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Patient Safety Awareness Week

Shining a light on a public health crisis

Each year, an important event is nationally recognized but frequently overshadowed by our busy lives: Patient Safety Awareness Week. Seven days are devoted to increase awareness about patient safety in the eyes of all healthcare professionals and the public. This year, patient safety week is March 11-17, 2018, and its importance is critical when you consider that preventable harm in healthcare is a public health crisis; estimates place it as a leading cause of death in the United States.

I'm amazed that so much hard work—by organizations such as the National Patient Safety Foundation—takes place months ahead of time to develop strategies to highlight the week's importance. After all, why isn't patient safety at the top of our minds all the time, just like the weather or our favorite topic on Facebook? Why do we need a special week to blow the whistle on the fact that more than 1,000 preventable deaths a day is too many?

Maybe it's because as a system we haven't taken full responsibility for the level of harm and our part in causing it. Although patients and families play a critical role in preventing medical errors and reducing harm, the responsibility for safe, effective care lies primarily with the leaders of all types of healthcare organizations and the physicians, clinicians, and staff who deliver the care. Many of the barriers to safe practice, such as lack of access to health records and few easy-to-understand tools and checklists for self-care, are the responsibility of the healthcare system.

Here's one example: Helping patients and families become more confident and effective in their interactions with all of us who serve as their healthcare providers enhances safe care. Many tools already exist, but the system must train professionals to use them and provide the time to educate patients to become effective partners. But what's usually the first item cut during budget reductions? You know the answer: education and training expenses. Add to that sad reality trying to deliver patient-centered care in our productivity-driven system. Just how much can we actually educate a patient in a 5- to 10-minute interaction?

So yes, we need a Patient Safety Awareness Week every year to shine a laser beam on this real problem. Yes, I'll settle for the focus during just 1 week out of 52. But I ask you, shouldn't we strive to make every day patient safety day?

I encourage all nurses and nursing leaders to partner with their patients and families to develop the best, safest, and most compassionate care possible, and to acknowledge that when we fail to deliver on that goal, we're responsible for both the result and the solution. We're the most trusted profession. We have the knowledge, skills, and experience to transform a broken system. And just as important, we have a vision of a better healthcare world and the creativity to get us there. But do we have the will? Do we have the collective desire to shun mediocrity and demand better? The nation will pause for a week in the month of March to think about that very issue. Better care at lower costs. We all deserve nothing less.

Lillee Gelinas

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Stopping acute upper-GI bleeds

Risk stratification and quick intervention can save lives.

By Carolyn D. Meehan, PhD, RN, and Catherine G. McKenna, MSN, RN

AN ACUTE upper-GI bleed (UGIB) is a significant cause of hospital admissions. (See *UGIB fast facts*.) Recent advances in care include risk stratification when the patient arrives in the emergency department (ED) to help predict the need for specific interventions, such as transfusions, therapeutic endoscopy, or surgery. The Glasgow-Blatchford Score (GBS), a stratification tool commonly used in EDs, is based on well-documented risk factors known to influence hospitalization and rebleeding. (See *GBS—A risk stratification tool*.)

In this article, we present a case study that uses risk stratification for early intervention of acute UGIB in the ED.

Mr. Sullivan arrives in the ED

Mark Sullivan, a 75-year-old retired teacher, is brought to the ED by his family. He reports abdominal pain and says he passed a dark maroon stool this morning and then fainted. Mr. Sullivan has a history of atrial fibrillation, heart failure, and degenerative joint disease. His current prescription medications include hydrochlorothiazide 25 mg daily, lisinopril 5 mg daily, aspirin 81 mg daily, and apixaban 5 mg twice daily. Mr. Sullivan denies smoking, alcohol abuse, or previous episodes of fainting or gastric bleeding, and he reports taking ibuprofen 400 mg every day for knee pain. His current vital signs are temperature 98.8° F (37° C), heart rate (HR) 103 beats per minute (bpm) and irregular, respiratory rate 18 breaths per minute and regular, pulse oximetry 91%, and blood pressure 110/60 mmHg when prone, 98/60 mmHg when sitting.

During the physical exam, Erin, the ED nurse, notes pallor, weakness, and poor skin turgor. She immediately places Mr. Sullivan on a cardiac monitor, inserts two 18G I.V. lines, starts oxygen via nasal cannula, and sends blood work for complete blood count (CBC), serum chemistry, type and crossmatch, prothrombin time, and serum lactate level. The provider orders no oral intake for Mr. Sullivan in preparation for potential procedures.

Finding the source

A UGIB occurs above the ligament of Treitz, located between the jejunum and duodenum. Possible causes include gastric and duodenal ulcers, esophagitis, gastritis, varices, and malignancies; drug-induced causes include overuse of nonsteroidal antiinflammatory drugs (NSAIDs). Aligning the potential cause of the bleeding with the symptoms helps providers determine the source, improving care and overall mortality.

UGIB fast facts

- Acute upper-GI bleeds (UGIBs) are associated with over 400,000 U.S. hospital admissions each year.
- The admission rate for UGIB is estimated to be six times higher than that for lower-GI bleeds.
- UGIB incidence is higher in men than women and increases with advancing age.
- Advances in pharmacologic therapies, such as proton pump inhibitors and antibiotics to treat *Helicobacter pylori* bacteria, have helped reduce the overall incidence of UGIB, except for patients more than 70 years old.

Initially, the bleeding source may be unclear, and examining the stool alone isn't a reliable indicator. Patients exhibiting hematemesis along with hematochezia may be bleeding from the upper-GI tract, esophagus, stomach, or proximal duodenum. However, when the patient doesn't have hematemesis, the distinction between UGIB versus lower-GI bleeding must be determined quickly by completing a thorough history, collecting laboratory data, and using a risk stratification tool.

Management in the ED

Many of the patients who arrive in the ED with significant UGIB are elderly; patients older than 75 are at an increased risk of dying from a UGIB because of multiple comorbidities and polypharmacy. Thoroughly review the patient's medical history and current prescription and over-the-counter medications—especially anticoagulants, aspirin, antiplatelet agents, and NSAIDs.

The patient's cardiopulmonary health, cerebrovascular conditions, and history of GI bleeding will help you prioritize care. Keep in mind that more than half of patients with a history of GI bleeding are bleeding from the same lesion, and the presence of a single comorbidity doubles the mortality rate, which can range from 6% to 10%.

Providers may make decisions about fluid resuscitation based on findings from the physical exam. You can assess the extent of intravascular volume loss by carefully checking vital signs, mucous membranes, and urine output. You can presume that patients with an HR greater than 100 bpm and positive orthostatic changes in systolic

GBS—A risk stratification tool

The Glasgow-Blatchford Score (GBS) is commonly used to stratify risk for patients who present to the emergency department with an upper-GI bleed.

Admission risk marker	Score component value
Blood urea (mmol/L)	
6.5-8.0	2
8.0-10.0	3
10.0-25	4
>25	6
Hemoglobin (g/dL) for men	
12.0-12.9	1
10.0-11.9	3
<10.0	4
Hemoglobin (g/dL) for women	
10.0-11.9	1
<10.0	6
Systolic blood pressure (mmHg)	
100-109	1
90-99	2
<90	3
Other markers	
Pulse ≥100 beats per minute	1
Presentation with melena	1
Presentation with syncope	2
Hepatic disease	2
Cardiac failure	2

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blood pressure (defined as dropping 20 mmHg or more when moving from lying down to sitting) have a significant fluid volume deficit of at least 15%. Dry oral mucous membranes and a decrease in urine output to less than 30 mL per hour should alert you to changes in intravascular fluid volume.

Initial treatment in the ED includes placing the patient on a cardiac monitor, applying oxygen therapy with continuous pulse oximetry to maintain oxygen saturation above 90%, and inserting two large-caliber I.V. catheters. Fluid resuscitation for active GI bleeding includes lactated Ringer's or normal saline solution and an immediate type and crossmatch for possible transfusion. The goal is to hemodynamically stabilize the patient.

Making the diagnosis

Diagnostic laboratory data include CBC, serum chemistries, prothrombin time, and serum lactate. Note that the initial hemoglobin in patients with acute UGIB may be falsely elevated. After 24 hours, hemoglobin will decline as the blood is diluted by extravascular fluid entering the vascular space and by the fluids administered during resuscitation. Depending on the severity of the bleed, monitor the patient's hemoglobin every 2 to 8 hours, as ordered.

Also monitor the blood urea nitrogen (BUN) and creatinine ratio to help determine the location of the bleed. Patients with a UGIB will have an elevated BUN to creatinine ratio (>20:1) as a result of increased blood protein absorption into the bowel. An elevated serum lactate may indicate decreased oxygen supply to the tissues and may be a useful predictor for increased mortality and a need for early intervention. Other diagnostic tools include gastric lavage. (See *Get a clearer picture.*)

Stratifying the risk

Assessment of an acute UGIB includes risk stratification to identify the need for intervention. The GBS is used in EDs to stratify risk and determine the best treatment options. Patients with a GBS of zero may not require any intervention and could potentially be discharged from the ED. Patients with scores from one to five are at risk and should be admitted to the hospital for further evaluation and management. High-risk patients with a score of six or more are admitted for immediate intervention to stop the bleeding.

After endoscopy, the GI team may conduct further risk assessment using the Rockall Score. This assessment tool includes clinical criteria associated with the GBS and endoscopic findings to predict the risk of rebleeding and death.

Choosing a treatment

After fluid resuscitation, the provider will determine whether transfusion is needed. Recent studies suggest transfusing the patient, depending on his or her clinical presentation, to maintain a hemoglobin above 7 or 8 g/dL. Typically, pa-

Get a clearer picture

Gastric lavage clears the gastric contents to aid visualization and upper-GI bleed (UGIB) treatment. A large-bore tube, such as a double-lumen gastric sump tube, is placed in the stomach to irrigate and evacuate the hemorrhage, removing bright red blood, coffee ground material indicative of a UGIB, and clots from the stomach, helping providers see the fundus for more accurate endoscopy.

The patient's level of consciousness must be taken into consideration during this procedure; a patient with a diminished gag reflex may require airway support with endotracheal intubation.

To avoid the risks (such as aspiration, esophageal injury, laryngospasm, electrolyte disturbances, and hypoxia) and patient discomfort associated with gastric lavage, the provider may use an alternative, such as I.V. erythromycin or proton pump inhibitors (PPIs). I.V. erythromycin (250 mg about 30 minutes before endoscopy) induces contractions of the stomach's antrum to accelerate emptying of gastric contents and increase visualization of the mucosa during endoscopy. PPIs provide potent and prolonged gastric-acid suppression, reducing the rate of rebleeding and stabilizing clots.

tients admitted with an acute UGIB are treated with I.V. proton pump inhibitors (PPIs) (for example, pantoprazole 40 mg twice daily) for 72 hours after endoscopy. Based on the patient's risk factors, the gastroenterologist will decide whether to continue PPI treatment after discharge.

Endoscopic therapy for high-risk bleeds includes vasoconstrictor injections, thermal coagulation, and mechanical clipping. Early endoscopy (within 24 hours of admission) decreases the need for transfusion and reduces length of hospital stay for patients at high risk on the GBS. Note that 80% to 85% of patients with an acute UGIB will achieve hemostasis without intervention.

The GBS is used in EDs to stratify *risk* and determine the best treatment options.

Mr. Sullivan's outcome

Mr. Sullivan's BUN is 24.1 mmol/L with a serum creatinine of 1.1 mmol/L, giving him a BUN to creatinine ratio of 21:8 and suggesting an acute UGIB. Taking into consideration Mr. Sullivan's vital signs and initial hemoglobin of 10 g/dL, Erin calculates his GBS to be 12, placing him in a high-risk category requiring immediate endoscopy. Subsequently, his provider diagnoses Mr. Sullivan with a bleeding peptic ulcer.

Before Mr. Sullivan is discharged, Erin teaches him how to recognize early symptoms of rebleeding, and she instructs him to notify his provider if he experiences palpitations, dizziness, coffee ground emesis, or dark, tarry stools. Because of Mr. Sullivan's comorbidities and anticoagulation therapy, the multidisciplinary team recommends that he remain on omeprazole 40 mg per day for his peptic ulcer disease. In addition to medication reconciliation at the time of discharge, alternative pain management (such as physical therapy for strength, flexibility, and balance; guided-imagery; biofeedback; and relaxation techniques) is recommended to eliminate NSAIDs. A follow-up home visit is planned to ensure that Mr. Sullivan adheres to the plan of care and to provide support and assess for rebleeding. ★

Visit americannursetoday.com/38813 to view a list of selected references.

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Why your nursing networks matter

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

Networks help you advance your career, provide high-quality care, and support your colleagues.

Maria is a direct-care nurse working on a medical/surgical unit in an acute-care hospital. She recently achieved certification and became a member of a national nursing organization for her specialty, both of which are needed to advance through the clinical ladder at work. However, Maria isn't sure why her hospital values membership in the national organization or how it will help her career. She has a busy personal life and doesn't have time to volunteer in her local chapter.

MARIA'S LACK of understanding about the value of professional networks isn't unusual. Many nurses never make the investment of getting involved with professional associations or take the time to ensure that they have a strong network of colleagues within and outside their own organization. They wonder why they should spend what free time they have on an activity that seems so indirectly related to their work, and they fail to see how a network can enhance their professional growth or be a wise career investment.

The value of professional networks

Maria, like all direct-care nurses, is part of the profession of nursing. As a member of the profession, she has the opportunity to develop through continuing education, certification, and membership in nursing organizations. These activities will help Maria evolve from a novice to an expert nurse and open doors to professional networks. Professional networks also will provide her with mentorship, support, and teamwork opportunities. For example, if Maria's interested in developing specific skills or advancing her education, she can use her network to identify a mentor for skill development or guidance on educational opportunities.

Professional networks are crucially connected to quality patient care. Specifically, healthcare demands evidence-based practice, but nurses across the nation frequently are faced with variations in patient care and deep-rooted sacred cows of practice that are neither evidence-based nor current. Working in silos of individual clinical settings, nurses are left with less-than-optimal patient care and the need to develop evidence-based solutions from scratch. This is where professional networks can promote evidence-based practice through collaboration. For example, as a member of a national organization, Maria has access to networking with other medical/surgical nurses. Together they can compare and share best practices or research findings from their clinical practice, reducing the need to re-create the wheel individually. The result is consistent evidence-based, high-quality patient care.

For young nurses like Maria, a strong network can help when looking for new career opportunities. Many positions are never advertised, and workforce recruiters acknowledge that their best referrals come from professionals whose judgment they trust. Today's healthcare environment is volatile, so building a strong network should be part of a professional insurance policy.

Steps to building a network

Building a professional network can take two paths: a network in your immediate clinical environment or one created through an organization. Both require common steps.

Expert advice

Put these best practices from networking experts at Essential Communications into action.

1. **Networking is about planting, not hunting.** Professional relationships are built over time. Never reach out to network and then abruptly ask for a job.
2. **Effective networkers add value to others.** When networking, adopt a mindset of abundance not scarcity. Think about what you can do for the other person first. Perhaps you can connect him or her with a colleague or share an interesting article. The best networkers are givers not takers.
3. **Build a professional image.** Make a positive professional impression by having an up-to-date LinkedIn page, a professional email address and outgoing phone message, and business cards.
4. **Be prepared.** Networking opportunities can occur in the most unlikely settings. Always carry business cards and be ready to build a relationship.
5. **Craft your elevator speech.** When you're asked, "What do you do" or "What are you looking for," have a short, coherent answer that easily rolls off your tongue.
6. **Be positive.** Don't complain about anything to people you network with—you're building a relationship, not seeking therapy.
7. **Share the airtime.** The best way to begin building a relationship is to ask other people about themselves and their careers. Spend as much time listening as you do talking.
8. **Follow up consistently.** If you've been helped by another, send a thank-you note. If you've been given some homework, get it done and provide follow-up.
9. **Dig your well before you're thirsty.** By the time you need to build relationships, it may be too late; they take time to cultivate. Networking should be an ongoing professional investment.

Source: Essential Communications. essentialcomm.com

First, establish an understanding of your goals and who can help you achieve them. For Maria, this could include using her knowledge and experience as a certified medical/surgical nurse to establish a unit-based education program or to take part in a unit-based council to work collectively with other nurses through evidence-based practice and nurse competencies. Maria also might be interested in tapping into the nursing organization she's joined to seek out up-to-date practice alerts. Regardless of the professional network, after goals are set and the right people are identified, you can interact, share knowledge, and receive plans to help you achieve your goals.

Today's healthcare environment is volatile, so building a strong network should be part of a professional insurance policy.

If you don't have a specific goal in mind, building a professional network might seem daunting or unclear. Start by putting yourself out there in the nursing profession. For Maria, who may not be able to commit to joining a committee within the nursing organization, she can plan to attend the organization's annual conference. While there, she can take steps to maximize the networking experience. First, she should think about some conversational topics and introductory questions to use when interacting with other attendees. Depending on Maria's professional goals, the topics and questions could revolve around clinical practice, leadership development, or advancing education. In addition, Maria should be professionally prepared for the conference, including wearing professional attire and taking business cards. She also should plan to attend all social events and interact with the conference vendors, who could be potential future employment opportunities or offer cutting-edge evidence-based products she can share with her clinical colleagues.

The golden rules of networking

Networking opportunities exist everywhere, including online with sites such as Facebook, LinkedIn, and Twitter. Many nursing organizations have Facebook and Twitter accounts that nurses can follow to support networking about clinical practice and professional development. LinkedIn, on the other hand, helps nurses identify mentors and colleagues with similar interests. Regardless of whether you're networking at a conference, within an organization, or online, you'll need to follow some rules. (See *Expert advice*.)

Networking for introverts

If you're naturally introverted, networking may not come easily. You may even avoid networking events because they're exhausting and force you outside your comfort zone. The hardest part can be walking through the door into a room. Fortunately, most people would rather talk than listen, so let others do the talking. You can never go wrong asking questions and establishing common ground. (See *Get the conversation started*.) Chances are that once you start asking questions, the conversation will flow easily. Most nurses like to be asked about their opinions and sought out for advice. You'll be seen as a great networker because you take the time to listen.

Join the networked world

Over the course of her career, Maria will learn that

Get the conversation started

Use these questions to jumpstart conversations at networking events.

- How did you get started in your role?
- What are your challenges?
- What significant changes are you seeing in your environment?
- What's the most innovative thing that's happening in your organization?
- What do you think will happen with healthcare reform?
- What trends do you see happening in nursing today?
- What advice would you give to an emerging nurse leader?
- How can I help you?
- Who else at this meeting would be helpful for me to speak with?

building a network is one of the most powerful opportunities that membership in a professional association can provide. A good network outside her clinical setting will help her gain access to and act on new information quickly. She'll also save time and energy by accessing other professionals who've overcome some of the same challenges she's facing. Many young nurses have fast-tracked their careers by getting involved with association committees or running for office.

We live in a networked world, so developing your networking skill set is important to your career success. You never know what new opportunities you'll encounter or who you'll meet until you extend your hand, introduce yourself, and start asking questions. ★

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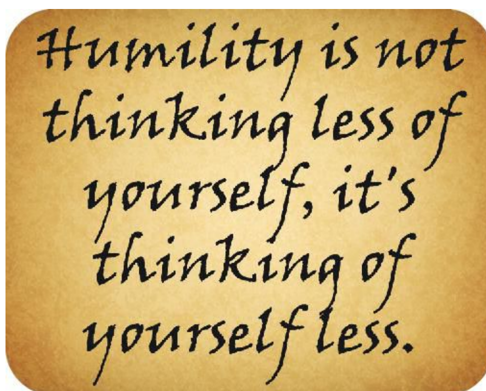
The imperative of humble leadership

By Donna Grande, MGA

Empower your team through shared responsibility.

IN THIS WORLD of social media, where people focus on self-promotion, it seems odd to address the issue of humility. But humble leadership is imperative in today's world. Humble leaders are critical for creating environments that enable diversity of thought and ideas. They create space for others to contribute by demonstrating acts of humility, empowering others to learn and grow, taking risks for the greater good, and holding people responsible for results. Engaging in different points of view is often contrary to what you might expect of leadership, but dialogue is far different from debate—and true humility is demonstrated when leaders suspend their own agenda and beliefs to truly hear another point of view.



Acknowledging others' opinions and ideas shows strength and competence, and that you're not threatened by others' valuable contributions. When people feel valued, they're more productive, which creates a positive atmosphere. Humility also stimulates professional growth as you become more self-aware, acknowledging that you can't do it all; none of us is infallible, and we need others to learn, grow, and be successful. A 2011 study found that admitting mistakes, highlighting follower strengths, and modeling teachability are at the core of humble leadership and are powerful predictors of an organization's growth.

Humility doesn't imply weakness. On the contrary; it enables you to be gentle but strong, forgiving, and appreciative. As a humble leader you share authority and responsibility, investing in others to build new leaders, taking risks in them, and trusting them with the vision.

Shifting to self-less

We also see humble leadership in successful entrepreneurs who have the self-confidence, dynamism, and tenacity to start and build a successful venture but may not have the acumen to run it, according to entrepreneur Richard Branson. Shifting from "self" to "self-less" is a critical part of the transition that empowers a team and enables an organization to operate smoothly and effectively. "The entrepreneur's job is effectively to put themselves out of a job each time the new company is up and running," Branson wrote. Clearly a tenet of humility.

A type-A, action-oriented, high-achiever may shudder at the terms "servant leader" or "humble leader," but studies show the power and influence these styles have on an organization. Humility is about honesty; it helps cut through the ego to overcome conflicts and create harmonious situations.

"People with humility do not think less of themselves; they just think about themselves less," explains management expert Ken Blanchard. Nurses regularly show humility—putting patients at the center of care and often before their own well-being. And, according to the American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements*, "The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population." You can't get more humble than that. ★

Donna Grande is vice president of products and services at the American Nurses Association.

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Diabetes—Pharmacologic management update

Concentrated insulin and noninsulin medications help patients manage their diabetes.

By Susan Renda, DNP, ANP-BC, CDE, FNAP, FAAN

In 1921, Dr. Frederick Banting and his assistant, Charles Best, made a life-changing discovery for people with diabetes. They extracted the hormone insulin from a dog's pancreas and injected it into a depancreatized dog with diabetes. This dog showed positive results and lived on insulin injections for 70 days. Next, the researchers processed insulin from the pancreas of fetal cows, and soon insulin was available for human use. Diabetes was no longer a death sentence.

THE NUMBER of people with diabetes is growing exponentially. According to data from the National Center for Health Statistics, 12.6% of adults 20 years or older in the United States have diabetes, but only 9.6% of them have been diagnosed with the disease. Diabetes continues to take a serious toll; for example, it's the leading cause of microvascular complications that lead to blindness, amputation, and kidney failure.

Preventing these complications requires aggressive management. Since the advent of insulin, many other medications and technologies have been developed to help with this management, including home and continuous glucose monitoring, multiple basal insulins, and new classes of oral and injectable medications. Most people with diabetes now take multiple medications to manage glucose levels and comorbidities. In fact, the average number of medications for a person over 20 years old with diabetes is 5.2. According to the National Health and Nutrition Survey of 2007-2010, 27% of people with diabetes take insulin.

This article provides an update on diabetes medications, focusing on concentrated insulin and noninsulin. (See *Pharmacologic options for diabetes management.*)

Concentrated insulin

Everyone diagnosed with type 1 diabetes is prescribed insulin. Those who have type 2 diabetes also may need insulin because of declining beta cell function. (See *Type 2 diabetes and insulin resistance.*) But when large volumes of insulin are injected subcutaneously, inadequate absorption, poor adherence, insulin leaking at the site of injection, and increased drug and supply costs can occur. Concentrated insulins, some offered in multiple versions, can help solve these problems and may improve patient satisfaction and adherence. (See *Concentrated insulin considerations.*)

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LEARNING OBJECTIVES

1. Differentiate types of concentrated insulin.
2. Compare three categories of noninsulin medications used to treat patients with diabetes.
3. Discuss nursing actions for patients with diabetes who are receiving concentrated insulin or noninsulin medications.

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Expiration: 3/1/21

Humulin R U-500

Overview: Humulin R U-500 is one of the first concentrated insulins; it's been available since the 1950s but rarely used until recently in response to the obesity epidemic; obesity can lead to insulin resistance. U-500 is five times more concentrated (1 mL contains 500 units of insulin) than U-100 insulin, which means less is needed per injection. For example, 100 units of U-100 requires 1 mL, while the same dosage of U-500 requires only 0.2 mL.

The pharmacokinetics of U-500 resemble both regular and intermediate insulin. It's clear and has a 30-minute onset, but U-500 stays at peak levels for 7 hours and is available to the body for up to 24 hours. This timing allows U-500 to be used alone to act as both a basal and bolus insulin.

Dosage: Until recently, U-500 required dosage conversion and was difficult to use. To eliminate conversion, it's now available in a pen (which can deliver up to 300 units in one injection) or a U-500 syringe. If a U-100 or tuberculin syringe is preferred, conversion is required. (See *Dosing conversion.*)

Indications/contraindications: U-500 is indicated for adults and children who require more than 200 units of insulin per day, but few studies exist in the pediatric population. It's pregnancy category B

Options for pharmacologic management of diabetes include a variety of concentrated insulins and noninsulin medications.

Concentrated insulins	Description	Delivery
Humulin R U-500	• Acts as basal and bolus insulin • Five times more concentrated than Humulin R U-100 insulin	• Pen for injection • Vial with U-500 syringe
Glargine U-300 (Toujeo SoloStar pen)	• Basal insulin • Three times more concentrated than glargine U-100 (Lantus or Basaglar)	• Pen for injection
Degludec U-200 (Tresiba FlexTouch pen)	• Basal insulin • Two times more concentrated than degludec U-100 insulin	• Pen for injection
Lispro U-200 (Humalog U-200 KwikPen)	• Bolus insulin for meals and correction of glucose elevations • Two times more concentrated than lispro U-100 (Humalog U-100 KwikPen)	• Pen for injection
Dipeptidyl peptidase-4 inhibitors		
Alogliptin (Nesina) Linagliptin (Tradjenta) Saxagliptin (Onglyza) Sitagliptin (Januvia)	• Prolong the effects of incretin hormones • Indicated for glucose lowering in type 2 diabetes	• Oral pill
Glucagon-like peptide-1 receptor agonists		
Albiglutide (weekly Tanzeum) Dulaglutide (weekly Trulicity) Exenatide (daily Byetta or weekly Bydureon) Liraglutide (daily Victoza) Lixisenatide (daily Adlyxin)	• Indicated for glucose lowering in type 2 diabetes • May have additional weight-loss benefit • Most common side effects are nausea and vomiting	• Pen for injection
Sodium-glucose cotransporter-2 inhibitors		
Canagliflozin (Invokana) Dapagliflozin (Farxiga) Empagliflozin (Jardiance)	• Work in the proximal tubule of the kidney to increase glucose excretion and lower blood glucose • Indicated for type 2 diabetes • May have additional weight-loss benefit	• Oral pill

and approved for use during breastfeeding. An open vial can be used for 40 days, and an insulin pen can be used for 28 days before it must be discarded. U-500 shouldn't be used intravenously or in an insulin pump, and it shouldn't be mixed with other types of insulin.

Glargine U-300

Overview: Glargine U-300 is a long-acting basal insulin three times more concentrated than glargine U-100. Its peak action occurs in 1 to 6 hours, it has a duration of 24 hours, and it reaches a steady state in 5 to 8 days. As the insulin reaches steady state, the patient may require a higher dosage when converting from U-100 to U-300; this requirement may continue in some patients.

Dosage: Glargine U-300 is delivered with an insulin pen that can dial to 80 units; no dosage conversion is necessary. The patient dials the pen to the dosage of U-100 insulin used, and the insulin volume reduces to one-third.

Indications/contraindications: Glargine U-300 is indicated for adults with diabetes and is typically recommended for patients who require larger-than-average basal doses. No clinical data exist for use in pregnancy, and whether it's excreted in breast milk is not known. Other insulins should not be mixed with glargine U-300. An opened pen kept at room temperature can be used for 42 days; unopened pens should be refrigerated until the expiration date and then should be discarded.

Degludec U-200

Overview: Degludec U-200 is a long-acting concentrated basal insulin that contains 200 units of insulin per mL. Note that degludec also comes in a standard 100 U/mL concentration (degludec U-100); don't confuse the two.

Degludec U-200's pharmacokinetics include the longest half-life (25.4 hours) of any basal insulin, and it can last 42 hours. It achieves a steady state in 3 to 4 days, which is the recommended interval between dosage adjustments. U-200's slow and prolonged effect makes it more forgiving if administration is

late or missed. Instruct patients that they shouldn't administer doses fewer than 8 hours apart.

Dosage: Degludec U-200 is given once daily by subcutaneous injection. It comes in an insulin pen that doesn't require dosage conversion but will deliver units in half the volume as U-100.

Adults who change from another basal insulin to degludec U-200 should use the same dosage. For children, reduce the dosage to 80% of the previous basal insulin. If someone with type 1 diabetes is insulin naïve, begin with a once-daily dose of 0.2 to 0.4 units/kg. For patients with type 2 diabetes, begin with 10 units once a day and titrate the dosage with adjustments 3 to 4 days apart to allow it to reach steady state.

Indications/contraindications: Degludec U-200 is indicated for anyone over 1 year old with type 1 or type 2 diabetes, but it isn't recommended for pediatric patients who use less than 5 units daily. No clinical data exist for pregnancy or breastfeeding. Degludec can't be used in an insulin pump or mixed with other insulins.

Lispro U-200

Overview: Lispro U-200 is a nonbasal, rapid-acting concentrated insulin. It's injected with meals and for glucose corrections. Lispro U-200 is bioequivalent to lispro U-100 but delivers the same units in half the volume. It comes in a prefilled 3-mL pen that has a maximum of 60 units per injection. Peak action is 30 to 90 minutes.

Dosage: Dosage conversion isn't necessary. Lispro U-200 may be helpful to patients who use large amounts of mealtime or correction insulin and find that they run out of insulin pens quickly.

Indications/contraindications: Lispro U-200 is indicated for children and adults, but it hasn't been studied in children younger than 3 years old. Lispro U-200 should not be administered intravenously, used with an insulin pump, or mixed with other insulins. Use in pregnancy is category B, and it's compatible with breastfeeding. An open pen can be kept at room temperature for 28 days; unopened pens should be refrigerated until the expiration date and then should be discarded.

Type 2 diabetes and insulin resistance

Type 2 diabetes is characterized by insulin resistance and a relative lack of endogenous insulin. Insulin resistance is the impaired ability of insulin (either endogenous or exogenous) to lower blood glucose. Severe insulin resistance is diagnosed when the patient requires more than 200 units of insulin per day; someone with extreme insulin resistance requires more than 300 units per day.

Noninsulin medication

Noninsulin medications for type 2 diabetes management include dipeptidyl peptidase-4 (DPP-4) inhibitors and incretin analogs, such as glucagonlike peptide-1 receptor agonists (GLP-1). Both mimic incretin hormones that are present in the small intestines of healthy people. These hormones are released when food is eaten to help increase insulin secretion; they also suppress glucagon release. Some incretin hormones can help increase satiety.

Another class of noninsulin medications, sodium-glucose cotransporter-2 (SGLT-2) inhibitors, reduces glucose by reducing its renal threshold.

DPP-4 inhibitors

Overview: DPP-4 inhibitors extend incretin hormone action time to help facilitate insulin secretion. These pill-form oral medications include sitagliptin, saxagliptin, linagliptin, and alogliptin. They're approved for the treatment of type 2 diabetes in adults as an adjunct to diet and exercise and in many cases are used as second-line medications or in addition to metformin. They've been tested and combined with other diabetes medications with tolerance and efficacy. When DPP-4 inhibitors are used as monotherapy, glycated hemoglobin (HbA1C) may be reduced by 0.6% to 0.9% with no concurrent fluctuations in weight or changes in lipids.

Dosage: DPP-4 inhibitors, which don't cause weight gain, are taken once daily with or without a meal;

Concentrated insulin considerations

Concentrated insulin is potent, so keep these key points in mind to promote its safe, effective use.

- Teach patients about the prevention, detection, and management of hypoglycemia, which is common with concentrated insulin.
- Instruct patients to rotate injection sites to avoid localized lipodystrophy.
- Use prefilled syringes with care, and instruct patients in their proper use.
- Teach patients not to switch between Humulin R U-500 and U-100 syringes.
- To prevent medication errors, follow hospital policies for dispensing and administering concentrated insulin.

if used in a combination form with metformin, they should be taken with meals. The dosage is lower for patients with renal insufficiency, except linagliptin for which no dosage adjustment is needed.

Indications/contraindications: DPP-4 inhibitors are pregnancy category B, but caution should be exercised with use when breastfeeding. DPP-4 inhibitors are generally well tolerated with a risk of hypoglycemia similar to placebo.

Adverse effects: The most common adverse effects are nausea, respiratory infection, and allergic reaction. Pancreatitis also has been reported, so use caution with patients who have a history of it; if pancreatitis is suspected, discontinue the medication.

In 2014, the U.S. Food and Drug Administration (FDA) warned that saxagliptin and alogliptin might increase the risk of heart failure, especially in people who have pre-existing heart or kidney disease. The FDA issued an additional warning in 2015, saying that DPP-4 inhibitors may cause severe and disabling joint pain. Patients made first reports of joint pain anywhere from the first day of use to years after starting the medication. The FDA advised people taking DPP-4 inhibitors to discontinue their use if joint pain occurred; symptoms disappear after stopping the medication.

Dosing conversion

Common dosing for Humulin R U-500—two or three times daily (30 minutes before meals)—is based on conversion from a total daily dose (TDD) of Humulin U-100. To begin U-500, stop basal and bolus insulins. U-500's duration of action creates a stacking effect; in other words, additional dosages add on to insulin that remains active from the previous dose. To avoid hypoglycemia, use the highest dose in the morning and the lowest in the evening.

First, calculate the TDD of U-100 insulin currently used. If the glycated hemoglobin (HbA1C) is ≤ 8%, reduce the TDD by 10% to 20%; if the HbA1C is ≥ 10%, increase the TDD by 10%. (See the table below for dosing options.) Because of the potential for error, using a pen or a U-500 syringe is recommended.

Humulin R U-500 dosing options

30 minutes before breakfast	30 minutes before lunch	30 minutes before dinner
60% of TDD		40% of TDD
40% to 45% of TDD	30% to 40% of TDD	20% to 30% of TDD

GLP-1 receptor agonists

Overview: GLP-1 is an incretin hormone produced by the small intestine when oral glucose is ingested. It helps promote insulin secretion by the pancreas and suppresses glucagon secretion by the liver. GLP-1 also delays gastric emptying, which slows glucose absorption and increases the feeling of satiety. As a result, the hormone can facilitate weight loss. GLP-1 receptor agonists mimic the effects of GLP-1.

The first available GLP-1 receptor agonist, exenatide, is indicated as an adjunct to diet and exercise for people with diabetes. The second, once-daily liraglutide, is better than exenatide at reducing HbA1C and fasting glucose. However, it's not indicated as a first-line medication. Other GLP-1 receptor agonists include lixisenatide, albiglutide, and dulaglutide.

GLP-1 receptor agonists are effective at lowering HbA1C up to 1.5%. Other benefits include weight loss, blood pressure reduction, improved cholesterol levels, improved beta cell function, and possible cardiovascular benefits. Lixisenatide has been shown to be safe in people with type 2 diabetes who've experienced recent acute coronary syndrome. In the LEADER study of people at high risk for or with existing cardiovascular disease (≥ 50 years with vascular disease or ≥ 60 years with at least one cardiovascular risk factor), liraglutide significantly reduced cardiovascular events.

Dosage: GLP-1 receptor agonists are injected by pen, either daily or weekly. When combined with metformin or thiazolidinediones, GLP-1 receptor agonists don't cause hypoglycemia; however, when combined with a sulfonylurea or insulin, the dosage of the sulfonylurea or insulin may need to be reduced to avoid low blood glucose.

Indications/contraindications: GLP-1 receptor agonists are not indicated for type 1 diabetes, and they haven't been studied in children. Their pregnancy use is category C and use when breastfeeding isn't recommended.

Adverse effects: The most common side effects of GLP-1 receptor agonists are nausea, vomiting, and diarrhea. Nausea and diarrhea are less common with albiglutide; vomiting is less common with exenatide. Precautions and warnings for GLP-1 receptor agonists include pancreatitis and thyroid cell carcinoma.

SGLT-2 inhibitors

Overview: SGLT-2 inhibitors (canagliflozin, dapagliflozin, and empagliflozin) work in the proximal tubule of the kidney to mediate reabsorption of glucose and increase urinary glucose excretion. The result is lower blood glucose. As monotherapy or as an additional diabetes medication, SGLT-2 inhibitors reduce HbA1C by 0.5% to 0.8%. Other benefits include weight loss as well as reduced blood pressure, waist circumference, and uric acid; dapagliflozin and empagliflozin reduce the progression of albuminuria.

SGLT-2 inhibitors have been shown to increase high-density

lipoprotein and low-density lipoprotein cholesterol. In the EMPA-REG OUTCOME trial, empagliflozin was "associated with a relative risk reduction of 38% in all-cause mortality…and 35% [reduction] in hospitalization for heart failure."

Dosage: SGLT-2 inhibitors are administered orally once a day: canagliflozin, 100 mg to 300 mg; dapagliflozin, 5 mg to 10 mg; empagliflozin, 10 mg to 25 mg.

Indications/contraindications: SGLT-2 inhibitors are indicated, in addition to diet and exercise, for adults with type 2 diabetes who have an estimated glomerular filtration rate greater than 45 mL/min. SGLT-2 inhibitors aren't indicated for patients with type 1 diabetes, and they can't be used in pregnancy or while breastfeeding.

Adverse effects: Adverse effects of SGLT-2 inhibitors include urinary frequency, increased rates of urinary tract infections, genital tract infections (especially in women), postural hypotension, diabetic ketoacidosis, acute kidney injury, acidosis, and possible increased rates of fractures.

Concern about decreased bone mineral density associated with canagliflozin resulted in FDA drug label warnings. After two large clinical trials, the FDA issued a safety communication change in product labeling with a boxed warning for canagliflozin because of an increased risk of leg and foot amputations. Based on reports of acute kidney injury with canagliflozin and dapagliflozin, the FDA revised warnings on drug labels to include information about the risk of acute kidney injury.

Nursing considerations

As the number of people with diabetes has grown, so has the number of diabetes medications. These medications provide the opportunity to treat diabetes from a variety of angles, including lowering glucose with incretin hormone action, eliminating excess glucose via the kidneys, and concentrating insulin for better delivery when insulin resistance occurs. Nurses who care for patients with diabetes in the hospital and community should be aware of these options. In addition, nurses are in an excellent position to educate patients on safe medication use. Pharmacologic treatments can make diabetes control better and easier. ★

Visit www.AmericanNurseToday.com/?p=38849 for a complete list of selected references.

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Please mark the correct answer online.

1. Severe insulin resistance is diagnosed when the patient requires how many units of insulin per day?
a. More than 50 units
b. More than 100 units
c. More than 150 units
d. More than 200 units

2. Which of the statements about concentrated insulin is correct?
a. Patients should rotate injection sites to avoid localized lipodystrophy.
b. Patients can switch between Humulin R U-500 and U-100 syringes.
c. Hypoglycemia is rare for patients who are taking concentrated insulin.
d. Patients can avoid localized lipodystrophy by not rotating injection sites.

3. A patient who requires 1 mL for 100 units of Humulin R U-100 insulin will require what volume when taking Humulin R U-500?
a. 0.1 mL
b. 0.2 mL
c. 0.5 mL
d. 1 mL

4. Which of the following should you consider when converting a patient receiving Humulin R U-100 to Humulin R U-500?
a. If the glycated hemoglobin (HbA1C) is ≤ 8%, reduce the total daily dose (TDD) by 10% to 20%.
b. If the HbA1C is ≤ 8%, reduce the TDD by 5% to 25%.
c. If the HbA1C is ≥ 10%, increase the TDD by 15%.
d. If the HbA1C is ≥ 10%, increase the TDD by 25%.

5. A good dosing option for Humulin R U-500 is
a. 40% of TDD 30 minutes before breakfast, 20% of TDD 30 minutes before lunch, and 40% of TDD 30 minutes before dinner.
b. 30% of TDD 30 minutes before breakfast, 20% of TDD 30 minutes before lunch, and 50% of TDD 30 minutes before dinner.
c. 50% of TDD 30 minutes before breakfast and 50% of TDD 30 minutes before dinner.
d. 60% of TDD 30 minutes before breakfast and 40% of TDD 30 minutes before dinner.

6. Humulin R U-500 stays at peak levels for
a. 2 hours.
b. 5 hours.
c. 7 hours.
d. 12 hours.

7. Glargine U-300 has a duration of action of
a. 8 hours.
b. 16 hours.
c. 24 hours.
d. 48 hours.

8. Degludec U-200 achieves a steady state in
a. 1 to 2 days.
b. 2 to 3 days.
c. 3 to 4 days.
d. 4 to 5 days.

9. Which concentrated insulin has the longest half-life?
a. Humulin R U-500
b. Glargine U-300
c. Degludec U-200
d. Lispro U-200

10. Which concentrated insulin may be most beneficial for patients who use large amounts of mealtime or correction insulin and find that they run out of insulin pens quickly?
a. Humulin R U-500
b. Glargine U-300
c. Degludec U-200
d. Lispro U-200

11. Which statement about dipeptidyl peptidase-4 inhibitors is correct?
a. They extend incretin hormone action time.
b. They shorten incretin hormone action time.
c. They are given by injection.
d. They can't be used with metformin.

12. A medication for treating diabetes that might cause severe joint pain is
a. dulaglutide.
b. exenatide.
c. sitagliptin.
d. dapagliflozin.

13. Which statement about glucagon-like peptide-1 (GLP-1) receptor agonists is correct?
a. They increase glucagon secretion by the liver.
b. They decrease gastric emptying.
c. They lower HbA1C up to 4%.
d. They may cause weight gain.

14. In which patient could a GLP-1 receptor agonist be indicated?
a. A teenager
b. A woman who is breastfeeding
c. A pregnant woman
d. A man with type 2 diabetes

15. Which statement about sodium-glucose cotransporter-2 inhibitors is correct?
a. They decrease high-density lipoprotein.
b. They reduce HbA1C by 3% to 3.5%.
c. They're used in patients with a glomerular filtration rate greater than 45 mL/min.
d. They increase the risk for heart failure.

Social media missteps could put your nursing license at risk

By Melanie L. Balestra, NP, Esq

Learn the rules and what to do if you make a mistake.

WITHOUT A DOUBT, social media has become an integral part of modern life. Today, seven in 10 Americans use social media to get news, connect with others, and share information. Facebook leads the way with more than 2 billion users worldwide, followed by other popular platforms such as Twitter, Instagram, LinkedIn, and YouTube. For nurses, social media use has daily applications in their personal and professional lives, facilitating conversations with colleagues about best practices and advancing healthcare.

Although social media offers many benefits, inappropriate use can create legal problems for nurses, including job termination, malpractice claims, and disciplinary action from boards of nursing (BON), which could negatively impact their nursing license and career.

What to avoid when posting

Remember that professional standards are the same online as in any other circumstance. And although you should approach all social media posts with caution, several high-risk areas deserve closer examination.

Breaches of patient privacy and confidentiality

Whether intentional or inadvertent, social media posts that breach patient privacy and confidentially are the most egregious. They include patient photos, negative comments about patients, or details that might identify them, the healthcare setting, or specific departments. Even when posted with the best intentions, such as trying to get professional advice from colleagues about patient care, these posts are discoverable and can lead to legal problems, with potential fines and jail time for Health Insurance Portability and Accountability Act (HIPAA) violations, termination or other discipline from your employer, action taken against your license by a BON, civil litigation, or professional liability claims.

According to the 2015 nurse professional liability exposures claim report update from the Nurses Service Organization, examples of civil litigation and closed claims in connection with inappropriate electronic and social media use include:

- An RN who took a picture of a man getting an electrocardiogram and posted it on Facebook.
- An RN who sent text messages to another nurse and physician describing a sick child and his mother in an unfavorable light.
- Staff members at a long-term-care facility who videotaped and photographed a certified nursing assistant colleague who was in labor. They allegedly mocked the woman, posting photos, including of her vaginal area, on various social media sites.

Unprofessional behavior

A second high-risk area are posts that could be considered unprofessional or reflect unethical conduct—anything defined as unbecoming of the nursing profession. For example, negative comments about your workplace, complaints about coworkers and employers, or threatening or harassing comments fall into this category.

The highly publicized firing in 2013 of an emergency department nurse at New York–Presbyterian Hospital demonstrates the risks connected with posting workplace photos. The nurse shared a photo on Instagram depicting an empty trauma room where a patient

How to avoid social media pitfalls

Using caution, you can enjoy the benefits of social media without risking the loss of your license and livelihood. Follow these tips to help keep your social media content in the clear.

- Always maintain patient privacy and confidentiality.
- Don't post photos or videos of patients or identify them by name.
- Don't refer to patients in a disparaging manner, even if they're not identified.
- Avoid connecting with patients or former patients via social media.
- Don't post inappropriate photos or negative comments about your workplace, colleagues, or employers. Instead, use social media to post positive comments about your workplace and its staff.
- If you haven't already done so, review and sign your employer's social media policy. Keep that policy in mind when using social media.
- Don't access personal social media while on duty.
- Share educational information that may benefit others, such as safety notices and medical news.
- Use social media to enhance the role of nursing in the community, among friends, and to the public.
- Know that using social media to make referrals to practitioners, specialists, and healthcare practices is permissible.
- Use caution when promoting healthcare services online, especially in aesthetics. For example, state law may require advertising to include the physician's name associated with a practice. This also extends to the controversial topic of Groupon and medical services; many state healthcare laws make getting paid for referring a patient to another medical practice illegal. Use care in this gray area.
- Know that your behavior off the job, such as drinking socially, could be discussed or photos posted on social media. Remove inappropriate photos and evidence of alcohol or drug use.
- Think before you post something that could be deemed offensive. This includes comments made when debating current events or other issues via social media where you might use language that you wouldn't use in a face-to-face conversation. If you're angry or emotional, wait 24 hours before making a post.
- Remember that online posts, Tweets, and blogs are not private communications and can be used against you in an investigation by your board of nursing.

had been treated after getting hit by a subway train. Although the post didn't violate HIPAA rules or the hospital's social media policy, she was terminated for being insensitive.

Posts about your personal life also can negatively affect your professional life. Posting photos or comments about alcohol or drug use, domestic violence (even comments about arguing with a spouse) and use of profanity, or sexually explicit or racially derogatory comments could lead to charges of unprofessional behavior by a BON. And keep in mind that complaints can come from anywhere, including employers and coworkers, family and friends, and intimate partners, so the privacy setting on the social media platform won't protect you.

To *protect* yourself, carry your own malpractice/disciplinary insurance.

Court rulings have supported disciplinary actions by BONs against nurses for unprofessional behavior in their personal lives. A key example is the 2012 decision by the California Supreme Court, which left intact an appellate ruling (*Sulla v Board of Registered Nursing*) that allowed a state board to discipline a nurse who was caught driving drunk, even though his arrest had nothing to do with his job. The BON placed the nurse on 3 years' probation after his arrest. The appeals court ruled that state laws authorize disciplinary action against a nurse who uses alcohol, on or off the job, in a way that endangers others. The result is that nurses in California who are convicted of driving under the influence will have their nursing license suspended by the BON. This has clear implications for social media posting about alcohol use (or any high-risk topic) in your personal life. (See *How to avoid social media pitfalls*.)

If you hear from the BON

If you receive a letter from the BON about an investigation, don't represent yourself. Hire an attorney who specializes in administrative law and procedure—ideally one who's familiar with your state BON. Decisions about a complaint can take from several months to more than a year, and outcomes can range from case dismissal for lack of merit or insufficient evidence to referral to the state's attorney general office for prosecution. If no settlement is reached, you and your attorney will argue the case at a hearing with potential outcomes that include public admonition/reprimand, restriction, probation, suspension, or revocation of your nursing license.

Other serious repercussions are possible. Decisions made by BONs are communicated via Nursys.com, a national database for verification of nurse licensure, discipline, and practice privilege administered by the National Council of State Boards of Nursing. If disciplined, you also

(continued on page 63)

Practice Matters

PART ONE IN A SERIES

Splash safety—Protecting your eyes

Take the time to protect your eyes from pathogens.

EDITOR'S NOTE: March is Workplace Eye Wellness Month. In this first of a two-part series on protecting your eyes from splashed body fluids that may contain pathogens, we share insights from two experts: Amber Hogan Mitchell, DrPH, MPH, CPH, president and executive director of the International Safety Center; and Linda Powell, MSN, RN, FNP, workers' compensation case manager for Scripps Green/Scripps Encinitas in California.

How many nurses are exposed to splashes at work?

Mitchell: Nurses sustain the largest percentage of blood and body fluid exposures (BBFEs) in acute care settings in the United States. According to the International Safety Center's Exposure Prevention Information Network (EPINet®) national surveillance data from 2012 to 2016, nurses experience a disproportionate number of all splashes and splatters—about 50% (range of 47.7% to 54%) compared to all other healthcare professionals. Almost 60% occur in patient or exam rooms, and about 25% occur evenly distributed between emergency departments and operating rooms. Nurses report that 62.8% of all splashes touch unprotected skin.

From 50% to 60% of those exposures are blood or body fluids visibly contaminated with blood. An unacceptable number of these incidents occur to the nurse's face (83.4%); of those, 66.7% occur to their eyes.

Although we hear less about splashes than needlestick injuries, nurses experience slightly more splashes at the bedside in patient or exam rooms (the primary settings for needlesticks as well as splashes).

What are the dangers of splashes to the eyes?

Mitchell: Splashes to the eyes can result in transmission of bloodborne pathogens, bacteria, multidrug-resistant organisms, and other microorganisms. Dozens of pathogens, including HIV, hepatitis C virus (HCV), influenza, severe acute respiratory syndrome, herpes B virus, plague, rabies, and Ebola, have been documented to be transmitted via eye exposures. Few facilities do active surveillance for employees, so we can't estimate how many eye and mucus membrane exposures result in colonization or infection with multidrug-resistant organisms—and how many of these may result in cross-contamination or transmission to patients, coworkers, or family members.

One might argue that eye exposures are the riskiest exposure types, potentially resulting in not just pain and injury, but also infection or illness.

Powell: Eye splashes can have damage beyond bloodborne pathogen exposures. The pH of medications and body fluids can cause corneal trauma and corneal ulceration, resulting in the loss of use of one or both eyes. Viruses and bacteria—including adenovirus, herpes simplex, *Staphylococcus aureus*, and rhinoviruses—can be spread to the ocular mucus membrane by splashes, coughing, or touching the area with a contaminated hand or finger.

Do most nurses wear eye protection?

Mitchell: Unfortunately, no. Of those nurses reporting any kind of BBFE, only 8.1% said they were wearing eye protection. The percentage is even lower for exposures specific to the eyes: In 2016, only 1.7% reported they were wearing eye protection when the BBFE occurred, compared to 2012, when 7.3% said they were. Interestingly, in 2016, 62.8% reported BBFEs occurred in a patient or exam room, compared to 2012, when 44% were reported in the same location. This may mean that nurses are experiencing more exposures at the bedside and were wearing eye personal protective equipment (PPE) less frequently.

This trend has to be reversed and exposures must be reported and recorded so that they can be addressed and prevented. Organizations should consider incorporating eye and face protection not just into their infection prevention and control caddies, but also as a permanent fixture in patient rooms (either door or wall mounted).

What are the costs of splashes to the organization?

Mitchell: BBFEs are serious business and can have a

negative effect on an organization. The effect may be disproportionate in smaller facilities compared to larger ones because a single exposure in a small practice can result in not only disruption of patient care, but also compromised staffing, time away from work, employee turnover, and financial impact. In larger facilities, the organizational impact is different but also substantial (disruption of patient care, an immediate need to shuffle staffing, and costs associated with patient/source and employee baseline testing, postexposure follow-up, and potential prophylaxis).

Cost can range from $800 to $6,000 for a single exposure to $80,000 to $1,000,000 or more if an employee seroconverts to a bloodborne disease such as HCV and needs lifetime treatment. Additional costs can be accrued through workers' compensation insurance costs and premiums, not to mention potential Occupational Safety and Health Administration (OSHA) fines if an inspection occurs as a result of an employee complaint.

But the greatest expense is emotional. Because of the underlying stigma associated with occupational BBFE and reporting it, employees may not receive the medical care they need after an incident, which may increase their likelihood of becoming ill or seroconverting.

What are the standards regarding eyewear protection?

Mitchell: Although standards from the government and professional associations state the need for eye protection, they're not sufficiently healthcare focused.

The OSHA PPE Standard (29 CFR 1910.132) includes requirements for eye protection but is focused on physical hazards that may cause injury rather than illness or infection. OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030) leaves selection and placement of eye protection up to the employer, based on its exposure assessment. The standard states, "When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns… *eye protection* [italics added]…." This is why tracking exposures is important, so that the circumstances surrounding them can be documented and appropriate PPE made available to employees.

The National Institute for Occupational Safety and Health states that "eye protection chosen for specific work situations depends upon the nature and extent of the hazard, the circumstances of exposure, other protective equipment used, and personal vision needs." The Association of periOperative Registered Nurses' standards on surgical attire include eye protection, and the American Optometric Association website provides guidance for workplace eye safety.

The lack of standard requirements for nurses' eye protection and the high prevalence of eye exposures compared to all other exposure types make it clear that we have work to do to convince policy makers, legislators, regulators, professional associations, and advocacy groups that we need to create or amend standards to protect nurses.

Powell: The Centers for Disease Control and Prevention recommends eye protection whenever staff may be at risk for acquiring infectious diseases through exposure to the ocular membrane.

When should nurses wear eye protection?

Powell: Eye protection should be used whenever exposure to body fluids or infectious viruses and bacteria *can* occur, not just when exposure is *likely* to occur. The rule of thumb is that if you put on gloves, put on eye protection.

Why don't nurses wear eye protection?

Powell: The two main reasons are lack of availability and failure to establish a habit of wearing it. Eye protection needs to be available at the point of service. If staff have to go outside of the patient room to obtain protection, odds are they won't do it. To encourage the habit of wearing eye protection, managers must set expectations and provide ongoing education about its importance. ★

In the second part of this series, Mitchell and Powell will focus on how organizations—and nurses—can reduce injuries from eye splashes.

This series is supported by an unrestricted educational grant from Tidi Products (tidiproducts.com).

When should you wear eye protection?

You should wear eye protection whenever you're working with blood and body fluids, including:

- when starting or discontinuing I.V.s
- when emptying indwelling catheters, bedpans, Hemovac drains, chest tubes, and Jackson-Pratt drains
- when irrigating indwelling catheters, percutaneous endoscopic gastrostomy (PEG) tubes, and nasogastric (NG) tubes
- when giving medications through PEG and NG tubes
- when working with constant irrigations of any type
- when in the operating room
- when drawing blood
- when working with patients on mechanical ventilation (suctioning, turning, transporting)
- when assisting with bronchoscopies
- during sanitary care
- during cardiac catheterizations
- during lumbar punctures.

Source: Linda Powell.

It's time for data-driven, patient-centered workforce management

By Karlene M. Kerfoot, PhD, RN, CNAA, FAAN, and Patricia Baran, MBA

How to transform data into effective staffing.

EDITOR'S NOTE: This is an excerpt from an upcoming toolkit on workforce management. Watch for more information on a workforce management webinar that's coming in June.

THE WORDS of the Ancient Mariner in Samuel Taylor Coleridge's poem "The Rime of the Ancient Mariner" convey exactly where we are with data-driven staffing today: "Water, water, everywhere…nor any drop to drink." Healthcare is awash with data, but it's not being transformed into information for real-time, patient-centered staffing decisions

Many sources of healthcare system data influence staffing outcomes, and the person accountable for staffing rarely has access to all of it. (See *Staffing influencers.*) But even if they did, they wouldn't be able to turn it into information for immediate staffing decisions. So instead, the various responsible parties look at staffing from many frames of reference and use opinion rather than data to make decisions. Executives, chief nursing officers, nurses in staffing roles, and frontline staff should all be looking at the same information and agree on the conclusions the data provide.

Make data a priority

In the age of evidence-based medicine and nursing, staffing based on data about the personalized needs of patients just makes sense. We set ourselves up for failure in the quest to meet quality indicators if we can't correctly assess those needs and appropriately match staff and patients. As the healthcare professionals most familiar with the impact of data-driven staffing and staffing outcomes, nurses—especially nurse executives—can help other leaders in their organization understand the impact on financial, operational, and clinical imperatives driven by a data-driven workforce management approach. Here's how you can begin the journey.

Build an interdisciplinary business case. Work with the chief financial officer and colleagues from other disciplines to build a business case for patient-driven staffing. Patient dissatisfaction scores and poor patient outcomes, which are directly related to inaccurate staffing, create lost revenue in an era of value-based purchasing. And nurse satisfaction affects patient satisfaction. Use the well-researched factors that link nurse staffing and quality care to build a business case with colleagues and organization leaders.

Champion the integration of patient care data into staffing decisions. Make your organization aware of the wealth of patient information available in the electronic health record (EHR). It's the source of truth about patient need and acuity. And because most healthcare systems use a single EHR, staffing based on patient need can be implemented system-wide. Why implement acuity systems based on opinion when you can assess acuity directly from the EHR?

Tap into knowledge from other departments. Staffing doesn't happen on individual units. Factors from other departments and across the healthcare system can lead to success or failure. Innovations, such as "command centers" that integrate central resource scheduling for all departments, are in place in many organizations.

These centers look at input from a variety of resources to improve staffing and scheduling. A collaborative system strengthens the effectiveness of the staffing processes.

Let research and evidence guide you. Published and locally available data and evidence, including information from patient acuity systems, are available to support a staffing initiative based on patients' documented needs and nurse characteristics. Work with clinically and analytically talented people to develop staffing processes based on this data.

Take advantage of technology. Excellence in staffing begins with information about the patient, which is then integrated with information about nurse competencies and environmental factors. For that reason, technology is essential for efficient and effective data-driven patient-centered staffing. In addition to the EHR, your organization should use other systems, *such as admission, discharge, and transfer information.* With access to real-time data, decisions can be made intra-shift as dynamics—such as acuity, admissions, discharge, transfers, and staff workload—change. Technology saves time, collects and analyzes copious amounts of data, and turns prospective and retrospective staffing data into information that allows healthcare teams to achieve excellent outcomes.

Staffing influencers

In many organizations, current census alone is used for staffing. However, data from many sources have an influence and should be used to make patient-centered staffing decisions.

Patient data

The electronic health record (EHR) is a treasure trove of data for making patient-centered staffing decisions. However, many organizations continue to staff based on census or a staffing matrix, while ignoring patient data.

Staff data

Many nurse and other healthcare staff characteristics—including skill mix, competencies, turnover, and dissatisfaction—significantly affect staffing outcomes.

Department data

Departments throughout an organization also influence staffing. Shortages in housekeeping, respiratory therapy, or pharmacy will slow the work on the unit. An unrealistic surgery schedule or an admitting department that operates ineffectually with the bed-management process can create chaos.

The time has come

Now is the time to move to data-driven staffing based on patient need. Nurses can help take their organizations and colleagues along so that everyone is committed to this goal. Changing long-held perceptions within nursing and healthcare organizations can be a challenge, but traditional resistance to patient-centered staffing is no longer valid in the face of data-driven acuity systems. EHR documentation can remedy human error and system flaws through retrospective audits. In addition, prospectively assigning nurses based on the actual hours of care needed versus an average creates staffing precision.

Many nurses leave healthcare organizations because of perceived or actual staffing assignment inequity. Technology creates assignment visibility and provides the opportunity to document the assignment of complex patients over a defined time so that a break from intense care is based on data.

With technology that provides data-driven support from the EHR for patient-centered staffing, we can improve patient outcomes, increase nurse satisfaction, and positively influence financial, clinical, and operational outcomes of healthcare organizations. The time is now for nursing to take the lead to make a data-driven workforce management approach a priority. ★

The authors work at GE Healthcare. Karlene M. Kerfoot is the chief nursing officer and Patricia Baran is the commercial leader.

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Transitions and transformation

A thank-you to Marla Weston.

THE INDELIBLE MARK left behind by a transformational leader is as unique as a fingerprint. Marla J. Weston, PhD, RN, FAAN, who stepped down as chief executive officer (CEO) of the American Nurses Association (ANA) Enterprise on January 1, has indeed been a visionary, transformational leader. Over the past 8-plus years, she helped ANA weather turbulent times and courageously pursued our journey to become a contemporary organization dedicated to advancing nursing and improving health for all.

An association accomplishes its work through many individuals, not just one person. The CEO, however, is the one who guides the staff to implement the actions of the board, strive for excellence, be creative, and lead with new ideas. The strong collaboration and shared vision between the president, board, and CEO—coupled with the engagement of our members nationwide—is paramount to success. We've enjoyed that success as ANA continues to increase its influence and stature and enlarge its footprint shaping the future of nursing.

We look back to recognize just a few of the advances ANA achieved during Weston's tenure.

Advocacy and health

Political advocacy is a critical component of ANA, and with Weston's leadership our influence remained strong. For example, ANA was a key player in helping craft provisions in the landmark Affordable Care Act, and more recently, we ramped up our advocacy around continued access to affordable, quality health care for all.

ANA also raised its national profile by addressing quality measurement and reporting, advancing evidence linking nurse staffing and positive patient outcomes, protecting nurses' ethical practice, and supporting a culture of safety. The Healthy Nurse, Healthy Nation™ Grand Challenge, launched with Weston's leadership, has successfully engaged individual nurses and organizations to take positive actions to improve nurses' health and wellness, and ultimately, the health of the nation. Answering *The Future of Nursing* report's call to increase the number of influential nurse leaders, she was instrumental in founding the Nurses on Boards Coalition initiative to expand RNs' presence on corporate, health-related, and other boards and panels.

Future-focused

Several years ago, the ANA board and CEO embraced bold new directions to take our professional association into the future. The goal was to ensure that the programs and services ANA offered—and the way nurses connect with us—are meaningful to new generations of RNs. This "race for relevance" to create a 21st-century association paid off in many ways. We increased our member engagement opportunities through professional issues panels that addressed fatigue, care coordination, and other vital issues, and we strengthened our ability to quickly respond to emerging policy and practice issues. One such critical issue involved the Ebola outbreak, during which ANA responded rapidly to address infection control and prevention through extensive education, traditional and social media, and advocating for policies and guidelines to protect nurses serving patients.

Unified and growing

Weston led the integration of ANA, the American Nurses Foundation, and the American Nurses Credentialing Center (ANCC) into a cohesive, forward-focused enterprise. She then concentrated on maturing the enterprise to tackle ANA's bold strategic plan, which calls for using new avenues to engage more nurses with ANA, focusing on innovation, and connecting with consumers to influence health. Weston has guided a cultural transformation of the ANA staff, expanded the Foundation's donor base, and achieved sustained growth of ANCC credentialing programs. During her tenure, membership has grown through innovative pilot programs at a rate outpacing most membership associations. And the number of specialty nurse organizations affiliated with ANA increased from 23 to 38.

Soon ANA will hire its next CEO, one of the most consequential actions the board will make for continued success on our transformational journey. We thank Marla Weston, who has clearly left her mark on ANA. We thank her for her dedication to ANA and know that her impact and legacy will be realized as we fulfill the vision of a powerful integrated enterprise.

Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN
President, American Nurses Association

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What your patient would like you to know about TBI

By Holly Carpenter, BSN, RN

Communication and compassion are key to facilitating recovery.

Staff Sergeant Sarah Zimmerman, United States Army, suffered a moderate traumatic brain injury (TBI) last summer during deployment in Afghanistan. A vehicle containing an explosive device rammed into the vehicle in which she and fellow paratroopers were traveling. Zimmerman was knocked unconscious and sustained multiple injuries, including burns, leg fractures, and a TBI. After a heroic rescue by uninjured soldiers, Zimmerman reported feeling "confusion, mostly." She added, "When I woke up inside the truck, I thought I was dreaming. I couldn't focus at first or comprehend what was happening. I couldn't hear much because my eardrums were blown and my head was foggy. As a medic, I knew pretty quickly that I was showing signs of a TBI."

Zimmerman offers the following tips to nurses caring for patients with TBI:

- "Don't take anything your patient says or does personally. My more prominent symptoms were agitation and irrational irritation. I would get mad at friends and family and have no idea why—but I couldn't control it.
- Patients without medical training may not know about the symptoms that come with a TBI. Explain symptoms in simple terms. You may have to do this repeatedly because of short-term memory problems.
- Ensure patients understand their treatments, care plan, and why following them is imperative.
- Let patients know that recovery takes time. Because TBI can be an invisible injury, many people don't understand its debilitating effects. For the patient, TBI may cause frustration and feeling like nothing is working properly. It took months for my symptoms to subside, and I still have residual issues. Encourage patients on their journey to recovery."

Photo: Drew Brooks, *Fayetteville Observer*

Staff Sgt. Sarah Zimmerman recovering after being attacked in Afghanistan.

What's a TBI?

Traumatic brain injury (TBI) occurs after damage or shock to the skull and brain, such as a severe blow to the head or an object entering the brain. Common causes of TBI include falls, vehicle accidents, being hit with an object, assault, self-harm, and contact sports.

In 2013, more than 2.5 million TBI-related emergency department visits were recorded and 282,000 hospitalizations. Symptoms can range from mild, such as a headache or vertigo, to severe, including seizures, coma, and severely altered mental status.

Treatment is focused on preventing further harm to the brain and promoting optimal support of body systems. TBI can result in chronic disabilities and the need for long-term care. Prognosis for TBI depends on its severity (mild, moderate, severe), where the brain was injured, length of unconsciousness, and other factors, such as the patient's age.

Zimmerman has returned to duty and reports feeling almost back to normal. She has memory problems and ringing in her ears, but the symptoms are decreasing. "When [others] can't see an injury, [they] may assume you don't have one. The help and understanding from my medical team, friends, and family go a long way in making sure I make a full recovery," Zimmerman said. ★

Holly Carpenter is the senior policy advisor in Nursing Practice and Innovation at the American Nurses Association.

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Promoting high reliability on the front line

Create a safety culture by recognizing and reporting unsafe conditions, behaviors, and practices.

By Coleen A. Smith, MBA, RN, CPHQ, CPPS

"It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm." —Florence Nightingale, Notes on Hospitals, *1859*

In 2000, the Institute of Medicine published the report "To Err is Human." Since then, patient safety has emerged as a priority for healthcare organizations. Although some notable advances in patient safety have been made (such as an average 17% reduction across a set of hospital-acquired conditions in the United States between 2010 and 2015), patient harm still occurs in unacceptably high numbers. The estimates of patient harm, including death, range from 98,000 per year to as much as five times that number.

To substantially impact this trend, practitioners, scholars, and accrediting bodies have advocated adapting and adopting the practices of high-reliability organizations (HROs) among frontline healthcare staff. HROs—such as nuclear power plant control rooms, aircraft-carrier flight decks, and commercial aviation—deliver consistently error-free performance despite operating in extremely complex, dynamic, and error-intolerant conditions.

High reliability

High-reliability healthcare is consistently excellent and safe for long

When the Swiss cheese holes line up

James Reason's Swiss cheese model illustrates how bad events happen. Harm can occur when weaknesses (akin to holes in a block of Swiss cheese) line up to allow hazards to reach a patient. These weaknesses, or gaps, happen for two reasons: active failures (unsafe acts) and latent conditions (unsafe conditions).

Active failures are errors or procedural violations. Everyone makes errors. The most common procedural violation in healthcare is known as a routine or corner-cutting violation (workaround). This is frequently seen when policies or procedures aren't well understood or are too difficult to follow. Active failures also occur when staff are feeling time pressure and safety is sacrificed to production.

Latent conditions, on the other hand, may not be related to a specific failure. Humans can't foresee all possible event scenarios, so when processes or systems are designed, they can't account for every possible type of outcome.

As nurses, we're often the last people able to thwart an accident sequence before it affects a patient. We do this by recognizing active failures and latent conditions.

periods across all services and settings. In 2013, The Joint Commission created a high-reliability model for healthcare that consists of 14 components and outlines three major changes healthcare organizations must make to ensure substantial progress toward high reliability (jointcommission.org/assets/1/6/Chassin_and_Loeb_0913_final.pdf):

1. leadership commitment to the ultimate goal of zero patient harm
2. development of a fully functional culture of safety throughout the organization
3. widespread deployment of highly effective process-improvement tools and methods.

Although many components in the model apply to a wide range of healthcare settings, it was specifically created for hospitals, where the most serious problems are found.

Safety culture

A strong safety culture is key to high reliability. It exists when an organization recognizes that most errors are caused by systemic defects in processes, not blameworthy individuals. A safety culture drives the recognition of unsafe conditions, behaviors, and practices, and it supports bringing these problems to managers' attention. Three attributes support these practices: trust, report, and improve. Staff exhibit enough trust in peers and leaders to routinely recognize and report errors and unsafe conditions. Trust is established when leadership eliminates intimidating behaviors that prevent reporting and acts quickly to address issues. Improvements are then communicated to the reporting individual and those who benefit from the improvements.

A strong safety culture is key to high reliability. It exists when an organization recognizes that most errors are caused by systemic defects in processes, not blameworthy individuals.

Many studies have shown a link between recognizing and preventing errors and a culture of safety. Although root cause analysis (retrospective review of patient-safety incidents with planned actions to prevent recurrence) is vital, of equal or greater importance is a proactive approach to harm prevention.

Some unique features of healthcare make creating and sustaining a safety culture difficult. Healthcare has developed a culture of low expectations—failure is an expectation rather than an exception. Routine operational failures, such as missing equipment and supplies, are common and result in caregivers spending time on workarounds instead of providing care. In addition, healthcare has a history of individual accountability. Staff have traditionally been "blamed and shamed" for errors that result from system deficiencies. This fosters silence when unsafe conditions are recognized. (See *When the Swiss cheese holes line up.*)

High reliability on the front lines

HROs encourage early recognition by creating an environment of collective mindfulness or mindful organizing. As Weick and Sutcliffe describe, one of the five principles of mindful organizing is preoccupation with failure—being alert to small signals that something could go wrong. Nurses and other frontline staff are perfectly positioned to aid in creating an HRO by recognizing and reporting small problems (unsafe conditions) before they become big problems (close calls or no-harm events) or cause harm (adverse events).

What should frontline staff report?

In a culture of low expectations, the issues seen in a typical day aren't recognized as "unsafe conditions" but rather as "everyday annoyances." For example, staff may have to spend additional time and attention obtaining a piece of equipment. This is common in many hospitals, and staff on some units may even hide or hoard equipment. Both the absence of equipment and the workaround to stash it are unsafe. Workarounds enable care delivery, but they reinforce a weak system. Substantial research suggests that frontline workers tend to compensate for failures rather than treat them as learning opportunities. But when frontline staff take issues to leadership, they and the organization can reduce errors and improve outcomes.

Tips for creating a safety culture

These measures can help create a culture of safety in your organization.

Share your story. Frontline staff can learn a great deal from hearing colleagues' experiences. Whether it's sharing everyday safety risks (such as missing equipment) or a recent error recognition, including these issues in change-of-shift reports or shift huddles enhances teamwork and safety. And telling a story is far more powerful than simply relating a sequence of events; describe what went wrong and what went right.

Support standard work and hold colleagues accountable. Customize care based on important patient differences, not staff preference. Normalized deviance occurs when staff become so used to departure from procedure or expectation that it's no longer noticed. Failure to follow recommended hand hygiene practices and use of two patient identifiers are examples of areas where staff may turn a blind eye to a colleague's actions. Hold each other accountable using a code word or phrase (such as CHIPs for Clean Hands = Infection Prevention) that indicates you noticed a lapse. This allows behavior correction that's nonthreatening and respectful.

For more sensitive situations where failure to speak up could result in immediate harm, consider using the CUS tool, one of many team tools in the TeamSTEPPS® framework. Staff use the following phrases to "stop the line": I am Concerned, I am Uncomfortable, this is a Safety issue.

Take a second. A 1-second stop has been shown to reduce errors by 90%. Called STAR for Stop, Think, Act, and Review, this action gives you time to stop and focus on the task or the patient and allows you to plan your actions, complete the task, and then review the results. Use STAR when you're feeling rushed, distracted, or tired. It takes only a moment, especially once it becomes a habit, but it can decrease the chance of an error by tenfold.

Don't interrupt. Your work environment (including workflow, space design, and organizational culture) can contribute to interruptions and distractions that threaten patient safety. Distractions can stem from lack of space to work, high noise levels, and tolerance of interruptions during critical tasks. In commercial aviation, pilots maintain a "sterile cockpit": during specified times, they don't engage in extraneous discussion or activities not related to flying the airplane. For nurses, such activities might include medication administration, I.V. pump programming, patient order review, and blood transfusion. Some organizations have spaces at the nurse's station or in the medication room that clearly limit interruptions and conversation. Staff need to honor these spaces and help communicate to physicians, therapists, and other staff that interruptions aren't tolerated.

Close calls are events or situations that didn't cause harm because they didn't reach the patient. They're valuable because their evaluation identifies points of failure and, because they're more common than adverse events, provide more learning. In addition, close calls provide the opportunity to understand what stopped an error or enabled the staff to recover from it. Examples include a prescription dosing error caught by the pharmacy, recognition of specimen mislabeling before sending it to the lab, and a patient alerting staff before a wrong procedure is performed.

Another way that frontline staff can be particularly helpful is by reporting the extra work spent locating and obtaining supplies, looking for personnel, compensating for poor communication systems, and completing redundant documentation.

To sustain this valuable input from frontline staff, leadership must analyze the information from these reports to design solutions. Communicating the solutions is crucial and can easily be integrated into a unit safety huddle. (See *Tips for creating a safety culture*.)

Goal: Zero harm

Healthcare organizations and frontline staff have many competing priorities, but everyone can support preventing harm. The pursuit of high reliability requires focus on specific areas of performance to move toward the goal of zero harm. Frontline staff have an invaluable role in this pursuit. Recognizing and reporting safety risks and role modeling safe behaviors are all tied to harm reduction. ★

Coleen A. Smith is the director of High Reliability Initiatives at the Joint Commission Center for Transforming Healthcare in Oakbrook Terrace, Illinois.

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Everyone is responsible for a culture of safety

Whether you're a direct-care nurse or a leader, you're responsible for speaking up and taking action to keep patients safe.

By Linda Paradiso, DNP, RN, NPP, NEA-BC

Leaders are essential to developing a safety environment, but all healthcare staff are responsible to practice safely. In a country where medical errors are the third leading cause of death, we can learn to decrease those deaths by improving our systems through voluntary reporting of errors and near misses. Nurses, because of their closeness to patients, can easily identify and report errors and unsafe conditions.

High-reliability organizations want to know what's working and what's broken so that improvements can be made. (For more about high-reliability organizations, see page 30.) Ideally, organizations are accountable for the systems they design, and nurses are accountable for the quality of their choices as they practice within those systems. In this perfect world, discipline is based on the behavioral choice an employee makes, not the injury to a patient. (See *The choices we make.*)

Error identification

Direct-care nurses are well positioned to identify errors. However, when they work in chronically understaffed and stressful conditions, the quality of their choices will suffer. Of course, direct-care nurses (and leaders) need to appreciate the acceptable reasons for violating a patient safety policy or procedure. For example, you wouldn't expect a pediatric nurse to stop for hand hygiene before rescuing a child climbing over the crib rail. High-reliability organizations understand this and develop as many system improvements as possible to keep justifiable risks to a minimum.

Accountability as a root cause

Almost every hospital identifies nonpunitive discipline in their quality-review processes, but many direct-care nurses report punitive discipline and negative responses from supervisors when incidents occur. Healthcare organizations tend to identify individual incompetence as a root cause, or in addition to, a systemic process error. Nursing quality performance committees rarely close incident review cases without monitoring or retraining the nurse involved, even if they identify a contributing system issue.

Nurses may end up as second victims of an error. The Center for Patient Safety defines second victims as "healthcare providers who are involved in an unanticipated adverse patient event, medical error and/or a patient-related injury and become victimized in the sense that the provider is traumatized by the event." This definition can be interpreted to include not just the event

The choices we make

Outcome Engenuity, a workplace accountability and reliability training organization, defines three types of behaviors: human error, at-risk, and reckless. Nurses who work directly at the bedside must recognize the behavioral choices they make every day and how those choices affect accountability of practice and liability.

Human error
Human error is another way of describing a slip or mistake. These behaviors (for example, a medication error) usually are made unwittingly and often identified by someone other than the person who made the mistake.

At-risk behaviors
At-risk behaviors are choices made consciously but the risk is either not recognized or is rationalized. One example of an at-risk choice is giving a discharged patient's unused meal tray to a newly admitted patient. This common practice has a low incidence of bad outcome; a nurse justifies that the newly admitted patient is hungry and that getting a tray from the kitchen takes too long. This type of choice—also called a work-around—is common and often becomes normal practice.

Reckless behavior
A reckless behavior is a choice taken with the understanding that the outcome could be substantially detrimental. For example, during medication administration a nurse overrides a bar-code system when alerted to an identification mismatch. The likelihood of a harmful outcome is high.

itself, but also colleagues' and the organization's response to it. Faulty systems should be redesigned; individuals working within the faulty system shouldn't be punished unless, of course, they engage in reckless behavior.

Patient safety teamwork

Direct-care nurses must actively participate in the peer-review and performance-improvement process, and nurse leaders must provide an environment where nurses feel safe to speak up. When leaders create an atmosphere of teaching rather than preaching, they destigmatize incident management and normalize patient safety events. The result is that nurses share the knowledge and rationale for a behavioral choice that supports a nonpunitive response by leaders and focuses improvement on the system instead of the individual.

Solutions developed by bedside nurses can be very meaningful. Through active direct-care nurse involvement and nurse leader system redesign, the organization can drive performance improvement from the bedside upward. Some facilities understand and bind employees and leaders through the creation of shared patient safety outcomes. Erin Bashaw noted that "Nurses in Magnet® facilities are more likely to report errors and participate in error-related problem solving because they feel empowered by the organizational culture and have supportive relationships with senior administrators."

A nurse leader who personally responds to an event and participates in a debriefing has a better understanding of the system in which the event occurred. Supporting the direct-care nurse by helping to identify and understand the behavioral choice can assist in identifying the opportunity for system redesign. Debriefing also should include stress management for the nurse involved.

Error identification is critical to process improvement but is often difficult. Leaders should reward nurses for this effort by offering them support. An algorithm can help leaders maintain objectivity so they can focus on the behavioral choices made with the knowledge the nurse had at the time. And although it takes courage for nurses to speak up, it also takes courage for nurse leaders to refrain from discipline when they're pressured to hold an individual accountable.

Make it safe to share

The quality of nurse leader response is critical to a safety culture where nurses feel safe to speak up. Nurses who trust their supervisors to listen, support, and console when they make human errors or risky choices will be more likely to escalate patient safety issues and speak up when participating in process improvement.

Human error is certain. Every nurse will find him- or herself in a situation that goes (or could have gone) wrong. Risky behaviors are frequently the result of faulty systems, so how we analyze the system in which the nurse is working will make the most impact on outcomes. Collaborative process improvement is fundamental to a patient safety culture. We all have to make it safe to share. ★

Linda Paradiso is an assistant professor at the New York City College of Technology – CUNY in Brooklyn.

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ANA ON THE FRONTLINE

NEWS FROM THE AMERICAN NURSES ASSOCIATION

Promoting health equity and valuing tradition

■ Political professor ■ Foundation news ■ Sexual harassment

The Center for Indigenous Nursing Research for Health Equity

Creating opportunities for nurses and giving respect to tradition

By Elizabeth Moore

With the stirring music and sacred smoke of a traditional Native American blessing, the first indigenous nursing research center in the world was dedicated in May 2017 at the Florida State University (FSU) College of Nursing in Tallahassee, Florida. Led by Executive Director John Lowe, PhD, RN, FAAN, the Center for Indigenous Nursing Research for Health Equity (INRHE) aims to attain health equity through research, education, and service by partnering with indigenous peoples, communities, organizations, and supporters globally.

Lowe, who is the McKenzie Endowed Professor for Health Disparities Research at FSU, envisions the center developing "a strong unity among global nurses" who are working to increase health equity in native communities. Lowe has spent his career exploring health disparities and inequities in indigenous communities and studying cultural practices and traditions that have proven helpful in alleviating the effects of those disparities.

Health equity goes further than eliminating health disparity. "Just because we reduce disparities [in indigenous populations] doesn't mean we are optimizing health," said Lowe, a Florida Nurses Association member. "As indigenous or Native American people, we believe health equity is an inherent right," he explained. "Our ancestors sacrificed land, lives, and culture so that their descendants could have what was promised through treaties and other means. But we were left with inequities and disparities. This context is important to why we strive for health equity."

The estimated worldwide population of indigenous people is 370 million; they belong to 5,000 different groups and speak about 4,000 languages. The INRHE center currently has projects in collaboration with multiple tribes in the United States and is developing projects with indigenous communities in Canada, Australia, Panama, and New Zealand.

Lowe would like to see the center build relationships with other health disciplines. And, he said, "We want to be a hub, not just for indigenous nurses, but for other nurses who know the issues." Connecting with indigenous populations globally also is critical, as they share common experiences with colonization and dispossession, he noted.

The center hosted the first International Indigenous Nursing Research Summit in May 2017. To ensure a broad array of viewpoints, the center's advisory board council is made up of indigenous and non-indigenous scholars from around the world.

Advisory Council Member Odette Best, PhD, RN, associate professor of nursing and midwifery at the University of Southern Queensland, called the summit the most empowering indigenous health conference she's ever attended. "This was due to Professor Lowe's ability to pull together global, indigenous nurses to present our research to fellow indigenous nurse researchers," said Best, who is an Aboriginal Australian.

Photos courtesy of FSU Photography Services/Bill Lax.

Indigenous nursing researchers and leaders from Australia, Canada, Panama, and Peru, as well as Native Americans, Alaska Natives, and Native Hawaiians gathered at the summit.

Traditions and clinical practice can coexist

A Cherokee Native American, Lowe is one of just a few Native American male RNs and was honored in 2016 with the American Nurses Association's Luther Christman Award, which recognizes the achievements of men in nursing. While earning his BSN, MSN, and PhD, Lowe worked in clinics and provided nursing instruction around the United States and in Tanzania, China, Jamaica, and Costa Rica. He has received funding from the National Institutes of Health for his work on Native American substance abuse prevention, including an after-school substance abuse prevention intervention called the Intertribal Talking Circle, which has been acknowledged by the U.S. Department of Justice's Office of Justice Programs as a Promising Evidence-Based Program for the well-being of youth.

Patricia Grady, director of the National Institute of Nursing Research at the National Institutes of Health, and John Lowe during the Summit.

Culturally congruent practice

Culturally congruent practice is the application of evidence-based nursing that's in agreement with the preferred cultural values, beliefs, worldview, and practices of the healthcare consumer and other stakeholders. Cultural competence represents the process by which nurses demonstrate culturally congruent practice. Nurses design and direct culturally congruent practice and services for diverse consumers to improve access, promote positive outcomes, and reduce disparities, according to the American Nurses Association's *Nursing: Scope and Standards of Practice*, Third Edition.

The Talking Circle is an example of the culturally congruent interventions that INRHE center researchers will focus on. "Healthcare professionals should learn more about [indigenous or native] practices and learn to work with them," Lowe said. "If a native or indigenous person were to present themselves in a healthcare setting and report that they were using a traditional medicine, how would the healthcare provider assess that respectfully?" Increased education about indigenous practices furthers understanding and can prevent potentially unsafe interactions. For instance, "If a native person is using some kind of traditional plant, [the healthcare provider] needs to be knowledgable about that" to avoid potentially unsafe interactions, Lowe explained.

In 2015, a new standard of professional performance, Standard 8: Culturally Congruent Practice, was added to the third edition of the American Nurses Association's *Nursing: Scope and Standards of Practice*, which is in accord with how Lowe hopes the INRHE center's work will translate into practice.

Competencies for RNs at all levels include:

- participates in lifelong learning to understand cultural preferences, worldview, choices, and decision-making processes of diverse consumers
- applies knowledge of variations in health beliefs, practices, and communication patterns in all nursing practice activities
- promotes equal access to services, tests, interventions, health promotion programs, enrollment in research, education, and other opportunities.

Additional competencies are delineated for graduate-level prepared RNs and include "develops recruitment and retention strategies to achieve a multicultural workforce." Similarly, additional competencies are specified for advanced practice RNs, including "promotes shared decision-making solutions in planning, prescribing, and evaluating processes when the healthcare consumer's cultural preferences and norms may create incompatibility with evidence-based practice."

"Nurses in indigenous communities around the world are delivering most of the health care. It only makes sense that nurses act as the catalyst for research," Lowe said. He sees nurses researching particular health problems in specific communities and how traditional living and healing practices are working—and how they might complement evidence-based interventions.

Increasing opportunities

Melessa Kelley, PhD, RN, is one of the center's post-doctoral fellows. Her current research focuses on obesity prevention among Native American youth.

Melessa Kelley

"The center has provided me with many amazing opportunities to network with nurse scientists around the world," said Kelley, who has presented her research at several conferences. Last summer, she was the only Native American selected to attend the National Institute on Minority Health and Health Disparities (NIMHD) Health Disparities Research Institute (HDRI) as a Research Scholar, where she learned about innovative approaches to research and grant opportunities that address health disparities. Kelley believes collaboration via the center will continue to elevate health equity research.

Although part of the center's purpose is to educate nurses and healthcare providers about the needs and characteristics of indigenous populations, it also serves to help increase the number of Native Americans who are PhD-prepared nurses. Lowe said he wants the center to provide "great research experiences" as well as opportunities for connection and networking. He hopes that fellows of the Minority Fellowship Program of the ANA see the center as a place where they can gain experience working with indigenous people and launch post-doctoral careers.

— **Elizabeth Moore is a writer at ANA.**

Minority Fellowship Program: Expanding research for ethnic and minority populations

John Lowe, PhD, RN, FAAN, is chair of the National Advisory Committee and an alumnus of the Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship Program (MFP) at the American Nurses Association. The MFP provides opportunities for minority nurses to attain a doctoral degree, with certification in mental health and substance abuse disorders prevention, treatment, and recovery across the life span.

The program's mission is to increase the number of rigorously educated nurses from under-represented ethnic minority groups to:

- conduct research about psychiatric/mental health issues and problems with minority populations across the life span
- assume leadership roles in the initiation of scientific investigations about phenomena that occur among ethnic/minority populations
- expand psychiatric/mental health literature about minority populations across the life span
- function as members of interdisciplinary research and treatment teams with the intent of improving the mental health status of ethnic/minority populations.

Learn more about MFP at www.emfp.org.

My professor is too political

To: **Ethics inbox**

From: **Perplexed nursing student**

Subject: **Political activism in nursing**

I'm a nursing student who's interested in the role of the nurse as a political activist. I understand that my actions are guided by the *Code of Ethics for Nurses with Interpretative Statements*, but in many of my classes I find that my professors are urging us to support a political view that conflicts with my personal beliefs. While I appreciate that my professors are encouraging me to be politically active and vote, should I be made to feel that I must vote for a certain candidate to be a "good" nurse?

From: **ANA Center for Ethics and Human Rights**

I'm pleased that you're interested in the role of the professional nurse as a political activist and policymaker. Both our profession and ANA need you!

The *Code of Ethics for Nurses with Interpretative Statements* doesn't distinguish partisan politics. Rather, the *Code* outlines the need for nurses to be involved in the political process, which is defined as "the formulation and administration of public policy usually by interaction between social groups and political institutions."

In the *Code*, Provision 8 outlines the role of the nurse, stating that "health is a universal right" and that "this right has economic, political, social, and cultural dimensions." Further, Provision 8 requires that nurses work with others to change unjust practices that affect the health of individuals, populations, and communities. Often this collaboration is done in the political arena through policy creation, but it isn't exclusive to that setting.

Provision 9 affirms the profession's responsibilities in that "the profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy." Registered nurses number about 3.6 million in the United States—we're the largest group of healthcare professionals—and we have the power to influence health policy and the type of care that's delivered to our individual patients and the communities where they live and work.

Interpretive Statement 7.2 of the *Code* ethically obligates nurse educators to "ensure that all their graduates possess the knowledge, skills, and moral dispositions that are essential to nursing." Nurse educators have a duty to respect students as unique beings with individual beliefs and must create safe, caring places where each student is encouraged to ask questions, engage in thoughtful discussion with their peers, and dissent with the majority if they choose. Consider speaking up to stimulate dialogue about the value of diverse opinions. Perhaps there are other students who feel pressured to support a political view that is not aligned with their personal values. Nurse educators should model respectful, kind, and compassionate behaviors in all interactions with students, faculty, and others in all settings and hold their students accountable for professional behavior.

The role of the professional nurse is evolving. Nursing students should be encouraged to integrate their practice of nursing into their worldview; nurse educators must help students understand the importance of the role nurses have in the greater society without injecting their personal bias.

So, the answer to your question is no, you don't have to sacrifice your personal political beliefs to be a "good" nurse. Interpretive Statement 6.1 of the *Code* outlines the attributes of moral character expected of a "good" nurse. "These include knowledge, skill, wisdom, patience, compassion, honesty, altruism, and courage." For these virtues to be operative, nurse educators must provide a moral milieu that enables them to flourish.

Selected reference

American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements.* Silver Spring, MD: American Nurses Association; 2015.

Response by Elizabeth O'Connor Swanson, DNP, MPH, APRN-BC, member of the ANA Ethics and Human Rights Advisory Board.

New documentary helps public better understand nursing

Elevating the image of the nurse drives the work of the American Nurses Foundation. The Foundation's aspiration to show the public what excellence in nursing looks like led to its partnership with Carolyn Jones Productions to promote *The American Nurse* (americannurseproject.com/film-trailer), a documentary released in 2013. And now the Foundation wants to help disseminate her latest documentary, *Defining Hope*.

Defining Hope tells the story of people weighing what matters most at the most fragile junctures in life and the nurses who guide them. "This film was made possible by the thousands of nurses who donated to the Foundation," said Tim Porter-O'Grady, DM, EdD, APRN, FAAN, chair of the Foundation's Board of Directors. "Like me, they know that everyone—from patients to insurers—needs a better understanding of nursing. *Defining Hope* captures and demonstrates the essential knowledge that nurses employ every day."

A patient at Children's National Health System, a Magnet®-recognized organization, featured in the film.

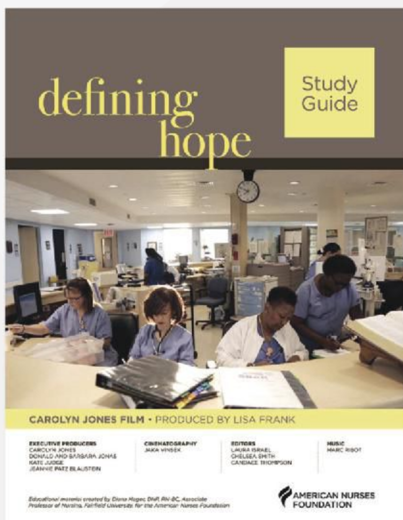
Now available on DVD

The film was released in theaters across the United States on November 1, 2017, and is now available on DVD (hope.film). A portion of the proceeds supports programs that advance expertise in palliative nursing practice at the Foundation and the Jonas Center for Nursing and Veterans Healthcare.

The American Nurse also can be purchased through Diginext (diginextfilms.com/projects/the-american-nurse) with a portion of its proceeds benefiting scholarships through the Foundation.

Real nursing to help teaching

Through the generosity of the Rita and Alex Hillman Foundation, the Foundation has created a free set of vignettes from *Defining Hope* that nursing faculty, students, and clinicians can use to explore real nursing in real settings. The vignettes are part of the *Defining Hope* study guide, created by Diane Mager, DNP, RN-BC, which covers topics ranging from differing family views of medical interventions to nurses' perceptions of hospice and palliative care.



"As a clinician and educator, I appreciate the importance of having innovative methods to encourage conversations about difficult and sensitive topics," said Mager, a Connecticut Nurses Association member. "We've created something that is easy to use, and is relevant for both current and future healthcare professionals."

The free vignettes, along with teaching prompts and resources, can be found at hope.film/study-guide-videos (password: hope).

Coming soon

Defining Hope will be shown on PBS during the month of April 2018 for National Patient Decision Month and again in May for National Nurses Week. To find it in your area, visit hope.film. If you'd like the film to be shown in your PBS viewing area, contact your local station to request it.

To help ensure that nursing is more visible, please consider supporting the American Nurses Foundation with an individual gift—especially one in honor of a nurse who has inspired you. Visit givetonursing.org to donate.

Sodexo partners with ANA Enterprise to transform the health and wellness of America's nurses

The ANA Enterprise announced on January 25, 2018, that Sodexo joined the Healthy Nurse, Healthy Nation™ (HNHN) Grand Challenge as a major partner in support of this transformative initiative.

The ANA Enterprise is the organizing platform of the American Nurses Association (ANA), American Nurses Credentialing Center (ANCC), and American Nurses Foundation. Sodexo Healthcare in North America provides Quality of Life Services in facilities management, environmental services, clinical technology management, and food and nutrition at 1,200 hospitals in the United States and Canada. Sodexo's multimillion-dollar contribution to the American Nurses Foundation is in direct support of the ANA Enterprise's HNHN Grand Challenge.

"The ANA Enterprise is grateful for Sodexo's support of Healthy Nurse, Healthy Nation," said ANA Enterprise Interim Chief Executive Officer Debbie Hatmaker, PhD, RN, FAAN. "We are proud to partner with a company that shares our goal of improving nurses' quality of life and nutrition as part of a comprehensive approach to wellness. Sodexo's leaders recognize the power and influence of the nation's most 'honest and ethical' profession, and share our belief that an investment in nurses' health is an investment in the health of the nation."

"Sodexo is proud to partner with the ANA Enterprise on the Healthy Nurse, Healthy Nation initiative," said Sodexo Healthcare Global Head of Marketing Simon Scrivens. "Through our comprehensive suite of Quality of Life Services, Sodexo is uniquely positioned to help ANA make a positive and lasting impact on the health and well-being of America's nurses."

Nurses are less healthy than the average American. Research shows that nurses experience 2.8 times more stress, have a 30% less nutritious diet, a 5% higher body mass index, and get 10% less sleep.

The HNHN Grand Challenge aims to transform the health of the nation by improving the health of America's 3.6 million RNs. Launched in May 2017, the Grand Challenge provides the framework to connect and engage individual nurses, employers of nurses, state nurses associations, and specialty nurses associations to take action to improve their health in five key areas: physical activity, rest, nutrition, quality of life, and safety.

Sodexo, the world leader in Quality of Life Services, will bring its market-leading programs and expertise to the HNHN core program areas of quality of life and nutrition, and will collaborate with ANA to develop new program activities to enhance the initiative.

The HNHN Grand Challenge has grown since its launch and currently has 270 partner organizations and almost 12,000 members. Partner organizations and individual members have access to a web platform to inspire action; cultivate friendly competition; provide content and resources to users; gather user data; and connect nurses with each other, employers, and organizations. Additionally, participants may join a variety of health challenges related to the five key areas.

Both individuals and organizational partners can learn about and sign up for the HNHN Grand Challenge at healthynursehealthynation.org.

Celebrate certified nurses on March 19

Certified Nurses Day™ recognizes nurses worldwide who contribute to better patient outcomes through board certification in their specialty. It is the perfect opportunity to invite all nurses to advance their career by choosing certification. Celebration resources are available from the American Nurses Credentialing Center at certifiednursesday.org.

Everyday advocacy

Throughout the Year of Advocacy in 2018, ANA will share stories of how RNs have used their influence to shape and bring about change, at the #BedsideAndBeyond.

The focus for the first quarter is nurse members advocating locally. ANA is recognizing Constance Ducharme, BSN, RN, CHP, an ANA-Rhode Island member, for her role in a program that helps senior patients navigate end-of-life care and assists with creating advance directives. Texas Nurses Association member Patricia Phelps, MSN/Ed, RN, has created a workplace violence prevention education program. Read more and get involved at RNaction.org.

ANA addresses sexual harassment as part of #EndNurseAbuse initiative

Abuse against nurses is a serious problem in hospitals, clinics, and other healthcare settings across the country. According to anecdotal reports from nurses, sexual harassment is a major challenge as well.

To address the problem, the American Nurses Association (ANA) emphasized in February 2018 that its #EndNurseAbuse initiative, which launched in 2017 to address workplace abuse against nurses, includes eliminating sexual harassment. Furthermore, as part of the initiative, ANA underscored its strong support for the #TimesUpNow movement that promotes accountability and consequences for abuse, harassment, sexual assault, and inequality in the workplace.

"Nurse safety is a critical component to ensure quality and safe care. 'Time's up' for employers who don't take swift and meaningful action to make the workplace safe for nurses," said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. "Together, nurses, employers, and the public must take steps to change our culture. Abuse is not part of anyone's job and has no place in healthcare settings."

#EndNurseAbuse puts the spotlight on these alarming and frequent incidents: In the past several months, a nurse in Massachusetts was stabbed by a patient. Two nurses in Illinois were taken hostage, and one was beaten and raped. A nurse in Utah was shoved and wrongly arrested by a police officer, and a nurse in Arkansas was pushed down a flight of stairs. Recently, cases of abuse were reported in New York, Pennsylvania, and North Dakota, yet many more go unreported by the media.

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In 2015, ANA adopted a policy of zero tolerance for workplace violence and called on nurses and their employers to work together to prevent and reduce violent and abusive incidents. (See goo.gl/3CDtvc.) According to ANA's Health Risk Appraisal (HRA), one in four nurses has been assaulted at work by a patient or patient's family member. (Read the HRA at nursingworld.org/HRA-Executive-Summary).

ANA has developed a pledge for nurses, other healthcare professionals, and the public to stand with nurses and is asking nurses to share their stories on workplace abuse. To date, more than 12,000 individuals have pledged to:

- ✓ **support** zero tolerance policies for abuse against nurses
- ✓ **report** abuse against nurses whenever safely possible
- ✓ **share** the pledge and ask friends and family to sign.

Additionally, ANA will convene a panel of experts to address barriers to reporting abuse against nurses. With more than 3.6 million RNs in the United States, #EndNurseAbuse (p2a.co/t84cVfR) strives to foster safe work environments for the largest group of all healthcare professionals. Read more on ANA's Capitol Beat blog at anacapitolbeat.org/2017/10/31/will-you-endnurseabuse.

Moral resilience report focuses on creating a culture of ethical practice

The report *Exploring Moral Resilience Toward a Culture of Ethical Practice: A Call to Action Report*, examines how moral resilience can guide healthcare providers to create a culture where moral and ethical practice can thrive. Developed by the ANA Professional Issues Panel on Moral Resilience, the report suggests moral resilience as a way to alleviate the complex psychological symptoms associated with challenging work environments.

Download the complimentary report at nursingworld.org/ExploringMoralResilience.

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Nursing Excellence

2018 Magnet®-Recognized Organization Success Stories

Special Section

Comparing Pathway to Excellence® and Magnet Recognition® Programs

Two roads to nurse engagement and quality outcomes.

By Christine Pabico, MSN, RN, NE-BC, and Rebecca Graystone, MS, MBA, RN, NE-BC

Creating a supportive practice environment fosters sustained excellence and inspires innovation. Nursing leaders recognize the benefit of the American Nurses Credentialing Center's (ANCC's) organizational credentials from the Magnet Recognition Program® (Magnet®) and Pathway to Excellence® (Pathway). Both programs provide valuable frameworks for achieving healthcare excellence that reinforce and build upon each other. Many organizations have used Pathway and Magnet frameworks to successfully improve a host of key measures, including nurse engagement, nurse retention, interprofessional collaboration, patient safety, quality, and outcomes.

But how do the two programs compare? Magnet and Pathway are two distinct programs with a complementary focus. Magnet recognizes healthcare organizations for quality outcomes, patient care and nursing excellence, and innovations in professional practice, while Pathway emphasizes supportive practice environments, including an established shared-governance structure that values nurses' contributions in everyday decisions, especially those that affect their clinical practice and well-being. This environment promotes engaged and empowered staff, an essential foundation for every organization. (See *Pathway and Magnet—Providing standards for excellence*.)

Achieving recognition

Both Pathway and Magnet recognition have a four-phase process: online application, document review, validation phase, and designation decision.

After healthcare organizations apply and are determined to meet eligibility requirements, they submit written documentation that undergoes rigorous peer review by expert appraisers. The validation phase varies by program. If the written documentation for Magnet recognition meets the threshold for nursing excellence, a site visit is conducted to validate, verify, and amplify compliance with and enculturation of the Magnet® Model components. For Pathway, instead of a site visit, all nurses have a voice through an invitation to participate in a confidential survey during the validation phase.

The final phase is a designation determination by the Commission on Magnet Recognition or Commission on Pathway to Excellence.

Work environment

Both Pathway and Magnet include standards and components related to the work environment. (See *Influential leadership*.)

Magnet addresses the work environment through the Magnet Model component Structural Empowerment, which fosters RN involvement in shared governance, decision-making structures, and processes that establish standards of practice and address opportunities for improvement. In addition, both Magnet and Pathway nurses support organizational goals, advance the profession, and enhance professional development through their work with professional and community groups.

Unique to Pathway is the well-being standard, which encourages staff to have a voice in organizational initiatives developed to promote work-life balance. Flexible scheduling and input into staffing, part of the well-being standard, are associated with increased job satisfaction and decreased intent to leave. Nurses are encouraged to be involved in

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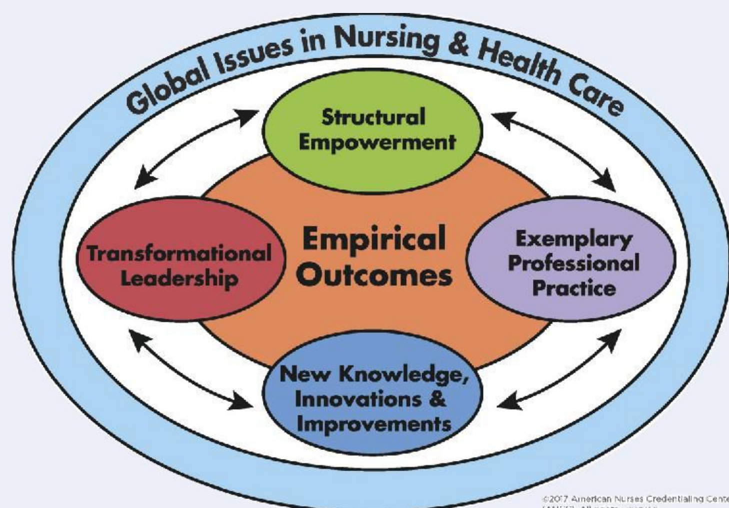
Magnet and Pathway—Providing standards for excellence

The American Nurses Credentialing Center's Pathway to Excellence and Magnet Recognition programs provide healthcare organizations with structures and standards for excellence.

Pathway to Excellence
The Pathway to Excellence Program, the premiere designation for positive practice environments, recognizes healthcare organizations across the care continuum that create workplaces where nurses can excel. To achieve the designation, organizations must demonstrate that the six Pathway standards (shared decision-making, leadership, safety, quality, well-being, and professional development), the essential elements of a positive practice environment, are fully integrated within the organization.

Magnet Recognition
The Magnet Recognition Program requires healthcare organizations to meet eligibility requirements and address standards within five major components that comprise the Magnet Model (below). The model guides the Magnet principles that focus healthcare organizations on achieving superior performance as evidenced by outcomes.



the community, and they're recognized for their contributions to improving population health. Practice environments that foster praise and recognition, another important Pathway component, positively impact nurses' satisfaction and organizational commitment. In addition, Pathway organizations promote a culture of lifelong learning to ensure the professional competency and growth of all nurses.

Professional practice

Several unique Magnet Recognition components—Empirical Outcomes, New Knowledge, Innovations and Improvements, and Exemplary Professional Practice—demonstrate nursing excellence. Empirical Outcomes, a component that differentiates Magnet from Pathway, is one way Magnet recognizes cultures of excellence and innovation. For example, Magnet-recognized organizations must demonstrate excellent patient care outcomes, including lower rates of patient falls with injury, central line–associated bloodstream infections, and stage II or higher hospital-acquired pressure injuries.

Pathway to Excellence emphasizes supportive practice environments that promote engaged and empowered staff. Pathway evaluates nurses' participation and involvement and considers how this has resulted in improved outcomes.

Magnet organizations build on positive practice environments that support exemplary professional practice. The care-delivery system is integrated within this model and promotes continuous, consistent, efficient, and accountable delivery of nursing care.

In addition, nurses in Pathway and Magnet-recognized organizations learn about evidence-based practice and research. Nurses in Magnet-recognized organizations systematically evaluate and use published research and generate new knowledge through research studies. This knowledge allows them to explore the safest and best practices for their patients and practice environment.

Framework for excellence

Both Pathway to Excellence and Magnet Recognition programs provide valuable frameworks for achieving healthcare excellence.

Many organizations have used the Pathway and Magnet frameworks to successfully achieve improvements in nurse empowerment, engagement, satisfaction, retention, care quality, and cost savings. By embracing change and innovation, Magnet and Pathway organizations, and those that are on the journey to recognition, are strongly positioned to meet new healthcare challenges and improve the future of healthcare delivery. ■

The authors work at the American Nurses Credentialing Center in Silver Spring, Maryland. Christine Pabico is director of the Pathway to Excellence Program. Rebecca Graystone is director of the Magnet Recognition Program.

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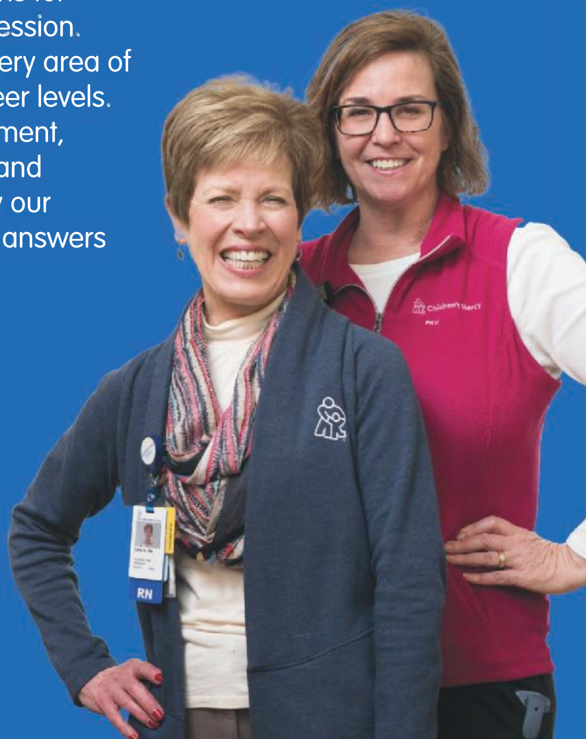

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Influential leadership

Leadership—from chief nursing officers (CNOs) at the organization level through nurse managers (NMs) at the unit level—plays a critical role in creating and sustaining positive practice environments. These leaders are aware of challenges experienced by nurses at the point of care and have the ability to remove obstacles that lead to staff dissatisfaction and frustration, allowing them to influence the practice environment.

The Pathway to Excellence framework fosters the development of leaders who empower and advocate for nurses and create an environment that protects the safety and well-being of staff and patients. Likewise, Magnet Recognition includes an entire component, transformational leadership, with standards related to the CNO and other nurse leaders' strategic position, influence, advocacy, and visibility to affect meaningful change within an organization.

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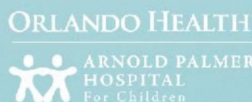

Novel ethics champion programs

Three pediatric hospitals share tips for success.

By Heather Fitzgerald, MS, RN; Angela Knackstedt, BSN, RN-BC; Karen Trotochaud, MN, MA, RN

Recognizing ethical issues, engaging colleagues in discussion, speaking up despite perceived risk, acting in response to ethical concerns, and addressing moral distress are essential to effective teamwork and patient well-being. However, these skills too often aren't sufficiently developed in education or clinical settings, leaving nurses ill-prepared in the face of ethical challenges. Studies show that nurses who experience moral distress and feel powerless to act effectively are at risk for moral disengagement, emotional numbing, and distancing from patients. Mitigating moral distress, promoting moral courage, and developing moral resilience are pressing priorities for nurse ethicists, scholars, educators, and leaders.

Ethics champions

An ethics champion program is one way to meaningfully connect nurses with the ethical foundations of nursing practice and to promote moral agency. Children's Hospital Colorado (Magnet®-recognized), Children's Mercy Kansas City (Magnet®-recognized), and Children's Healthcare of Atlanta are three pediatric centers with robust ethics champion programs. Each site has distinct approaches, but all provide supportive, educational, unit-based, hospital-wide forums to address moral distress, deepen moral sensitivity, increase confidence in recognizing and responding to ethical issues, and connect colleagues to available ethics resources.

Ethics champions augment their professional roles by serving as visible and accessible ethics representatives in their respective settings. They attend meetings for ethics education to deepen knowledge and practice in the complex skills necessary for effective communication, ethical decision-making, conflict resolution, and diminishment of moral distress among peers and interdisciplinary colleagues. The champions take these skills back to their settings to help clinical colleagues navigate ethically complex issues and take advantage of hospital ethics resources, such as the ethics committee.

All three programs are grounded in the American Nurses Association's (ANA's) *Code of Ethics for Nurses with Interpretive Statements*, which offers a clear charge to integrate ethics into clinical practice and promote ethical environments. Provision 4.3 states that "nurses must bring forward difficult issues related to patient care and/or institutional constraints upon ethical practice for discussion and review." And Provision 6 states, "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 healthcare."

Elements of success

Hospital-supported nurse ethicists direct all three programs. Working collaboratively, they conducted a survey across the three settings to describe their respective program aims. (See *Champions make an impact*.)

The nurse ethicists believe that the comments and results of the survey positively reflect the programs and provide feedback of their impact on each ethical environment. The ethicists agree that the following elements are necessary for success when launching an ethics champion program:

- Approach the hospital ethics committee to confirm support for the program. Ethics champions programs aren't a replacement for the committee; they're a mechanism to extend the committee's reach throughout the organization.
- When possible, administer a baseline assessment of the organization. For example, a hospital ethical climate or moral distress survey can provide valuable data to guide and measure program interventions.
- Engage key stakeholders—such as nurse executives, nurse directors, and nurse managers—to assist with member recruitment, share perspectives about organizational needs, and foster ownership. To provide clarity about the scope of the effort, confirm support for staff time to participate and the number of ethics champions approved per unit.
- Customize your recruitment and engagement approaches to the setting, and consider individ-

(continued on page 54)

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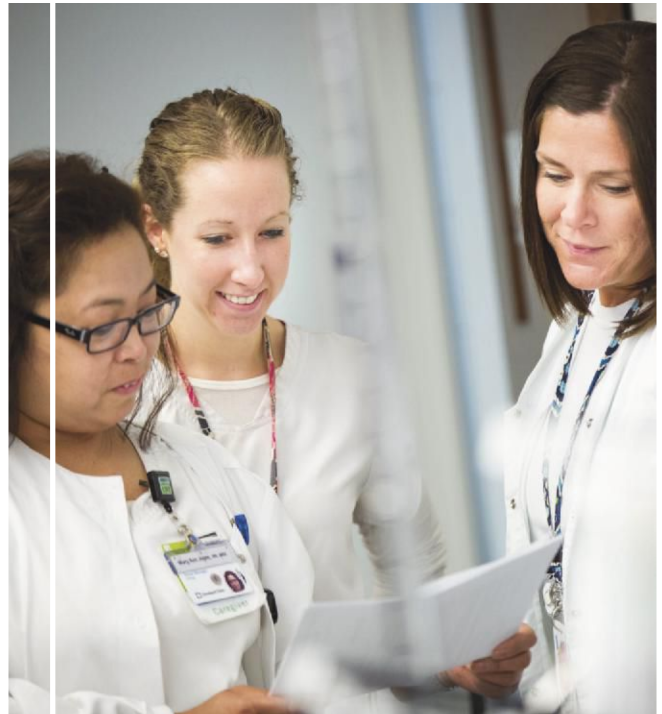

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Champions make an impact

When the nurse ethicists directing the ethics champion programs at Children's Hospital Colorado, Children's Mercy Kansas City, and Children's Healthcare of Atlanta conducted evaluations of their programs, participants responded to a narrative question about the impact on clinical practice. Their responses clustered into eight major themes:

1. increased awareness and recognition of ethical issues in their practice
2. importance of available support in addressing ethical issues
3. increased individual moral agency for determining ethical choices and acting on those choices
4. greater knowledge of ethical issues and ability to professionally share that knowledge with others
5. increased recognition of the opinions and values of others and capacity to seek different perspectives
6. empowerment to use ethics resources, such as the ethics committee, and act as a resource to others
7. better understanding of how participation makes a difference in the clinical practice by giving nurses a voice
8. recognition of the value of ethics discussions and patient care to support providers.

One participant said: "I believe 100% that [being an ethics champion] has made me a better nurse. Overall, I have found that I am able to look at a situation more objectively and I can appreciate the opinions of others when addressing an issue. I have also changed the way I have interacted with my patients and families and I have found it easier to maintain a therapeutic relationship with my patients."

uals' inherent leadership qualities, interest in ethics, and "early adopter" attitude. Consider connecting the ethics champion role to professional advancement within the organization to offer a measurable benefit to program members and the clinical setting.

- Create an ethics education curriculum based on baseline survey results and cultivated over time in response to emerging organizational needs and current bioethics issues. To keep participants engaged, develop a mix of approaches, including study of ANA's *Code of Ethics for Nurses with Interpretive Statements*, literature reviews, case discussions, guest speakers, ethical analysis tools, films, podcasts, blogs, book clubs, and "ripped from the headlines" ethics topics. If possible, offer free continuing-education credit at monthly meetings to provide an additional benefit to participants.
- Develop education for regularly scheduled ethics champion meetings so that the content can be easily replicated in their respective settings for ethics champion–facilitated, unit-based ethics education and discussion.
- Promote interdisciplinary inclusion and discussion at these sessions.
- Include the ethics champions in hospital-wide ethics committee meetings and activities to build relationships and increase awareness of available resources.
- Match ethics champion program development (through education, consultation, and policy guidance) with the ethics committee to increase participants' skills, knowledge, and engagement with the committee's work.
- Plan an annual program evaluation to elicit feedback and shape program development.
- Establish a "true north." For example, incorporating ethical discernment of everyday practice into cognitive action.
- Above all, provide a safe place for the ethics champions to bring ethical concerns, develop skills for effective ethics conversations, and share skills and abilities with their colleagues to benefit patients and families in their care.

Meet your ethical obligations

Marsha Fowler, in the *Guide to the Code of Ethics for Nurses with Interpretive Statements: Development, Interpretation, and Application*, 2nd edition, states that "nurses, in all roles, must create a culture of excellence and maintain practice environments that support nurses and others in the fulfillment of their ethical obligations…the Code goes beyond a foundation of support for nurses; it seeks to construct a culture of excellence wherein meeting ethical obligations is an everyday expectation." These three ethics champion programs aim to do just that and provide an example for other organizations to follow.

Heather Fitzgerald is a clinical nurse ethicist at Children's Hospital Colorado in Aurora. Angela Knackstedt is a health literacy/bioethics clinical coordinator at Children's Mercy Kansas City in Missouri. Karen Trotochaud is a nurse ethicist at Children's Healthcare of Atlanta in Georgia.

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Staffing committees: A safe staffing solution that includes engagement

With nurse input, this hospital strives for staffing satisfaction.

By Ann Blankenhorn, MSN, MBA, RN, NEA-BC

Reading Hospital, a 700+ bed acute care hospital in Reading, Pennsylvania, achieved ANCC Magnet Recognition® in 2016. In October 2017, along with the acquisition of five additional hospitals, the organization became part of the Tower Health System.

As in many organizations, staffing and scheduling practices can be a source of staff satisfaction or dissatisfaction. In 2014, in an effort to ensure staffing satisfaction, nursing leadership formed a nurse-driven staffing and scheduling committee composed of 50% direct-care RNs. We began our journey focused on safe staffing practices, using the American Nurses Association's principles for nurse staffing as our foundation.

The committee first worked to develop a solid charter that identified functions and responsibilities, including:

- developing, reviewing, evaluating, and implementing hospital-wide nurse staffing plans
- creating recommendations for unit-based staffing teams and identifying opportunities to optimize staffing resources
- providing education on topics such as benchmarks (including ActionOI® and the National Database of Nursing Quality Indicators®) and policy.

Building a solid team

The current committee is made up of 65% direct-care nurses and 35% hospital leadership and support staff, including patient care assistants, payroll and electronic staffing system members, representatives from the reassignment team and patient safety, and a member from human resources (HR). We meet once a month for 90 minutes.

The clinical staff provides insight into what's happening in practice and how it's managed throughout the nursing areas.

Alignment with interprofessional committee members helps with problem solving and idea sharing. For example, the HR member provides a direct link to that department to identify and quickly address topics such as pay and compensation, as well as policy and practice. Receiving accurate information quickly helps the team better understand problems and solutions and provides transparency to the divisions and units. And with the help of the reassignment team member, we moved the reassignment survey to an electronic format, which lets participants respond anonymously, giving us more open feedback.

Achieving accomplishments

During the last 3 years, we've achieved many accomplishments, including aligning pay to hours, incorporating turnover and vacancy data, creating vacation and holiday time guidelines, standardizing call-off time requirements, and balancing schedules by divisions before posting.

We continue to work to ensure consistent and fair practices for all nursing staff. Currently, we're exploring the following topics:

- incentives to pick up extra shifts
- best practices related to 12-hour shifts
- automated emails for the reassignment survey
- staffing effectiveness and safety issues.

For example, the organization offers financial

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Tools you can use

The nurse-driven staffing and scheduling committee at Reading Hospital has developed several tools aimed at improving staffing.

Web page

The committee's web page provides full transparency to its work. Information available to all hospital staff includes:

- meeting minutes
- committee roster
- charter and strategic planning initiatives
- outcomes achieved in the previous fiscal year
- unit staffing guidelines
- reference guides for staff reassigned to a unit
- up-to-date divisional reference guides and individual practices.

Electronic scheduling tools

We developed an education plan for staff and managers. Education included use of electronic scheduling tools, such as how to self-schedule and scheduling around requests. We've incorporated tip sheets into weekly huddles, so the information can reach as many staff as possible.

Learning board

Our committee meetings include an open forum at the beginning so that hot topics are addressed. The forum includes a learning board on each unit where staff can post concerns on any topic, as well as potential solutions. When first submitted, a topic is in the red zone, which means it hasn't yet been reviewed. As it's reviewed and work begins, the topic moves to yellow; when it's completed, it moves to green with a summary of what occurred. This format closes the loop with the entire team and makes follow-up information available to everyone.

incentives to encourage nurses to pick up an extra shift. However, the staffing and scheduling committee identified that not everyone is motivated by the same thing, so we conducted a brainstorming session to look at what motivates people. We learned that extra paid time off and the ability to reduce accrued attendance points were important to some staff.

Learning lessons

Nurse-driven staffing committees help encourage engagement around the most difficult topic nurse leaders face. Our committee has been very realistic and effective in making difficult decisions that incorporate the greater good of the organization and the patients. Turnover reports for the last 2 years identify the top four reasons for leaving: another job opportunity, family obligations, relocation, and retirement. The committee will continue to identify any connections between global scheduling issues and turnover. ■

Ann Blankenhorn is the senior nursing director at Reading Hospital in Reading, Pennsylvania.

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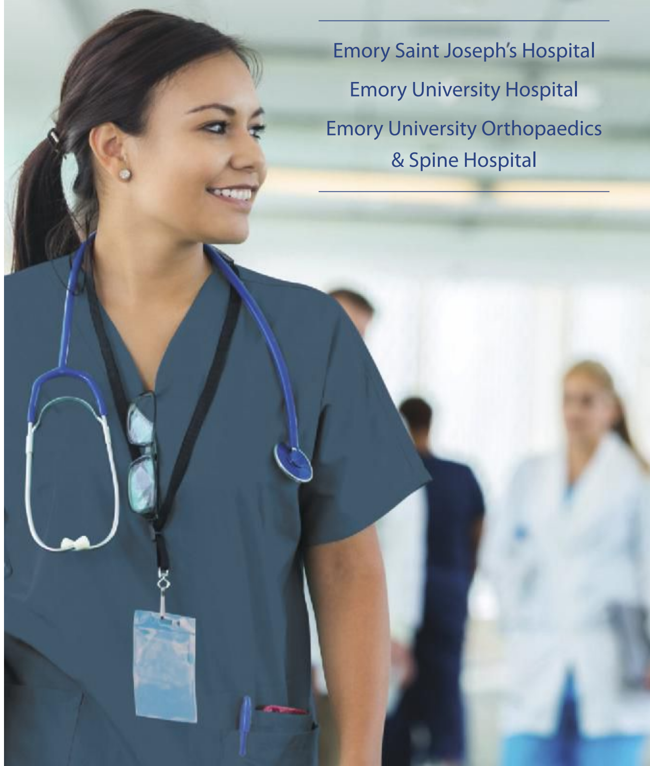

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WELLNESS 101

Emotional wellness

By Bernadette Mazurek Melnyk, PhD, RN, CPNP/PMHNP, FAANP, FNAP, FAAN, and Susan Neale, MFA

Learn how to manage stress for a healthy life.

This is the third installment in a series of articles on wellness. You can read the first two articles at americannursetoday.com/wellness101.

PICTURE YOURSELF in a stress-free environment: you're on a beach, listening to the gentle waves, with nothing to do but relax and enjoy the natural world around you. Bliss, right? Imagining emotional wellness when stress is absent isn't hard. In the demanding world of nursing, though, we face more stress than ever. Burnout, compassion fatigue, depression, and poor work-life balance are at alarmingly high levels for nurses and other healthcare professionals. In response, the National Academy of Medicine has launched an Action Collaborative on Clinician Well-Being and Resilience (goo.gl/q4QY7S), with the following three goals:

1. improve baseline understanding of challenges to clinician well-being
2. raise the visibility of clinician stress and burnout
3. elevate evidence-based, multidisciplinary solutions that will improve patient care by caring for the caregiver.

Fortunately, being emotionally well doesn't mean eliminating all stress from your life. That would be impossible—and boring. "A human being needs stress," says Jack Groppel, cofounder of the Johnson & Johnson Human Performance Institute. Stress, when well managed, can help you grow and build resilience, just like exercise helps build muscles.

When you're emotionally well, you can cope with stressors in healthy ways so that they don't become overwhelming and interfere with your functioning or lead to unhealthy coping strategies, such as overeating, alcohol or drug use, or smoking. It also means you're able to identify and express your feelings. Don't ignore anxiety, sadness, depression, and anger. These emotions may be uncomfortable, but they're important and they're telling you something. Persistent anger or irritability, in particular, may be a sign of underlying anxiety or depression. If your feelings or emotions interfere with your ability to concentrate, engage fully in your work, or enjoy things you typically like to do, it's time to seek help from a qualified mental health professional. Here are some ways to combat stress, reduce anxiety and depressive symptoms, and keep yourself on an even keel.

Cognitive-behavioral skills

Cognitive-behavioral skills can help you promote mental health, build resilience, and deal with unavoidable stressors. They also can help reduce anxiety and depressive symptoms. These skills are based on components of cognitive-behavioral therapy (CBT), the gold standard evidence-based treatment for mild to moderate anxiety and depression. Cognitive-behavioral skills building (CBSB) begins with learning to recognize the relationship between what we think and feel and our behaviors.

Many of our emotions result from our thoughts. Negative thoughts are often followed by feelings of anxiety, stress, and depression. Negative thinking also

can lead to unhealthy behaviors. This pattern is called the thinking, feeling, and behaving triangle. Most people don't consider their thought patterns because they've become automatic or preprogrammed in the brain. The first step in CBSB is to learn the ABCs:

- Activating event—A stressful event occurs.
- Belief—The stressful event results in a negative belief or thought.
- Consequence—You feel emotionally bad or behave in an unhealthy way.

One key to emotional wellness is catching your automatic negative thoughts and turning them into positive ones. When you feel your mood change for the worse, or when you feel physical symptoms of anxiety—such as rapid heartbeat, headache, stomachache, and sweating—ask yourself, "What was I just thinking?" Many negative thoughts become automatic, like any other habit. We don't choose them; they just happen.

Recognize triggers, change the script

Learn to recognize what triggers negative thoughts. Let's say a car cuts you off in traffic. This activating event might provoke a negative automatic thought—"That careless driver could have just caused an accident"—sending your mood into a downward spiral. When you notice negative automatic thoughts, though, you can turn them around and rewrite them. You may want to write down ahead of time what you'd like to think in stressful situations, or you can simply encourage yourself to think positively in the moment.

So, the next time a car cuts you off in traffic and you start to have a negative thought, turn it into a positive one: "That person may be under a great deal of stress. Thank heaven, I'm safe." This change buffers you from feeling stressed and anxious.

Practice, practice, practice

Thirty days is the time breaking an old habit or making a new one takes, including the way we think. With time and practice, you can change your thinking in response to the stressors in your life, and that will change how you feel. For the next 30 days, try monitoring your thoughts in response to activating events or stressors. Keep a journal of stressful events, the thought patterns that followed, how you felt and behaved, and what you'd like to think instead. Notetaking apps can help you store thoughts quickly.

Eventually, frustrating or challenging situations may start to feel like opportunities to practice CBSB. You'll gain a feeling of control over these situations and soon you may feel better overall as fewer automatic negative thoughts present themselves.

More coping strategies

In addition to using CBSB to deal with stressful events that disrupt your emotional equilibrium, remember that the nine interconnected dimensions of wellness (physical, intellectual, emotional, social, spiritual, creative, career, financial, and environmental) can lend a hand in improving your emotional well-being, too. Here are more ways to relieve stress and feel better.

Start a journal. Keep track of stress symptoms you're experiencing daily, such as anxiety, irritability, trouble sleeping or concentrating, or habits like nail-biting or overeating. Make a list of what might be causing you the most stress. Some of these stressors will be unavoidable, but others may be avoided or reduced. List ways you can remove these stressors from your day, including creative solutions. For example, you might choose a route to work that takes longer but is less stressful to drive. Setting aside a little extra time to avoid stress triggers is worth it. Journaling is a good way to express and release your emotions, too.

Engage in regular physical activity. Any activity helps to reduce cortisol buildup. (Cortisol has many negative effects on the brain and body.) If you're short on time, stretch your muscles with a resistance band for a few minutes, go for a short walk, or learn a few simple yoga postures you can do anywhere. Remember, 30 minutes of physical activity 5 days a week is the evidence-based recommendation.

Use proprioceptive (body awareness) techniques. Try leaning against a wall or simply pressing your palms together. These moves give your mind a reassuring sense of where your body is positioned in space, which can be calming, and are easy to do even during a busy workday.

Get at least 7 hours of sleep each night. Sufficient sleep refreshes your mind and allows your body to repair and heal itself. Anything less than 7 hours results in increased cortisol production, and evidence shows a link between sleep and depression; an inability to fall asleep or stay asleep is one of the signs of depression.

Use abdominal breathing exercises. These exercises can help slow your heart rate and decrease your blood pressure. Try this: Breathe in through your nose for a slow count of five while your abdomen expands, then out through your mouth for a slow count of five and pull your abdomen in. On the breath in, think "I am calm"; on the breath out, think "I am blowing all stress out." Just a few minutes of deep breathing can calm you down. You can work this into your meal break.

Think positive. Read a book about being positive (such as *How Successful People Think: Change Your Thinking, Change Your Life* by John C. Maxwell, *The Power of Positive Thinking* by Norman Vincent Peale, and *How to Stop Worrying and Start Living: The Tested Methods for Conquering Worry* by Dale Carnegie) for 5 to 10 minutes every morning to start your day off right and shield yourself from negativity during the day.

Stay in the present moment. Worry about the future and guilt about events in the past can cause stress. Learn how to stay in the present moment; for example, chew a piece of gum and count the number of chews it takes before the gum runs out of flavor. The book *The Present: The Gift for Changing Times* by Spencer Johnson is a great quick read that teaches the value of living in the present moment.

Meditate. Meditation can calm your mind and ease anxious, negative thoughts. Even a few minutes of visualizing a calm environment can release tension. Try a mobile phone app, such as Calm, to engage in guided imagery, or The Mindfulness App, which also has a health component.

Go outside. Enjoying nature can be a great way to relax, shed stress, and elevate your mood. If you're stuck indoors for a while, use screen savers with calming outdoor images or listen to recordings of nature sounds in your car.

Disconnect to socially connect. Technology can be overwhelming, so regularly disconnect from the TV, phone, computer, and social media to stay connected with family and friends and to cultivate new relationships whenever possible. Talk to someone you trust about how you feel.

Get help. If you're feeling overwhelmed and it's interfering with your functioning, get help. Don't feel ashamed if you need to see a mental health professional to help you strengthen your coping skills.

Take action

You can learn to cope positively with stressful or emotionally draining situations using the strategies outlined in this article, moving regularly, expressing your emotions, and letting go of guilt and worry. As the Dalai Lama once said, "The suffering from a natural disaster we cannot control, but the suffering from our daily disasters we can." With these action tactics, you'll feel more relaxed, healthier, and maybe even ready for new exciting challenges you'll enjoy. ★

Both authors work at The Ohio State University in Columbus. Bernadette Mazurek Melnyk is the vice president for health promotion, university chief wellness officer, dean and professor in the College of Nursing, and professor of pediatrics and psychiatry in the College of Medicine. She is also a member of the research, data, and metrics working group for the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience. Susan Neale is senior writer/editor of marketing and communications in the College of Nursing.

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could receive a letter from the U.S. Department of Justice restricting your ability to work in any facility that receives reimbursement from Medicare and Medicaid. In addition, disciplinary action in one state may affect your license in another. After you've been disciplined, each state in which you hold a license can review or open the case.

To protect yourself, carry your own malpractice/disciplinary insurance (don't rely on the insurance carrier for your hospital or private practice). This is especially important with the anticipated increase in medical professional liability claims associated with social media use.

Think twice

Social media is a great way to connect personally and professionally. But remember that online posts live forever and that social media misfires could negatively affect your license and ability to practice. To protect yourself, think twice before you post content that could be judged as unprofessional. ★

Visit www.AmericanNurseToday.com/?p=39407 for a list of selected references.

Melanie L. Balestra is nurse practitioner and has her own law office in Irvine and Newport Beach, California. She focuses on legal and business issues that affect physicians, nurses, nurse practitioners, and other healthcare providers and represents them before their respective boards.

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Why some people are healthy, and others are not: Part 2

By Leah Curtin, RN, ScD(h), FAAN

Does healthcare policy effect stress and health?

ONCE YOU'VE DECIDED that early childhood development is one key to a healthy life, you're forced into a world that's part neurobiology and psychoneuroendocrinology, part immunology, and part sociology. We know from developmental neurobiology that billions of neurons in a newborn's brain and body must form quadrillions of connections. The quantity and quality of these connections is determined by how well the baby is nourished and stimulated from in utero to about 3 years of age. This in turn determines the development of basic competency and coping skills, which drives school performance and the ability to withstand stress and health risks later in life. We've known for decades that poor early childhood development leads to poor health throughout life.

Stress and health

We all encounter challenges, and the stress level of each encounter is determined by how well we cope. Challenges trigger the endocrine (fight-or-flight) system, which suppresses all other systems not immediately needed to counter the threat. If we cope well, these endocrine chemicals quickly return to resting levels. If we don't, they continue to suppress the immune system and even some brain functions.

To put the matter succinctly, what happens in early life determines whether we suffer chronic stress. Marmot's 20-year study of civil servants in England clearly demonstrated the effect of stress on health: "I have made the case that a richer understanding of poverty, based on control and social engagement, links the social gradient in health, and poverty and health. We should focus not only on extremes of income poverty but on the opportunity, empowerment, security, and dignity that disadvantaged people want in rich and poor countries alike."

Stress, particularly chronic stress, is a primary catalyst of many diseases—even genetic diseases—making those whose early childhood is compromised more vulnerable. However, even among those raised in ideal conditions, the effects of chronic stress can be felt later in life among those who work in high-demand jobs but have little control; for example, those who work for and with unpredictable or unreasonable bosses, those who work in situations where rewards don't correlate with good performance, and, of course, those who live and work in unjust or war-torn countries.

It's not biology or society that determines who gets sick, who lives longer, and who copes better; it's both. We need biological understanding of disease to change disease risk, but we also need to understand how society influences biology.

Ramifications today

After several attempts to repeal the Affordable Care Act (ACA), politicians made repealing the ACA's health insurance mandate part of the *Tax Cuts and Jobs Act of 2017* (TCJA). The Congressional Budget Office estimates that repealing this provision—which requires that everyone have health insurance if they can afford it—will take healthcare away from 13 million Americans and increase premiums by about 10% for millions more. Thus, significant and long-term increases in illness can be anticipated—not only because of lost coverage, but also because the poor will become poorer, and the lower middle class will become poor. The social safety net is unraveling, and the impact on health is incalculable, which is why the American Nurses Association and just about every healthcare organization in the country opposed TCJA.

Leah Curtin

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