful rounding and catheter care.

Role of technology in preventing missed care

With greater patient acuity comes the need to implement practices that support standards



of care. Healthcare technologies offer proactive decision support and alerts to help prevent missed-care episodes. Without technology to automate reminders and report actionable data electronically, missed care will continue to pose a problem that's difficult to measure and manage. In many organizations, nurses report missed-care episodes manually, sometimes with questionable reporting accuracy.

Some nursing education pro-

grams use healthcare technologies resembling those used in hospital settings, such as the electronic health record and barcode scanning. Simulations give students the chance to practice the skills they need to help prevent falls and infections, maintain patients' skin integrity, and communicate effectively with other interdisciplinary team members.

In education programs that use simulation technologies with electronic reminders, faculty can review students' missed-care

Role of nurse leaders

Nurse leaders can play an important role in preventing missed care by advocating for electronic nursing reminder technologies and their inclusion within nursing standards and job descriptions. To ensure a nurse-friendly design of these technologies, healthcare organizations should collaborate with vendors and information technologists or clinical informaticists.

episodes to raise awareness of the problem before students provide actual patient care. Students with more simulation experience and education on the consequences of missed care are less likely to omit care.

Simulation technologies that include electronic reminders can improve accuracy of missed-care reporting and replace manual methods. Proactive electronic alerts promote prevention of missed care and help students gain confidence in their ability to provide safe, effective care. Similarly, novice nurses can benefit from electronic reminders to prevent missed care. For the broader healthcare team, proactive electronic alerts promote care coordination. (See *Role of nurse leaders*.)

Bridging the gap

As the population ages and many experienced nurses retire, the demand for nurses will continue to rise. To promote good patient outcomes, we need to find ways to bridge the gap between student and practicing nurse. Use of simulation technologies by nursing students can help us bridge this gap and reduce the incidence of missed care.

Students exposed to state-of-the-art nursing unit technologies in simulation laboratories have the advantage of early engagement and heightened awareness of missed care through the use of

Simulation technologies that include electronic reminders can improve accuracy of missed-care reporting and replace manual methods.

proactive electronic reminders. Younger nurses and nursing students are more acclimated to technology in both simulation and actual patient care. Many were introduced to technology in their formative years and thus are more accepting of new processes that use it. Nurses who perceive a positive impact of healthcare technology on their practice and who use care reminders have fewer reports of missed care.

While advanced clinical knowledge undoubtedly enhances patient care, we must never overlook basic nursing care. Each nurse should ask herself, "What's the purpose of this basic intervention to help my patient? If I omit this nursing care activity, what could be the consequence to my patient?" Student simulations and engaging student nurses in the essence of nursing care can help prevent missed care.

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The essence of nursing, in our readers' words

Readers share their “essence of nursing” experiences.

Promoting health and easing suffering—these goals lie at the heart of the essence of nursing. Given the many demands of nursing—call lights, phone calls, alarms, questions, and more—we can easily lose sight of that essence. To help remind us of the heartwarming, touching, and humorous aspects of being a nurse, we asked readers to send us their stories. (For ways to infuse the essence of nursing into your patients' experiences, see *Tips to improve the patient experience*.)

Being a patient

Here are readers' insights into being a patient.

The value of listening

Throughout my childhood, I spent a lot of time in and out of hospitals. During one stay, I met a nurse I'll never forget. She came into my room and introduced

herself. Although she was pleasant, I was a teenager and in a “mood.” I just wanted her to check my vitals, give me my medication, and leave me alone. She must have understood how I was feeling because after her introduction, she gave me medication and left the room.

Later that evening, she came back in. “How are you feeling?” she asked. “Fine,” I replied. She checked my vitals again and then sat down on the bed. “So, what are you working on?” she asked. This simple question sparked a long conversation about college and my dreams and ambitions, which seemed to last forever.

What made this moment so memorable? She listened. She asked questions that weren't health related. She asked about me as a person and my homework. She cared about me as a person outside the hospital, beyond the “patient me.” She truly cared and was interested in me. It was enlightening, thoughtful and encouraging.

Carolyn Weese

Insights from the other side of the bed

Having practiced nursing for nearly 40 years, I know how to approach many healthcare situations. However, I found I wasn't prepared to be a receiver of care. A few years ago, a diag-

Tips to improve the patient experience

Simple things can do a lot to enhance the experiences of patients and their families. Consider these tips:

- 1** Look directly at patients when talking with them (unless it's not culturally appropriate).
- 2** Take a deep breath to center yourself before you enter a patient's room. You don't want patients to pick up on your own stress.
- 3** Make sure your name tag is visible.
- 4** Practice patience with patients and their families. Being in the hospital (or having a loved one in the hospital) is a huge source of stress and not everyone handles it well.
- 5** Keep patients and families informed, even if it's just to tell them you're still trying to reach the physician to increase the pain medication dosage.
- 6** Make regular rounds on patients. Consider using such tools as the four P's from the Studer Group: potty, position, pain, and possessions. (Some organizations use “placement” instead of “possessions” to emphasize the need to ensure that needed items are placed within the patient's reach).
- 7** Listen to the patient.



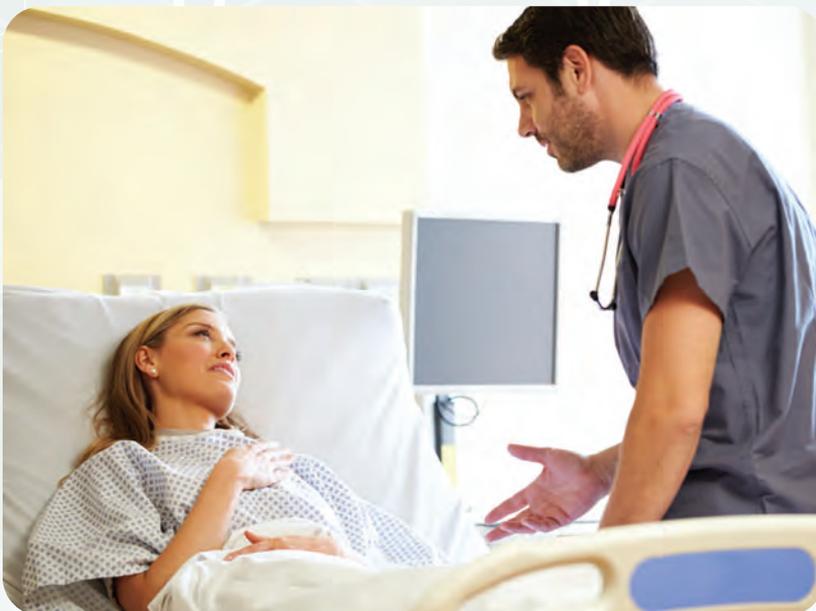


nosis of breast cancer took me by surprise, throwing me into a whirlwind of information gathering and decision making. Although all aspects of my treatment (surgery, radiation, and chemo) were delivered in outpatient settings, I related the experiences to inpatient care. Here are some of the lessons I learned:

- As a patient, I had to be my own advocate. Don't get me wrong: I had excellent healthcare providers. But none of them were mind readers. I

was the only one who knew what I was experiencing, and I had to be very clear about what I needed to get through the process.

- For a healthcare provider to deliver appropriate care, he or she must demonstrate competence and compassion in equal measure. Doing the right things in the correct way with kindness and understanding is what the patient needs and deserves.
- Hope and encouragement,



as well as doses of laughter, are important parts of every patient's plan of care.

*Carol Hatler, PhD, RN
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The little things

After several experiences of being on the other side of nursing care, I realized I prefer to be on the caring side. Nurses can be in control of the caring. A patient is at the mercy of caregivers.

I always wondered how patients can be so accepting of our care. When you're sick, you don't have the physical or emotional energy to even have a voice. Yet you search for the human side in your nurses. When you feel better, you want to show your appreciation. You remember even the little things, such as a housekeeper making sure you had water.

Loraine Strombeck, BS, RN

Easing the fear

As an RN going in to have a carotid endarterectomy, I knew too much for my own good. God must have put this certified registered nurse anesthetist on my case. He knew how terrified I was, and once he had his paperwork done and was waiting on me to go back, he pulled a



chair up and talked to me. He showed me that I meant something to him, even though he'd never met me before, because I was human.

*Nancy Creech, RN, MSN
Nurse Recruiter*

Being a patient's family member

These anecdotes recount what it was like for nurses whose loved ones were in the hospital.

Germ on the cell phone

Please wash your hands and always change your gloves! My husband, a microbiologist with more than 25 years' experience, recently was admitted to his hospital of employment—an acute-care teaching hospital—for a sudden, life-threatening respiratory illness. As an experienced nurse (30+ years as an RN, 16 years as an APRN), I felt I needed to be with him 24/7.

Because of his "unknown infection," he was prescribed a cocktail of highly vein-toxic antibiotics. The RN assigned to his care came in to establish a new I.V. site. During the procedure, she received a phone call on her hospital-assigned cell phone. She promptly answered the phone, responded to the call, and then returned to the procedure. My husband quickly stopped the pro-

cedure and stated, "Please change your gloves! Do you know how many germs are on your cell phone? Cellphones carry ten times more bacteria than most toilet seats."

Antoinette Towle, EdD, APRN

Unforgettable nurses

I am an RN, but I was his wife, the mother of his child, and the one left with a hole in my heart that I thought would never close. He was my world and he was dying. I was helpless, but not hopeless. I'll never forget his nurses—whether I saw them face-to-face or just knew they'd provided care for my husband. And I'll never forget the support they gave to both him and me.

*Nancy Creech, RN, MSN
Nurse Recruiter*

In good hands

My grandson was only 10 months old when he had open-heart surgery for a major defect. While he was there, I discovered the true meaning of a Magnet®-recognized hospital. In the pediatric open-heart ICU, all the nurses were pediatric CCRNs. Thank God! I knew he was in good hands. Now, at age 3½, he's just fine.

*Nancy Creech, RN, MSN
Nurse Recruiter
WTVAHCS*

Humorous moments

These stories reflect the lighter side of nursing.

Blind date

For many years, I worked on an electrophysiology unit (cardiology stepdown), where many of the patients had life-threatening arrhythmias and required a calm, nonthreatening environment. I encouraged one of my frequently admitted patients to talk about his concerns and fears. This led to a discussion of what it was like to stay in the hospital for extended periods and be exposed to many different nurses and personalities. He told me, "It's like having three blind dates a day. How stressful would that be?"

*Peggy Newman RN,
MSN, PCCN*



The art of pickling dentures

The transition unit was short staffed on the 3 PM-11 PM shift, so I volunteered to work. As I assisted a patient with his nighttime routine—cleaning his dentures—he placed his dentures in a small jelly jar with a denture cleanser tablet and water. He shook the jar and watched the tablet fizz, explaining, "I'm pickling my dentures!" We both laughed.

*Julie Thibeau,
MSN, RN, CNOR*

For more readers' experiences, visit AmericanNurseToday.com/?p=21653.

The Essence of Nursing

Use these key points to help you provide the essence of good care.

Be proactive



- Build a caring culture.
- Maintain a healthy work environment.
- Round on patients. Check the four Ps:
 - Potty
 - Position
 - Pain
 - Possessions

Prevent patient harm



- Falls are the leading adverse events in hospitals.
- Evaluate types of fall risk factors found.
- Have patients wear proper footwear.
- Teach patients and families about fall risks.
- Choose the proper support surface to prevent pressure ulcers.

Wash your hands



- Remember, the CDC says hand hygiene is one of the most important ways to prevent infection spread.
- Use CDC education and reminder tools available at cdc.gov/handhygiene/index.html.
- Consider an electronic monitoring system.
- Make sure everyone knows the "5 moments for handwashing" from the World Health Organization:
 - before touching a patient
 - before a clean or aseptic procedure
 - after body fluid exposure risk
 - after touching a patient
 - after touching patient surroundings.

Above all...

Engage patients



- Listen, listen, listen.
- Repeat important information.
- Keep patients and families informed.
- Practice patience.
- Teach patients about their condition and treatments.

Keep patients moving



Some ventilated ICU patients can lose up to **25%** of peripheral muscle strength within 4 days.

Incorporate range-of-motion exercises into care.

Provide mobility education for patients and families.

Use such tools as whiteboards to track progress.

Apply 6 steps from TeamSTEPPS® program for sustaining early-mobility program:

- Provide practice opportunities.
- Ensure that leaders emphasize new skills.
- Provide regular feedback.
- Celebrate wins.
- Measure success.
- Update current plans.

Promote sound nutrition



1 in 3 Number of hospitalized patients who are malnourished

Assess nutritional status, checking for risk factors and:

- trouble chewing
- swallowing disorders
- weight history
- height and weight measurement
- skin integrity
- presence of edema
- electrolyte abnormalities
- hand-grip strength.

Partner with dietitians.

Monitor nutrition status.

be a patient advocate.

Remember—the nurse is the only healthcare professional who's with the patient and family 24/7/365.

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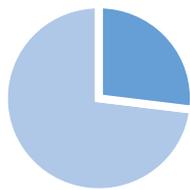
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Reference: Davis K and Kotowski SE, J Nurs Care Qual, Feb 2015.