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Antibiotic stewardship for staff nurses

Five key ways you can influence antibiotic use

By Mary Lou Manning, PhD, CRNP, CIC, FAAN

OVER THE PAST DECADE, antibiotic resistance has increased and spread dramatically throughout the world. According to the Centers for Disease Control and Prevention (CDC), antibiotic use is the single most important factor leading to antibiotic resistance. The CDC estimates that every year, 2 million Americans develop serious infections involving bacteria that resist one or more antibiotics, and these infections kill at least 23,000 each year.

Antibiotic prescribing in U.S. acute-care hospitals is common—and often unwarranted. A 2014 study found that up to half of hospitalized patients received at least one antibiotic and in 30% to 50% of these cases, antibiotics were unnecessary or inappropriate. Such antibiotic misuse contributes to the emergence and spread of antibiotic-resistant organisms, such as methicillin-resistant *Staphylococcus aureus* and vancomycin-resistant *enterococci*. (See *Unheeded warnings*.)

If you're a staff nurse, you've probably witnessed firsthand the consequences of inappropriate antibiotic use, ranging from development of *Clostridium difficile* (a well-recognized cause of health-care-associated infectious diarrhea) to fatal infections with multidrug-resistant pathogens against which no effective antibiotic therapy exists. What's more, antibiotic-resistant infections add considerably to medical costs, with estimates as high as $35 billion a year.

As a nurse, you need to be aware of the dramatic rise in various antibiotic-resistant gram-negative bacteria, including carbapenem-resistant *Enterobacteriaceae* (the "nightmare bacteria") and multidrug-resistant strains of *Pseudomonas aeruginosa* and *Acinetobacter baumannii*. Infections caused by these organisms can significantly worsen clinical outcomes, with mortality rates up to four times higher than infections caused by susceptible strains. The potential for widespread and rapid transmission of these pathogens poses a great danger. (For illustrations of how antibacterial resistance develops and spreads, visit www.cdc.gov/drugresistance/pdf/2-2013-508.pdf.)

Unheeded warnings

In 1928, Alexander Fleming discovered penicillin. By the 1940s, natural and semisynthetic penicillin had come into widespread use. During the latter part of the 20th century, additional antibiotics classes were developed, including cephalosporins, fluoroquinolones, and aminoglycosides.

Antibiotics often are called miracle drugs because they kill bacteria, curing potentially fatal bacterial infections. Not only have they saved millions of lives; they've also have paved the way for significant medical advances by protecting patients after medical and surgical procedures, such as kidney and heart transplants.

However, antibiotics have been used excessively and with little attention to potential resistance. Resistant bacterial strains were detected within 10 years of Fleming's discovery of penicillin. In his 1945 Nobel Prize acceptance speech, Fleming warned of the danger of overreliance on antibiotics and the threat of bacteria becoming resistant. Yet despite warnings from him and others, selective pressure caused by casual, liberal, and unchecked antibiotic use over the past 70 years has made nearly all disease-causing bacteria resistant to one or more of the antibiotics commonly used to treat them.

Today, growing levels of bacterial resistance to antibiotics threaten our ability not just to treat infectious diseases but also to perform other procedures and treatments that depend on affordable, effective antibiotics. To compound the problem, development of new antibacterial agents has slowed, putting more pressure on clinicians to maintain the effectiveness of currently available antibiotics for as long as possible.

A leading health threat

The CDC has named the escalating threat of antibiotic resistance one of the top five health threats in the United States. In response, President Barack Obama issued an executive order directing a federal interagency task force to develop the National Action Plan for Combating Antibiotic-Resistant Bacteria. Released by the White House in March 2015, this document outlined federal actions to be taken over the next 5 years to slow the emergence of resistant bacteria and called for antibiotic stewardship programs in all acute-care hospitals by 2020.

To advance antibiotic stewardship, the White House convened a diverse group of stakeholders at the first-ever Forum on Antibiotic Stewardship in June 2015. Antibiotic stewardship refers to a set of interprofessional coordinated strategies to improve antibiotic use by ensuring that every patient gets an antibiotic only when clinically indicated—and only with the right antibiotic, at the right dose, administered by the right route, for the right duration. A growing body of evidence suggests hospital antibiotic stewardship programs decrease unnecessary antibiotic exposure, slow the development and spread of antibiotic resistance, improve patient outcomes, and save healthcare dollars.

Role of the staff nurse

Nursing's perspective and active engagement are crucial for successful antibiotic stewardship programs. Staff nurses play an important role in addressing antibiotic resistance by participating in hospital antibiotic stewardship activities. Every day, we make critical decisions regarding safe antibiotic administration and monitoring processes and practice.

In 2014, the CDC released the Core Elements of Hospital Antibiotic Stewardship Programs. The ultimate goal of these programs is to achieve the best clinical outcomes for antibiotic use while minimizing antibiotic toxicity and other adverse events, thus limiting the emergence of antibiotic-resistant bacterial strains. Although the Core Elements report doesn't explicitly state the role of nursing, it stands to reason that to achieve optimal success, antibiotic stewardship programs need the active participation of direct-care nurses. Nurses make up the largest segment of healthcare workers and stand at the center of patient care. We spend more time with patients than any other healthcare professionals. We form the cornerstone of the patient-care team, providing consistency, continuity, and coordination of care.

Frontline nurses also bear the crucial responsibility for administering antibiotics. Perhaps most important, in many cases the nurse is the last professional to evaluate the appropriateness of a prescribed medication before it's administered.

How can you contribute to your hospital's antibiotic stewardship program? Here are five key ways to influence antibiotic management decisions and help prevent further emergence of antibiotic resistance.

1. Ensure pertinent information about antibiotics is available at the point of care

In hospitals, antibiotics sometimes are continued unnecessarily simply because some clinicians caring for the patient aren't sure why the antibiotic was initiated or how long it's supposed to be continued. A direct-care nurse who doesn't know why the patient is receiving an antibiotic might have difficulty asking if it should be stopped. If all healthcare team members have access to key information about their patients' antibiotic therapy (including indication, dosage, and duration), nurses would be less reluctant to inquire about changing or stopping therapy when appropriate.

2. Question the antibiotic administration route

An early switch from I.V. antibiotic therapy to oral therapy helps shorten hospital stays and reduces the

(continued on page 6)

How you can avoid laboratory errors

Phlebotomy education, performance monitoring, and feedback can help nurses avoid potentially serious laboratory errors.

By Jean A. Proehl, RN, MN, CEN, CPEN, FAEN

You might be wondering: Since when do nurses make laboratory errors? Actually, we make them fairly often—typically by using improper technique when collecting and handling samples and specimens. Preanalytic errors (those occurring before the sample or specimen is analyzed) account for 60% to 75% of all lab errors. These errors happen before the specimen even reaches the laboratory, usually during collection. They can lead to incorrect laboratory values with a potentially serious impact. For instance, they can result in a misdiagnosis and inappropriate treatment, leading to a life-threatening condition.

Some studies have found higher error rates in blood samples collected by nurses and other non-laboratory personnel, especially in the emergency department. This happens not from nurses' lack of ability but from their lack of knowledge of and adherence to laboratory collection practices. Many factors must be considered during blood collection, so the chance of error is high unless nurses are well educated about the procedure. Common errors in blood sample collection include incorrect identification, wrong tube, insufficient sample quantity, clotting, hemolysis, and contamination.

Incorrect identification

Unlike some other errors, mislabeling of blood samples is 100% preventable. Consequences can be catastrophic if the labeling error goes undetected; in some cases, the patient may receive the wrong blood in a transfusion. Fortunately, the solution is simple: Positively identify the patient and apply the correct sample labels. And never let unlabeled samples or specimens leave the patient's bedside.

Wrong tube, insufficient sample, and clotting

Using the wrong tube, collecting an insufficient quantity, and blood clotting can lead to delays in care and erroneous lab values. Electronic systems that generate labels specifying which type of tube to use can virtually eliminate wrong-tube errors. Otherwise, consult with the laboratory if you're unsure which tube to use.

Also, fill tubes with the recommended blood volume. This is especially critical with blue-top tubes used for coagulation studies, because accurate results hinge on the blood-sodium citrate ratio. Transfer blood from syringes to tubes promptly and gently invert the tube 8 to 10 times to ensure blood is mixed with the additive and to prevent clotting. For a summary of key actions to prevent these errors, see *Preventing blood-collection errors.*

Preventing blood-collection errors

- Positively identify the patient with two identifiers.
- Verify which tubes are needed.
- Fill blood tubes in the correct order.
- Promptly transfer blood withdrawn by syringe into tubes via a transfer device.
- Fill tubes to the recommended volume. If you have trouble obtaining an adequate sample volume, consider using pediatric tubes.
- Gently invert blood tubes 8 to 10 times to ensure adequate mixing of additive and blood.
- Label blood tubes at the bedside.

Hemolysis

Numerous studies have investigated the causes of blood sample hemolysis, but findings are somewhat contradictory. Many studies concluded that compared to peripheral blood draws, blood withdrawn through an I.V. catheter is more likely to lead to hemolysis. But other studies found no difference, and the vast majority of samples drawn by I.V. catheter (more than 93% in most studies) are not hemolyzed. In light of this success rate, plus certain clinical factors (such as patient anxiety and discomfort, as well as the nurse's risk of a needlestick injury), obvious reasons exist for drawing specimens from I.V. catheters.

Nonetheless, take additional steps to mitigate risk by using other hemolysis-reducing strategies as

well. (See *Avoiding blood-sample hemolysis.*) For instance, keep in mind that red blood cells are fragile, so try to decrease the physical forces transmitted to blood at every step of the process. If you encounter resistance or turbulence when withdrawing blood, reposition the needle or catheter slightly to improve the flow. If this doesn't work, consider discarding that blood sample and changing your phlebotomy technique.

Many clinicians believe certain types of equipment can increase hemolysis risk, but conflicting evidence exists on the effects of needle gauge, syringes vs. vacuum tubes, low (partial) vacuum tubes, and pneumatic tube systems to transport specimens. Be aware that drawing blood through an I.V. extension set or a needleless connector hasn't been shown to increase hemolysis. Clearly, no single solution exists for blood-sample hemolysis, so be sure to use a multifactorial approach.

Avoiding blood-sample hemolysis

- Withdraw blood samples from larger veins, such as those in the antecubital fossa.
- Minimize tourniquet time.
- Consider performing direct venipuncture with a steel needle instead of withdrawing blood through an I.V. catheter.
- For difficult withdrawals or slow blood return into a vacuum tube, use a syringe and aspirate gently.
- Fill blood tubes to the recommended level, especially if they will be transported via a pneumatic tube system.

Blood-culture contamination

Each year, more than 1 million blood cultures in the United States are contaminated or produce false-positive results. Contamination may lead to incorrect diagnoses and inappropriate patient care, increased morbidity and mortality, billions of dollars in additional testing, unnecessary antibiotic therapy, and extended hospital stays. Longer stays, in turn, increase patients' risks for additional healthcare-related errors or complications. Inappropriate antibiotic use exposes patients to potential adverse effects, including development of drug-resistant organisms.

Each year, more than *1 million* blood cultures in the United States are contaminated or produce false-positive results.

Contaminants can arise from equipment or the patient's skin, so be sure to clean both. First, wash your hands and assemble supplies. Then scrub the tops of culture bottles with alcohol and let them air dry. Next, find the venipuncture site and clean the skin, using alcohol or a chlorhexidine-alcohol solution; both prevent blood-culture contamination more effectively than other skin-preparation solutions. Scrub the skin vigorously for 30 seconds and let it air dry completely for maximum effect. Unless you're wearing sterile gloves, don't palpate the site after it's prepped. (See *Preventing blood-culture contamination.*)

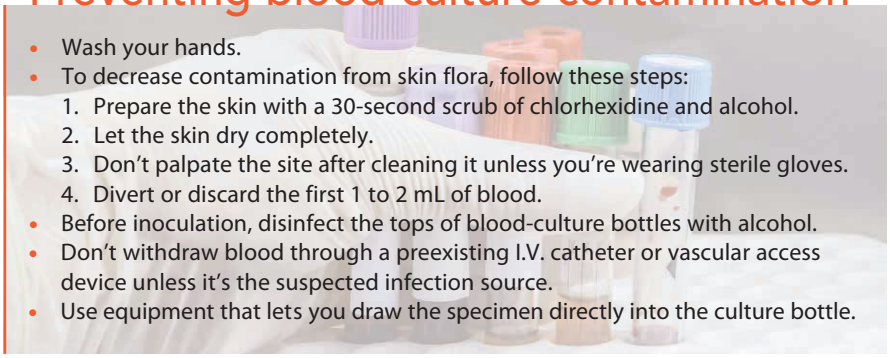
Skin cells can enter the sample from the hollow-bore needle puncture of the skin, causing contamination. To avoid this, divert the first 1 to 2 mL of blood away from the culture bottle with a discarded syringe or plain vacuum tube (the top of which has been prepped with alcohol).

The needle used for venipuncture can cause contamination if it's used to inoculate the culture bottles. Changing needles before inoculation increases the risk of needlestick exposure, so instead use equipment that lets you draw the sample directly into the culture bottle.

Bacteria colonize I.V. catheters rapidly after insertion. Avoid drawing blood-culture samples from a preexisting vascular access device unless the device itself is a suspected infection source. However, know that studies show blood can be withdrawn through a newly inserted peripheral I.V. catheter without increasing contamination. Don't use newly inserted central venous catheters to collect blood cultures because these have been associated with an increased contamination rate.

Limiting blood-culture collection to dedicated phlebotomy staff also has been effective in reducing contamination and decreasing costs and risks associated with contaminated cultures. Other interventions that show promise in reducing contamination are procedural checklists, use of a sterile field, routine use of sterile gloves, and prepackaged supply kits.

Preventing blood-culture contamination



- Wash your hands.
- To decrease contamination from skin flora, follow these steps:
  1. Prepare the skin with a 30-second scrub of chlorhexidine and alcohol.
  2. Let the skin dry completely.
  3. Don't palpate the site after cleaning it unless you're wearing sterile gloves.
  4. Divert or discard the first 1 to 2 mL of blood.
- Before inoculation, disinfect the tops of blood-culture bottles with alcohol.
- Don't withdraw blood through a preexisting I.V. catheter or vascular access device unless it's the suspected infection source.
- Use equipment that lets you draw the specimen directly into the culture bottle.

Collaboration is key

The chain of events used to obtain accurate laboratory test results is long—and only as strong as the weakest link. Collaborate with laboratory personnel to implement an improvement plan that addresses both individual and departmental performance. To help ensure nursing isn't the weakest link, nurses should receive thorough phlebotomy education and training, performance monitoring, and feedback about laboratory errors, especially hemolysis and blood culture contamination. ★

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risk of infection from I.V. catheter access. Every day, assess your patient's I.V. antibiotic therapy for appropriateness. If you have doubts, discuss a switch to oral therapy with the physician and other healthcare team members.

3. Reassess antibiotic therapy in 2 to 3 days

Generally, antibiotics are initiated before the patient's full clinical picture is known. Usually within 2 to 3 days, additional information on microbiology and clinical status becomes available. When it does, consult with the physician or ask the care team during rounds if the prescribed antibiotic is still warranted or effective against the identified organism. If data suggest the patient needs the antibiotic, this can be a good time to advocate for narrow-spectrum antibiotic therapy and ask for clarification about the projected duration of therapy. Be sure to monitor the patient for side effects and toxicity.

4. Review antibiotic therapy when your patient develops a new *C. difficile* infection

The first step in treating a *C. difficile* infection is to evaluate the patient's antibiotic therapy and stop all unnecessary antibiotics. If your patient acquires a new *C. difficile* diagnosis, make sure to review the prescribed antibiotic regimen and discuss with physician and care team whether all prescribed antibiotics are still indicated.

5. Reconcile antibiotics during all patient-care transitions

Patient-care delivery often involves moving the locus of care among sites and providers. To help reduce inappropriate antibiotic use during these transitions, evaluate the need for antibiotic therapy at your patient's transition points—especially between such care settings as hospital and outpatient as well as between points within the facility, such as the intensive care unit and general care unit. Also, direct-care nurses should discuss the indication and duration for antibiotic therapy with other nurses during each change-of-shift report.

Reversing the tide

Improving antibiotic use in hospitals benefits individual patients and contributes to reducing antibiotic resistance nationally. Staff nurses are ideally positioned to contribute to antibiotic stewardship efforts and help reverse the incidence and potentially fatal consequences of antibiotic resistance. ★

Mary Lou Manning is an associate professor at Jefferson College of Nursing, Thomas Jefferson University in Philadelphia, Pennsylvania.

Visit www.AmericanNurseToday.com/?p=23242 for a list of selected references.

Sulfonylureas lower blood glucose in an elderly patient

Drug therapy and skipped meals cause severe hypoglycemia.

By Dorothy Moore, DNP, RN, CCRN

Myrna Klein, age 82, is admitted to the medical-surgical unit from the emergency department (ED) at 9 PM for an exacerbation of chronic obstructive pulmonary disease. She also has hypertension, diabetes type 2, and mild dementia. Ted, her nurse, obtains her initial vital signs: heart rate 89 beats/minute (bpm), blood pressure 145/71 mm Hg, respiratory rate 10 breaths/minute, oxygen saturation 95% on 2 L oxygen, and temperature 97.7° F (36.5° C). Her blood glucose (BG) level is 90 mg/dL.

History and assessment hints

Mrs. Klein tells Ted that her husband and grown daughter care for her at home. She says she was too tired to eat much dinner that day. She is pleasant and slightly confused, although she can be reoriented. Her daughter, who accompanied her to the hospital, says this is her baseline state.

The patient's complex home medication regimen includes glyburide, a first-generation sulfonylurea oral antidiabetic drug. On admission, she was switched to the fast-acting lispro, a sliding-scale insulin. Ted determines Mrs. Klein didn't receive insulin coverage in the ED. As ordered, he performs preprandial and hour-of-sleep point-of-care (POC) BG checks.

Mrs. Klein declines a snack. At 10 PM, Ted sees her sleeping comfortably. An hour later, her daughter, who's spending the night with her, tells him, "Something's not right with Mom."

On the scene

Ted finds Mrs. Klein hard to arouse, confused, and slurring her words. Her daughter tells him her mother slept most of the day, didn't eat, and took "all of her meds," including glyburide at home at 7 PM. On assessment, Ted finds the patient's hands cold and clammy; her heart rate is 110 bpm. A fingerstick BG level reads 38 mg/dL. Per standing orders, Ted immediately administers 1 ampule of dextrose 50% I.V. and alerts her primary care provider. Mrs. Klein revives quickly. A POC BG check shows a level of 120 mg/dL.

Mrs. Klein is transferred to a step-down unit. Because patients who've taken sulfonylureas may experience refractory hypoglycemia, she's placed on a protocol that includes hourly BG checks and I.V. fluid containing 5% dextrose.

Outcome

In the step-down unit, Mrs. Klein is observed for 24 hours, where she has no further hypoglycemia signs or symptoms. Her primary care provider reevaluates her medications and decides to switch her from glyburide to a different oral antidiabetic class.

Education and follow-up

Hypoglycemia is a serious and potentially lethal problem for all patients, particularly the frail elderly. Stay alert for factors that can cause hypoglycemia in these patients—sulfonylureas, polypharmacy, illness, declining kidney function, skipped meals, increased activity or exercise, and previous hypoglycemic events. After care transitions, take the time to understand the patient's medication history, including the last time the patient ate and took medications.

Glyburide stimulates the pancreas to secrete insulin; in patients who skip a meal, it can cause hypoglycemia. Also, it stays in the body for up to 24 hours, prolonging hypoglycemia risk. The drug peaks at about 4 hours and in some cases can cause abrupt hypoglycemia onset. To anticipate and prevent hypoglycemia in patients on sulfonylureas, make sure you understand the onset, peak, and duration of these drugs. Given the hypoglycemia risk with oral antidiabetic drugs and insulin, many practitioners now de-emphasize strict BG control in the frail elderly. Instead, they set patient-specific goals and focus on quality of life, including healthy eating.

Ted's quick response to Mrs. Klein's declining level of consciousness helped prevent a poor outcome. On discharge, he teaches Mrs. Klein and her family about hypoglycemia signs, symptoms, and treatment; the need to check her BG level regularly; and the importance of taking oral antidiabetic drugs with meals. ★

Visit AmericanNurseToday.com/?p=24229 for a list of selected references.

Dorothy Moore is an emergency department staff nurse at Kaiser Medical Center in Oakland, California and an adjunct lecturer at California State University in Hayward.

VIEWPOINT

Let's take the lead in educating the public about nursing

By Sandy Summers, MSN, RN, MPH, and Harry Summers

Lack of respect for nurses undermines our profession.

Editor's note: The authors are the executive director and senior advisor, respectively, of The Truth About Nursing, a nonprofit organization that seeks to increase public understanding of nurses' role in health care and to promote more accurate, balanced media portrayals of nurses.

AMERICANS continue to rate nursing as the most honest and ethical profession. And in private conversations, many people rave about nurses' virtue and compassion.

But as we saw last September with ABC's television show *The View*, public affection for nurses doesn't mean everyone understands the education and skill needed to practice nursing. The show's hosts mocked a Miss America contestant for the monologue she performed in the talent competition. Dressed in scrubs, sneakers, and a stethoscope, Miss Colorado Kelley Johnson, a registered nurse, spoke about her conversations with an Alzheimer's patient. One *View* host sarcastically remarked, "She shockingly did not win." Another asked why she had on "a doctor's stethoscope." Clearly, these comments reflect lack of respect toward nurses—an attitude that undermines the nursing profession and puts patients at risk.

So who should take the lead in improving the public's understanding of nursing? Dr. Oz? Oprah? No—nurses should. We must play the leading role in educating the public about us. We have the power and responsibility to foster change for our profession.

Project a strong self-image

Obviously, we need to change how media outlets portray nursing. But global change starts with local action. Certain stereotypes have damaged nurses' self-image—to the point that some nurses need to be reminded of their own value before they can persuade the public of it.

To convey self-respect, project a professional image in all interactions. When you meet someone (including patients), introduce yourself as a nurse. Include your last name, as physicians do. This doesn't mean you should be cold or formal; just do what other self-respecting professionals do. Tell patients what your role is, including your duty to advocate for them, even in a casual way. (For ideas on what to say, download our organization's poster, "I am your registered nurse," at http://goo.gl/q86gVY.)

Consider "nursing out loud" by describing your assessments and interventions as you perform them (consistent with patient confidentiality and sensitivity). This can help patients, family members, and physicians better understand your education and skills.

Even your clothes influence how others see you. Some nurses wear scrubs with cartoon characters on them. But consider: How many physicians, architects, teachers, or other educated professionals do that?

Educate colleagues

Nurses already teach physicians a lot about clinical care, but they could do more to show physicians the value of nursing itself. You might consider starting a

joint learning or nurse-shadowing program, such as those at the University of Michigan Medical School (http://bit.ly/1Og5nUu) and Dartmouth Medical School (http://bit.ly/DartmouthShadowing).

Don't hide

The benefits of nursing care—including preventing adverse events—can be hard for people to see. At the same time, many nurses have become expert at masking their expertise, in part to avoid conflict with physicians.

But that's dangerous. We must advocate for patients and ourselves. We're not saying you should brag, but don't let others get credit for nurses' lifesaving work. If not for yourself, do it for your colleagues. We've designed a bumper sticker that tries to help; it reads: "Save Lives. Be a Nurse." Contact us at info@truthaboutnursing.org and we'll send you some.

Advocate for progress on public health matters

In 2014, the American Nurses Association (ANA) advocated on behalf of a Navy nurse who declined on ethical grounds to participate in force-feeding detainees at Guantanamo Bay. When nurses and nursing organizations speak out on such issues, the public sees they are committed, engaged healthcare professionals.

Establish relationships with local media representatives and try to get coverage for nursing in your workplace. Many hospital websites highlight only physicians, so consider forming a working group to increase awareness of nursing achievements and innovations. Tell your organization's public relations personnel about nursing expertise and ask them to promote the organization's nurses to the media as health experts. Make it a priority to help media producers and reporters understand nursing when they ask. Respond promptly and, once again, don't hide. Many nurses shrink from media attention and hide from the cameras. But remember—nurses save lives, and nursing deserves positive attention.

Some nurses gain positions of influence and appear in the media—yet their nursing status doesn't appear with their image or name. So try to display your degree and RN status; if you can use only one credential, use "RN." That shows the public you are a nurse. Your language will reveal your education.

Seek to change media portrayals of nurses

To improve media portrayals of nurses, we need to work directly with media outlets. You can help by developing your own media expertise. Observe experts who appear on major media outlets. Focus on good presentations of nursing, like Diana Mason's 2014 appearance on the *Katie* show (http://bit.ly/DianaKatie) during a tribute to nurses. If you expect to have ongoing contacts with the media, consider getting formal training. (Visit www.truthaboutnursing.org/action/media_training.html for resources.)

Praise the media for what it does well

For many years, The Truth About Nursing has issued annual awards for the best and worst portrayals of nursing. We try to find positive elements even in media reports or programs that are harmful to nursing. Of course, that can be difficult. (Yes, we're looking at you, *Grey's Anatomy!*) Submit feedback to media outlets; phone calls and hard-copy letters probably have the biggest impact, but you can also give positive reinforcement through email, social media, and Twitter hashtags (for example, #midwife delivers information to new readers about OB nursing expertise).

Persuade the media to reconsider specific content

When you observe negative nursing portrayals anywhere—TV shows, advertising, websites, billboards, or elsewhere—contact the responsible party and urge them to reconsider. Suggest specific alternative approaches for the media outlet to consider. Advocate for positive nursing portrayals via social media, phone calls, emails, and letter-writing campaigns, as The Truth About Nursing has done with petitions on Change.org (http://chn.ge/1AJuUwr). When trying to influence ongoing media portrayals, such as advertising, identify key decision-makers; then collaborate

(continued on page 15)

Scrubbing out MTV's "Scrubbing In"

Changing media portrayals of nursing doesn't always happen as quickly as it did with *The View*. In October 2013, MTV introduced the nurse reality show *Scrubbing In*. The program included degrading sexual imagery and reality-show drama, with virtually no impressive clinical interactions.

Wisconsin nursing student Milka Stojanovic started a Change.org petition to cancel the show. Using social media, she and Ontario nurse Tyler Kuhk got more than 30,000 signatures. Nursing groups, including the Canadian Nurses Association, called for the show's cancellation. The Truth About Nursing added a petition with an analysis of the show, which gained more signatures.

MTV executives contacted The Truth About Nursing to negotiate. Ultimately, the network agreed to air the remaining episodes at a less prominent time, reedit later episodes, and take steps to convey accurate information about nursing. They also worked with us to create two MTV website features, one providing information about becoming a nurse and the other a day-in-the-life portrait of a skilled New York City nurse.

Medical alert: Delirium do's and don'ts

By Ann Kolanowski, PhD, RN, FAAN

DELIRIUM is a state of confusion and altered level of consciousness that comes on suddenly and lasts for hours or even weeks before resolving. A serious and often deadly medical condition, it requires prompt action by healthcare providers.

Delirium commonly affects critically ill patients, frail older adults, the very young, and those with preexisting cognitive impairments. The American Delirium Society (americandeliriumsociety.org) estimates that more than 7 million hospitalized Americans suffer from delirium each year. These patients have higher mortality rates, longer hospital stays, and a higher risk of developing dementia than those who don't experience delirium. They're also more likely to be institutionalized. For all of these reasons, healthcare providers should initiate measures that prevent delirium in those at risk, be able to detect delirium when it occurs, and treat delirium in a timely fashion.

Prevention

Anyone at any age can develop delirium, but generally the condition occurs in neurologically vulnerable patients when they experience stressful events. Major surgery, sepsis, adverse drug reactions, untreated pain, lack of sleep, bed rest, physical restraint, and sensory deprivation are common precipitating causes.

Follow these tips to help prevent delirium:

- *Do* identify those at greatest risk for delirium and reduce stressful factors that are modifiable. For instance, ambulate patients early and often; promote sleep hygiene using nonpharmacologic interventions; make sure patients who need eyeglasses and hearing aids wear them; use engaging and reaffirming conversation; orient the patient to the surroundings; provide cognitive stimulation; and maintain hydration and nutrition.
- *Don't* use physical restraints or medications that unnecessarily increase cognitive burden. (See 2015 Updated Beers Criteria at http://onlinelibrary.wiley.com/doi/10.1111/jgs.13702/abstract.)

Detection

Nurses and physicians commonly fail to detect delirium, especially in older adults and those with dementia. Become familiar with delirium signs and symptoms: acute and fluctuating changes in cognition or mental status, inattention, disorganized thinking, and altered level of consciousness. Remember that delirium can manifest as hyperactive or hypoactive subtypes, the latter being common in older adults.

- *Do* establish every at-risk patient's baseline mental status by asking the patient, family, or those most familiar with the patient (such as a nurse in a long-term care facility) if they've noticed a recent change in mental status.
- *Do* screen at-risk patients for delirium at least once per shift using a valid, reliable tool, such as the Confusion Assessment Method. Promptly report changes in mental status to the primary care provider.
- *Don't* assume confusion is normal in older adults or those with dementia.

Treatment

No established treatments for delirium exist because the underlying disease mechanisms are unknown. Little evidence supports the use of antipsychotic medications, which may actually prolong the delirium.

- *Do* try to identify what might have precipitated the delirium, such as an overwhelming infection, and intervene accordingly. Use nonpharmacologic methods (see "Prevention" do's). Also, use sitters to ensure safety and timely support for the patient. During transitions across the healthcare system, provide all patients, their family members, and healthcare providers with an appropriate delirium treatment plan that ensures ongoing follow-up.
- *Don't* make delirium worse—for instance by administering p.r.n. sedative, antipsychotic, or hypnotic medications to treat delirium without first addressing the underlying cause.

The American Nurses Association has partnered with the American Delirium Society to promote delirium awareness and provide education for all nurses. Watch for upcoming delirium webinars and conferences sponsored by these organizations to improve the quality of nursing care you give to prevent, detect, and treat delirium. ★

Ann Kolanowski is a professor in the College of Nursing at Pennsylvania State University in University Park. She serves on the Delirium Steering Committee, a collaboration between ANA and the American Delirium Society, and is a member of the Pennsylvania State Nurses Association.

Tools to improve your collaborative skills

By Meigan Robb, PhD, RN, and Teresa Shellenbarger, PhD, RN, CNE, ANEF

Learn about technology-based solutions that can make collaboration more effective.

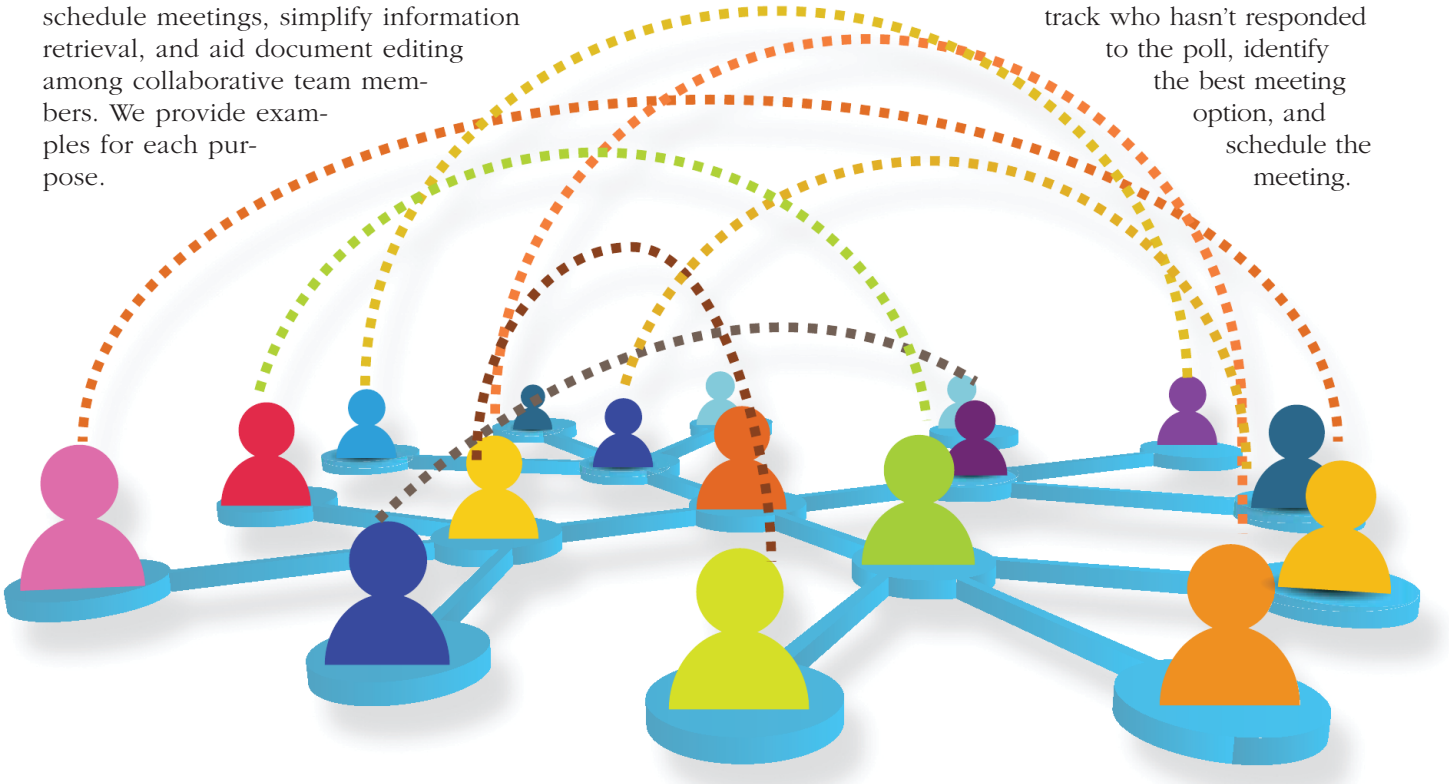
No matter what your practice environment, you need to collaborate effectively with other nurses and other disciplines to excel in your career. Nurses are expected to participate in joint initiatives that embrace research and evidence-based practice. Through collaborative projects, valuable changes can be made to educational processes, administrative practices, and patient-care protocols.

As you're no doubt aware, role, time, and resource demands can create barriers to successful collaborative endeavors. Fortunately, online applications and mobile technology offer solutions that reduce time and location restraints. This article discusses technology-based services and apps you can use to schedule meetings, simplify information retrieval, and aid document editing among collaborative team members. We provide examples for each purpose.

Scheduling meetings

Working collaboratively requires attendance at group meetings, where team members can brainstorm, assess progress of activities (such as development of evidence-based practice guidelines), and disseminate information. But scheduling meetings can be tricky, burdensome, and time consuming. Traditional methods, such as calling people to determine their availability or asking them to e-mail their availability, can lead to wasted time as numerous emails are exchanged or people wait for phone calls to be returned. Technology provides a powerful and efficient alternative scheduling method.

With Doodle (doodle.com), a free online service that doesn't require an account or registration, you simply identify dates and times for a possible meeting and create an electronic poll that outlines those dates and times for group members' consideration. Then you share the poll by email with team members and invite them to respond online. Each person can quickly and easily enter his or her availability for the specified dates and times. As the scheduler, you can monitor poll activity, view a visual result summary, track who hasn't responded to the poll, identify the best meeting option, and schedule the meeting.



You can also synchronize the meeting with your electronic calendar. Doodle eliminates frustration associated with traditional scheduling and allows group members to use their time more efficiently. Similar services include WhenIsGood (whenisgood.net) and TimeBridge (timebridge.com).

Online apps and mobile *technology* help reduce barriers to successful collaborative endeavors.

Simplifying information retrieval

Healthcare providers can encounter clinical problems that may require them to find references and research to support their work, gather additional information, or review materials to aid decision making and implement practice changes. They may need to share these materials with colleagues. Typically, resources are retrieved from the Internet or databases and stored on an individual's desktop or laptop computer, flash drive, or mobile device. However, this method can be unacceptable or cumbersome if reference files are misplaced, documents are duplicated across platforms, information is inaccessible at certain remote locations, or a flash device becomes corrupted or unavailable. Technology offers a more efficient way to manage resources across platforms and share materials with colleagues.

Mendeley (mendeley.com) is a free reference manager with cloud storage capabilities. It allows users to create a personal library of reference documents, annotate and make notes on saved PDF files, import new documents, and export documents and notes in a public or private community. Team members can access up-to-date resources as information is synced across all devices. Mendeley also lets you easily generate appropriately formatted reference lists from your stored resources and makes managing resources easier for collaborative activities that require references. Zotero (zotero.org) and Citeulike (citeulike.org) offer similar reference management tools.

Aiding document editing

Collaborative projects commonly require team members to draft proposals, reports, and presentations for use in developing new initiatives, monitoring projects' progress, and disseminating information to others. Traditionally, one team member creates the document and shares it with team members by email; each person then makes edits, saves the file, and shares it with other team members. But this process can lead to poor use of time and decreased productivity through lost files, time spent searching through emails to locate the document, or someone mistakenly editing the wrong file version.

Dropbox (dropbox.com) supports secure file synchronization and backup. It offers 2 GB of free cloud storage space that users can access from any Internet-capable device; additional storage space is available for a fee. You simply set up an account, which generates a user's folder. After creating a file, you save your work to the Dropbox folder, which is automatically updated and synchronized across devices and among users. Then you invite others to share the folder and access the saved files. Invited users access a secure environment where the document isn't accessible for public viewing; the files and folders are available only to invitees. Within the special user folder, you and other team members can create additional folders to categorize and sort files.

Using Dropbox gives you and other team members immediate access to current files for editing. Because the service notifies each invited team member once a file has been updated or a new document has been added to the shared folder, it takes the guesswork out of which file is the most current version. Similar services include Google Drive (google.com/drive/) and Microsoft OneDrive (onedrive.com).

Points to consider

Before using any of these apps with a team, assess individual team members' technology skills. Even though these apps promote collaboration, they shouldn't be used if they will frustrate someone who lacks the technology skills to implement them. Instead, find supportive resources, such as online tutorials or website support for the app in question, or take the time to help those team members gain the technology skills they need.

Using applications like Doodle, Mendeley, and Dropbox with your team to schedule meetings, retrieve information, and edit documents can optimize communication, save time, enhance productivity, decrease frustration, and promote sharing of work, all of which makes collaboration easier and more effective. Effective collaboration will help you achieve personal and team goals—and advance your career. ★

Meigan Robb is an assistant professor of nursing at Chatham University in Pittsburgh, Pennsylvania. Teresa Shellenbarger is a professor in the nursing and allied health professions department at Indiana University of Pennsylvania.

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Improving your coaching skills

By Rose O. Sherman, EdD, RN, NEA-BC, FAAN; and Tanya M. Cohn, PhD, MEd, RN

Employees value managers who develop a coaching style of managing.

SUSAN *is a seasoned nurse on a telemetry unit. One day, she arrives 20 minutes late, without explanation, to a mock code that the unit clinical educator is holding. The educator asks her to leave because she can't participate in the code in progress. Susan is offended. She sees herself as an experienced nurse and has complained in the past that mock codes are a waste of time.*

The clinical educator reports the incident to Nancy, the unit manager. Nancy schedules an appointment with Susan and the clinical educator to discuss the incident.

Coaching is a critical part of the nurse leader's role. But a busy leader like Nancy may have difficulty finding time in her schedule to work through performance issues such as Susan's. Nancy's initial reaction of exasperation could stem from her frustration with Susan and her belief that she shouldn't be cavalier about participating in mock codes.

Michael Simpson, a coaching expert and author, recommends leaders adopt a viewpoint that coaching is about understanding that everyone can grow and become better despite the situation that's driving the coaching. Coaching unleashes a person's potential.

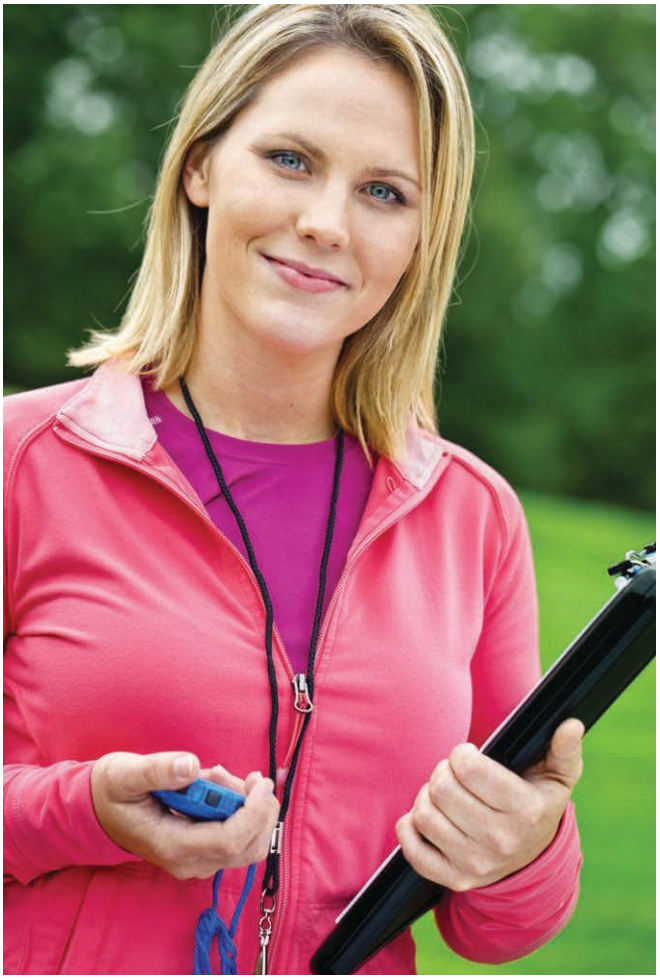
Good coaching is an art. A good coach is an active listener and adept at asking open-ended, reflective questions. The investment a nurse leader makes in becoming a skilled coach can have a profound influence on staff engagement. Mary Koloroutis, an author and healthcare consultant, suggests that when coaching, leaders should emphasize the present moment with a willingness to help staff members let go of their past mistakes, make new choices, and forge a different future.

Six stages of coaching

To coach staff members to a higher performance level, work in stages, as described below.

Stage 1: Build an atmosphere of trust

Trust is an essential component of a healthy coaching relationship. You can't be an effective coach if you don't have genuine concern for the welfare of the person you're coaching. The coachee deserves and expects honesty, integrity, sincerity, and confidentiality. Whatever takes place within the context of the coaching environment must remain confidential.



Stage 2: Clarify the purpose of coaching

As a leader, you need to be specific about the coachee's unacceptable behavior in an objective, nonjudgmenntal way. For instance, Nancy needs to ask Susan reflective questions to gain insight into her behavior and find out what she found challenging in the mock code situation. She also needs to ask why she chose to come 20 minutes late to the mock code without offering an explanation.

Assessing your coaching effectiveness

To improve as a coach, practice self-reflection after each coaching session. Replay the session in your mind, assessing your vocal tone, energy pattern, and awareness of your reactions. Consider this a chance to critique yourself and think about what you might have done differently.

During self-reflection, ask yourself the following questions:

- Could I have used a different approach that might have been more successful?
- Did I talk too much and listen too little?
- Did I ask questions the right way?
- Did I end up with the coachee's commitment to act?
- Did we develop a follow-up plan together?

Self-reflection nurtures open-mindedness

For many coaches, their deeply held views frame their thinking, which can lead to narrow-mindedness. Self-reflection can open their minds. As natural problem solvers, nurse leaders may want to jump into a discussion of the incident in question as an example of inappropriate behavior, and they may try to devise an instant solution. For instance, Nancy could simply have pulled Susan aside and told her she needs to be on time and play an active role in mock codes. But if instead she coaches her in a focused, nondistracted way, the outcome can be much more powerful.

Stage 3: Ensure a commitment to improve

Coaching for the purpose of improving staff performance can be challenging unless both parties agree on the need for change. Nancy needs to be clear that Susan didn't meet performance expectations in the mock code situation and should explain why even experienced staff must participate in mock codes.

Stage 4: Explore alternative behaviors

In this stage of coaching, Nancy could help identify solution-oriented strategies by asking Susan such questions as, "What would you do differently if this happened again?" The best strategies come from the coachee. In our scenario, these would be strategies Susan believes are feasible and achievable. Performance expectations for alternative behaviors need to be made clear, and strategies should be specific and action-oriented.

Stage 5: Get a commitment to act

Once the two parties choose a corrective strategy, the coachee needs to commit to working on changing her behavior. The coach should ask her if she can do anything else to help her achieve the desired behavior change. If this desired change is critical, the coaching plan should be written down and both the coach and coachee should sign it.

Stage 6: Provide feedback

Effective coaching involves giving timely and specific performance feedback. During the next mock code, Nancy will want to give Susan feedback about her performance in a positive, encouraging way.

Dos and don'ts of coaching

In your role as a coach, follow these guidelines:

Do use a person-centered, solution-focused approach

To make coaching both person- and solution-focused, be mindfully present during the coaching session. Although tuning out the demands of running a unit can pose a challenge, you should silence your phone and ignore emails or texts during this time. Instead, focus your full attention on the coachee. Maintain eye contact and listen actively to fully understand her perspective.

Do ask reflective questions

Ask the coachee questions that elicit her reflections on the situation in question. For instance, Nancy should ask Susan questions that elicit her perception of the value of mock codes, the need for nurses to always conduct themselves professionally, and the essentials of being part of a team in a unit.

Do draw a line between acceptable and unacceptable behaviors

Be clear with the coachee about what behavior is and isn't acceptable, so that neither the coachee nor other team members view unacceptable behavior as appropriate.

Do use silence strategically

Although silence can be uncomfortable, you can use it during a coaching session as a way to avoid the urge to jump in and fill the vacuum with words.

Do develop a clear, specific plan

End the coaching session on a positive note by formulating a clear, specific plan. In our case scenario, the plan should include Susan's commitment to arrive at mock codes on time and curb her negative attitude toward taking part in them. Nancy needs to make sure Susan understands that her commitment to being an active team member reflects her commitment to the unit. She should emphasize that as a seasoned nurse, Susan must keep in mind that she's a role model for less experienced nurses and her behavior could influence their thinking and behavior.

Don't be authoritarian

When dealing with seasoned nurses like Susan, leaders might be inclined to take a more authoritarian approach by maintaining a strong presence and keeping

the power dynamic in their favor. However, unless the situation is critical (such as an actual code instead of a mock code), an authoritarian approach can build resentment and reduce approachability. So reserve that approach for situations with little margin for error.

An authoritarian approach can build resentment and reduce approachability.

Instead, your coaching style should mirror your leadership style. It should be built on motivating through crucial conversations. These conversations need to be timely (occurring shortly after the incident) and conducted in a respectful, peer-to-peer manner. Both parties should regard the conversation as a partnership without minimizing the issue in question.

Don't play the blame game

During coaching sessions and crucial conversations, avoid the blame game. Focusing on who's at fault is unproductive and hinders development of behaviors that enhance performance and effectiveness.

Be a manager who's also a coach

Coaching for performance is an ongoing process. If you commit to it, it gets easier over time. (See *Assessing your coaching effectiveness*.)

Remember—true change in staff behavior comes from increased self-esteem, professional empowerment, and the support of a great coach who has staff members' best interests at heart. Research shows that staff highly value managers who develop a coaching style of managing. With this approach, you can become the leader no one wants to leave. ★

Rose O. Sherman is a professor of nursing and director of the Nursing Leadership Institute at the Christine E. Lynn College of Nursing at Florida Atlantic University in Boca Raton. You can read her blog at emergingrnleader.com. Tanya M. Cohn is a nurse scientist in nursing and health sciences research at West Kendall Baptist Hospital in Miami, Florida. *Note:* Names in scenario are fictitious.

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(continued from page 9)

with other advocates. And above all, be persistent.

Take on large-scale advocacy

The Miss America brouhaha demonstrates the value of diverse, large-scale advocacy. After the offensive *The View* episode, nurses took to social media to protest the hosts' remarks. Virginia nurse Amanda Claybrook's Change.org petition got more than 50,000 signers; ANA and other nursing groups released statements expressing dismay. As a result, *The View* lost major sponsors. The Truth About Nursing also started a petition and discussed with *The View*'s publicity director specific ways the show could make amends.

Meanwhile, the mainstream media ran stories and op-eds about the incident. Within a week, *The View* apologized for the hosts' remarks and invited nurses onto the show "to share firsthand what these hard-working nurses do on a daily basis." Two nursing professors appeared on the show to explain some aspects of nursing. *The Dr. Oz Show* devoted an entire episode to nursing, although information about nursing skills was sadly limited. Media creators' responses to nurses' protests and petitions show the media can be persuaded to let nurses play a role in shaping program content. (See *Scrubbing out MTV's "Scrubbing In"*)

Praise the media for what it does well. Submit feedback to media outlets; phone calls and hard-copy letters probably have the biggest impact, but email, social media, and hashtags also are good.

Of course, no one knows nursing as well as nurses themselves do. Ideally, we should create our own media and tell our own stories, in vehicles ranging from broadcast TV shows to modest websites and blogs. But that's a topic for another time. Meanwhile, The Truth About Nursing offers many ideas on how to improve nursing's image at www.TruthAboutNursing.org/action and in our book, *Saving Lives: Why the Media's Portrayal of Nursing Puts Us All at Risk*. We hope you'll join us in taking a stand for nurses and patients. ★

The authors of *Saving Lives: Why the Media's Portrayal of Nursing Puts Us All at Risk*, Sandy and Harry Summers are the executive director and senior advisor, respectively, of The Truth About Nursing, a 501(c)(3) nonprofit organization. You can reach them at www.truthaboutnursing.org.

Safeguarding patients:
The courageous communication solution

By Amy Steinbinder, PhD, RN, NE-BC

How to confront colleagues about your safety concerns

PREVENTABLE MEDICAL ERRORS account for 440,000 deaths each year and are the third leading cause of death in the United States. According to The Joint Commission, communication failure is the third most commonly identified root cause of all sentinel events. A 2005 study titled "Silence Kills: The Seven Crucial Conversations in Healthcare" reported that more than half of 1,700 nurses, physicians, clinical care staff, and administrators witnessed coworkers "break rules, make mistakes, fail to support others, demonstrate incompetence, show poor teamwork, act disrespectfully, or micromanage." Yet, the study states, "despite the risks to patients, less than 10% of physicians, nurses, and other clinical staff directly confronted their colleagues about their concerns."

Building skills for courageous conversations

So how do you get a colleague's attention when you have a safety concern? The Department of Defense partnered with the Agency for Healthcare Research and Quality (AHRQ) to develop a teamwork and communication system to improve safe healthcare delivery. Called TeamSTEPPS, this evidence-based framework optimizes team performance across the healthcare delivery system.

One TeamSTEPPS tool, called CUS, serves as an effective verbal alarm, empowering healthcare providers to "stop the line." When you speak the signal words of the CUS tool—Concern, Uncomfortable, Safety—you alert team members and cue them to clearly understand not just the issue but also its magnitude or severity.

Here are the CUS steps:

1: State your **C**oncern.
2: State why you are **U**ncomfortable.
3: State that this is a **S**afety issue. Identify why it's a safety issue and state what actions you think should be taken.

CUS in action

Billy Evans, age 4, has a history of Type 1 diabetes.

After an episode of uncontrolled blood glucose, he's admitted to the pediatrics unit. Later, although his blood glucose level has nearly stabilized, his pediatrician wants to delay his discharge until the afternoon, just to be sure his blood glucose remains stable.

At the scheduled time for his insulin injection, his nurse Joanne prepares his injection. Her coworker, nurse Bonnie, approaches her, stating, "Joanne, the amount of fluid in that syringe looks quite large for Billy's insulin dose. How much insulin are you preparing to give him?" Joanne replies,"10 units." Bonnie uses the CUS tool to express her concern.

Bonnie: "I'm CONCERNED that you may be giving him too much insulin."
Joanne: "Why do you think that?"
Bonnie: "It's not uncommon to give adults with diabetes 10 units or more—but Billy's a child and much smaller than an adult. What's his blood glucose level now? I'm UNCOMFORTABLE because 10 units could cause severe hypoglycemia."
Joanne: "I have to hurry and get this done."
Bonnie: "This is a SAFETY issue. I really need you to stop what you're doing and double-check the order."

Joanne puts down the syringe, goes to the computer, and pulls up Billy's chart while Bonnie double-checks the insulin vial. They both want what's best for Billy.

How to use the Caring Feedback Model

If you witness something that makes you anxious, speak up—on behalf of others or yourself. The Caring Feedback Model provides a framework for doing this with a caring, compassionate approach to raising issues and confronting others.

Begin by stating your positive purpose. Then, talk about the behavior you observed. Next, explain the consequences of what you observed. Offer empathy, and state your suggestion, request, or expectation.

Explain your positive purpose.	"I want to help you to be even safer in your nursing practice as you work with nursing colleagues."
Ask permission to give feedback.	"May I give you some feedback?"
Describe the specific behavior you noticed or heard about.	"I noticed you interrupted a colleague in the med room who was getting medications for her patient."
Name the consequences for you, your team, your patients, and the organization.	"This could have distracted the nurse from what she was doing and caused a mistake with the patient's meds."
Offer a pinch of empathy.	"I realize you might have been totally focused on the importance of the information you needed to share, and it's hard not to interrupt."
Offer your suggestion, request, or expectation.	"Still, I think it's important to resist the urge to interrupt when you see a colleague busy in the medication room, and instead wait until she leaves before you talk to her. This would make it clear that safety is your first priority."

Note: This table is based on the Caring Feedback Model, copyrighted by Language of Caring®, LLC. To see the original version, visit http://goo.gl/TAEo4a.

Caring Feedback Model

To improve both patient safety and satisfaction, staff at every level of a healthcare organization should hold each other accountable to high standards of care. In addition to the CUS method, you can use the Caring Feedback Model to give colleagues feedback about their actions (or inactions) that have safety consequences. Using this model helps people hear your feedback with less defensiveness, because they hear your caring coming through. (See *How to use the Caring Feedback Model*.)

CUS and the Caring Feedback Model in action

Joe Wilson, age 41, has a history of hypertension. After a recent myocardial infarction (MI), he comes to the cardiology clinic for follow-up care. An electrocardiogram (ECG) shows no evidence of changes, although his blood pressure is a little high. All of his other vital signs are normal, so Dr. Ross is ready to let Mr. Wilson go home—until he has the following conversation with Tracy, RN.

Tracy: "Dr. Ross, Mr. Wilson is complaining about tightness in his chest. He appears to be in some pain and his blood pressure is 170/90. He told me he takes several nitroglycerin tablets every day for chest pain. I'm CONCERNED his cardiac status is unstable."

Tracy is expressing her concern that the patient's condition is a safety issue.

Dr. Ross: "I hear you, but his ECG shows no ischemic changes, his oxygen saturation is good, and he's not short of breath."

Dr. Ross isn't concerned at this point.

Tracy: "I'm uncomfortable letting him go home alone now."

Tracy is taking her concern to the next level, expressing her discomfort.

Dr. Ross: "I understand. We could always let him go home with instructions to call the office tomorrow if he's having any problems."

Dr. Ross is starting to recognize the potential problem and offers a solution.

Tracy: "I'm concerned he might be having symptoms of another MI, since he's having pain and his blood pressure is elevated. I'm UNCOMFORTABLE letting him go home because he lives alone and it would be a SAFETY issue if his pain worsens. I really need you to reevaluate him more closely before letting him leave."

Tracy restates her concern for the patient's safety and expresses her discomfort with Dr. Ross's solution.

Dr. Ross: "You might be right. Let's get some STAT blood work to be sure Mr. Wilson is safe to go home."

Tracy: "Thanks, Dr. Ross. We'd both feel terrible if something happened that we could have prevented. I'll let Mr. Wilson know we want to keep him here until we see his lab results."

Expanded CUS format

Using an expanded CUS format that includes the Caring Feedback Model helps you express appreciation, identify consequences of failing to address the safety concern, convey empathy, and offer a suggestion. (See *Combining CUS with the Caring Feedback Model*).

Combining CUS with the Caring Feedback Model

You can combine the CUS and the Caring Feedback Model to promote more effective communication in a difficult situation.

CUS	Caring feedback model	Example
	Explain your positive purpose and ask permission to give feedback.	"I know you want what's best for our patients, so I'd like to share a concern with you. Is that OK with you?"
C: State your concern.	Describe the specific behavior.	"I'm *concerned* that we're letting Mr. Wilson go home. Although his heart rate is fine and he's not having shortness of breath, his blood pressure is elevated and he's complaining of tightness in his chest and some pain."
U: State why you are uncomfortable.	Identify the consequences for the patient.	"I'm afraid he might be headed for another myocardial infarction, and I'm *uncomfortable* about letting him leave. I think it could be dangerous, especially because he lives alone."
	Add a touch of empathy.	"I realize Mr. Wilson wants to go home and you want to make that possible for him."
S: State that this is a safety issue.	Make your request.	"Still, I'm uncomfortable with him leaving because he lives alone and it would be unsafe for him if his pain gets worse. I'm asking you to re-evaluate his situation more closely before deciding to let him leave. This is a *safety issue*."

Using the powerful feedback process with your team

With your management team or work team, engage colleagues in planning caring feedback so they can become more comfortable with the language involved. Start by creating a two-column worksheet with each step of the Caring Feedback Model and the CUS steps listed in the left column. In the right column, provide space for effective language to accomplish that step. Next, have team members work with a partner on one of the situations below.

Situation 1: You overhear a staff member say to a patient, "I know who you are. I won't bother you with all those redundant questions."

Situation 2: A staff member tells a patient, "Look, we're really busy. We've had several people call out, and we don't have enough staff."

Situation 3: You overhear an RN say to a nursing assistant, "You're great at inserting urinary catheters. I trust you. So please go into Mrs. Smith's room and put her catheter in, OK? I have your back if someone complains."

Situation 4: Dr. Jones leaves your unit after seeing Mrs. Smith. You ask him if he ordered pain medication for her severe back pain. He replies, "I'm on my way to the operating room and I don't have time to go back to the unit and enter that order. So just go into the electronic health record and enter the medication as a phone order from me."

Situation 5: A transporter arrives on the nursing unit with a patient to be admitted from the emergency department. A nurse who sees the patient coming says to a coworker, "Oh no! Another admission!"

Finally, invite team members share their caring feedback language with the whole group.

Courageous communication: The key to patient safety

When you combine the evidence-based approaches of CUS and the Caring Feedback Model, you engage in powerful, compassionate, direct communication that improves patient safety and helps you and your colleagues fulfill your caring mission. ★

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