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Cooper Bridges

A publication for nurses and healthcare professionals

SPRING/SUMMER 2011 ▪ VOLUME 5, ISSUE 1

Equal Access to Health Care

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From the Chief Nursing Officer

Dianne Charsha, RNC, MSN, NEA-BC, NNP-BC • Senior Vice President for PCS/CNO

As nurses, we are constantly learning new information and/or processes. I hope that this edition of *Cooper Bridges* provides something new to each and every one of you who reads the articles contained within this publication.

Recently, I learned of a wonderful process improvement tool. Robyn Harvey, RN, BSN, MBA, Sr. Director of Maternal Child Health brought a new patient safety and quality of care process to Cooper which will enable us to review our quality of care and patient safety procedures throughout the Department of Patient Care Services. This process will also get us ready for upcoming Departmental and Hospital-Wide Surveys. We have chosen to call this process:

Cooper
On-going
Organizational
Preparedness
Education &
Responsiveness
Fridays.

During each Cooper Friday, we will review one patient care standard, national patient safety goal, an environment of care standard or a law. Surveyors are sent to the units and do observations and interviews of our patient care staff. This process enables each of us to get used to answering a surveyors questions, enables surveyors to recognize staff for knowing these standards/goals/regulations, and to learn where we have breakdowns in processes or unclear policies that require modification. Overall, our experience with Cooper Fridays has been excellent and I hope that you will have an opportunity to participate and/or learn about the changes that are being made to improve our compliance with the reviewed standards.

Dianne Charsha, RNC, MSN, NEA-BC, NNP-BC
Senior Vice President for PCS/CNO

Email comments to **charsha-dianne@cooperhealth.edu**

Cooper Bridges Mission Statement:

"To communicate and educate nurses and healthcare professionals to foster excellence in the delivery of patient care."

Cooper Nurses interested in authoring an article for a future edition of *Cooper Bridges* may obtain submission guidelines by contacting: **Yhlen-kathleen@cooperhealth.edu**

The Nurse's Role in Protecting the Rights and Welfare of Human Research Subjects

Carole-Rae Reed, PhD, RN, APRN, BC

Earn Contact Hour Credit (Contact Hour: 1.0)

Learning Objectives:

1. Define the 3 ethical principles used in protecting human research subjects.
2. Give an example of the nurse's responsibility in protecting the rights and welfare of patients who are research subjects.

Evidence based practice in nursing and medicine is essential to ensure the best patient outcomes. As a result, the number of research studies involving human subjects is increasing. This means direct care nurses are much more likely to care for patients who have consented to participate in a scientific study. Nurses have a duty to protect the rights and welfare of patients who are also research subjects. Therefore, it is important for nurses to understand both the ethical implications of research and the basics of protecting human research subjects. For instance, nurses must be familiar with the requirements for informed consent, the study purpose and procedures including knowing who to call if a problem is suspected or if the patient has questions (Connelly, 2009; Stutzer-Treimel, 2008; Havens, 2004). They also need to know the resources within their workplace for reporting potential conflicts and concerns involving a specific research study.

Ethical Principles

Research that violates ethical principles is rarely done out of a knowing disregard for human rights, but more often occurs because the researchers believe so strongly in the importance of the research that they may not fully consider the effects on human rights (Polit & Beck, 2008). In 1978, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (NCPHS, 1979) issued the Belmont Report. This code of ethics outlines principles for research and is the basis of most guidelines and

Table 1 Ethical Principles in Research

Beneficence	Justice	Respect for Persons
• Do no harm • Includes the right to freedom from harm and discomfort • Researchers must maximize benefits and minimize potential harm • Includes emotional and psychological discomfort as well as physical • Includes right to protection from exploitation Participating in the study and giving personal information should not end up being used against subjects in any way, or place them at a disadvantage	• Ensures fair and equitable treatment • Selection of participants must be fair & non-preferential • All qualifying subjects should have equal chance to participate & equal chance of being in treatment or control group in experimental studies • Researchers may not neglect or discriminate against groups who may benefit from research, such as excluding women or minorities; unless there is scientific reason • Vulnerable subjects must be protected • Vulnerable subjects include: infants & children; severely ill or physically disabled; the mentally, emotionally, or cognitively impaired; pregnant women; fetuses; prisoners; institutionalized people; terminally ill or brain dead (Havens, 2004); those unable to give informed consent for any reason	• Also referred to Respect for Human Dignity • Incorporates at least two ethical convictions: 1. Individuals should be treated as autonomous agents 2. Persons with diminished autonomy are entitled to protection (NCPHS, 1979) • Right to self-determination: involves understanding & ability to evaluate risks and benefits based on full information • Right to make own decision without pressure, coercion, or control from others • Includes right to full disclosure of what will be done and why, as well as risks and benefits • Right to privacy is inherent (Havens, 2004) • Subjects can expect that all their personal information will be kept confidential & Health Insurance Portability and Privacy Act (HIPAA) (1996) standards will be followed

regulations in use by organizations and government agencies in the United States. The US Department of Health and Human Services (DHHS) issued regulations, updated in 2005 that are the most widely used guidelines for evaluating the ethical aspects of studies (Polit & Beck, 2008). The United States Code of Federal Regulations is updated yearly and contains the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is based on the DHHS regulations and includes regulations on the protection of human subjects in research conducted by all branches and agencies of the US government (US Government Printing Office, 2010). The Belmont Report (NCPHS, 1979) specified three basic ethical principles on which ethical conduct of research is based: beneficence, respect for human dignity, and justice (See Table 1). Nurses must be aware of these principles to ensure that patients who are research subjects are treated ethically.

Informed Consent

In order to participate in a study, a person must give informed consent, usually in writing. Informed consent is based on the ethical principle of Respect for Persons. There are four essential elements of informed consent: comprehension, understanding, competence, and voluntariness (Yoder, 2006b). The consent to participate in the study is not valid if any one of these four elements is missing. Comprehension addresses the manner and context in which the information is given, and must be presented within the person's capacity to understand (NCPHS, 1979). In the event that potential subjects do not speak English, consent forms must be translated into the person's native language by a certified translator (Yoder, 2006b). Use of interpreters is not considered adequate when obtaining informed consent. Understanding and competence indicate that the person has the ability to understand the information presented, evaluate it and make a rational decision (Havens, 2004). In the case of those who lack adequate understanding or competence, as in the case of children or the cognitively impaired, third parties may be called upon to make the decision, but they must have the legal authority to do so. Voluntariness means the decision to participate must be made free from coercion or undue influence (NCPHS, 1979). Another important factor is that the person must be given enough time to understand the options and make an informed decision (Yoder, 2006a). The research subject must be given a copy of the signed consent form, a copy should be retained in patient record, and a copy kept by the researcher.

During the admission process, the course of hospitalization and outpatient care, nurses should consider asking whether or not a patient is in a research study (Connelly, 2009). Even though this information may not be required by the institution, it may be important in planning care. In addition to planning care, nurses must act as patient advocates. Supporting patients and their families in the decision whether or not to participate in research, and in their right to withdraw at any time are key aspects in this role of the nurse (Stutzer-Treimel, 2008).

All studies must have the approval of the appropriate Institutional Review Board (IRB) used by the institution. The IRB is a committee responsible for protecting the rights and welfare of research subjects ensuring that researchers follow all required procedures (Yoder, 2006b; Connelly, 2009). A study must not be allowed to begin until IRB approval is obtained (Connelly, 2009). It is the researcher's and the nurse's responsibility to insure that all patients approached to participate in a study, are able to give informed consent. Do not try to sway, coerce, or pressure the patient's decision, or allow anyone else to do so. Reassure patients that their decision will not affect their care, other than regarding the study procedures. Make sure all patients participating in a study have given informed consent and are aware of all study procedures. If not, contact the investigator to discuss study requirements with the patient (Yoder, 2006a). If the nurse is caring for a patient involved in a study that the nurse is unfamiliar with, it is his/her responsibility to contact the investigator and/or attending physician to obtain information (Connelly, 2009). The nurse must contact the attending physician and investigator if a patient, who is a research subject, has reactions or health concerns that could be a result of study participation (Stutzer-Treimel, 2008). Contact the appropriate personnel & IRB if there are any concerns regarding the ethical aspects or human rights of study participants in any study, or if you think that violations may have occurred. Nurses must report immediately any "evidence of coercion, inconsistencies with the protocol, or deviation from the usual plan of care" (Stutzer-Treimel, 2008, p. 133). Know your resources. Every nurse must be aware of the institutional policies regarding research and the process to follow if concerns or problems are identified. Nurses play a critical role in the protection of the rights and welfare of all patients. Advocating for the rights of research subjects is an extension of this important role.

The author would like to acknowledge Jonelle O'Shea, MSN, RN for compiling the post-test and Cheryl Koehl, RN, MSN, CEN for arranging the contact hour.

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POST TEST:
The Nurse's Role in Protecting the Rights and Welfare of Human Research Subjects

Earn contact hour credit (1.0) • Please circle the correct answer.

1. **You are walking past your patient's room and see a researcher trying to obtain consent for a study. You know that the patient has dementia and her daughter has the power of attorney. The daughter is not in the room with the patient and your patient signs the consent form. You know that the daughter is unaware of this research study. Which ethical principal(s) are the researchers violating?**
   a. Beneficence only
   b. Justice only
   c. Justice & respect for persons
   d. Respect for persons only

2. **You know that your patient's ethical rights have been violated in the situation above, so you approach the research team and tell them that the patient has Alzheimer's and cannot be consented. They say "ok" and walk off the floor. What should you do next?**
   a. Reassure the patient that their inclusion in the study will not affect their care
   b. Call the IRB
   c. Ask for a copy of the protocol
   d. Administer the study drug as ordered

3. **A researcher asks you to participate in the informed consent process with your patient so that you can be a witness to consent. During the informed consent process the researcher says "If you do not participate in the study then I will not take care of you anymore." You do not sign the consent as a witness. Which essential element of informed consent do you report to the IRB as being violated?**
   a. Understanding
   b. Comprehension
   c. Competence
   d. Voluntariness

4. **Nursing responsibilities for subjects involved in research studies are to:**
   a. Understand the study and request information from the investigator if you do not understand
   b. Support the subject's decision whether or not he or she decides to participate in research
   c. Contact the principal investigator or attending physician if there are any reactions or health concerns that could be a result of study participation
   d. All of the above

5. **The patient is scheduled for a study related procedure. The nurse has explained the procedure and determined that the patient has a full understanding of the risks and benefits involved. The patient tells the nurse he does not want to have the procedure done. The nurse cancels the procedure, and calls the attending physician and principal investigator, explaining that the patient has refused. Which is the primary ethical principle guiding the nurse's action?**
   a. Autonomy.
   b. Beneficence.
   c. Justice.
   d. Fidelity.

EVALUATION FORM (required)

Have the following learner objectives been met? Circle response please.

1. Define the 3 ethical principles used in protecting human research subjects. Yes No
2. Give an example of the nurse's responsibility in protecting the rights and welfare of patients who are research subjects. Yes No

Please rate each of the following.
A (Excellent) B (Good) C (Fair) D (Poor) E (N/A)

3. This teaching method was effective .....A B C D E
4. Opportunity to keep my knowledge current .....A B C D E
5. Expectation of earning continuing education.....A B C D E
6. Relevance of course agenda to practice .....A B C D E
7. Opportunity to enhance professional effectiveness and practice.....A B C D E

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HOW TO EARN A CONTACT HOUR

1. Read the article.
2. Take the test. You must achieve a score of 80% (4 of 5 questions correct).
3. If you do not pass the test you may take it again.
4. Complete the evaluation form.

Effectiveness of Palliative Care on Quality of Life in Cancer Patients: An Action Research Study

Barbara J. Sproge, MSN, RN, OCN
Immaculata University/ Cooper University Hospital

Patients undergoing treatment for advanced cancer often experience a decrease in quality of life due to suffering from physical and emotional side effects of the cancer treatment. Multiple symptoms such as pain, nausea, depression, anxiety, dyspnea, and others routinely occur during and after aggressive cancer therapies.

SIGNIFICANCE: During 2010, the American Cancer Society predicts that approximately 1.5 million people in the United States will be diagnosed with cancer, many with an advanced stage of disease. In the last decade, technological and medication treatment options for advanced cancer have rapidly expanded. The National Consensus Project for Quality Palliative Care and the National Comprehensive Cancer Network recommend incorporating a palliative care program concurrently with traditional therapies.

PURPOSE: The purpose of this pilot project is to explore the question: if palliative care is provided concurrently with treatment for advanced cancer, can a patient's quality of life be improved?

METHOD: A contemporary model of palliative care was used as the framework for the project, which provides patients with intensive symptom management at any time in the disease trajectory. The Edmonton Symptom Assessment Scale (ESAS) was used to assess and reassess symptom burden.

RESULTS/INTERPRETATION: All patients in the study experienced at least a 50% decrease in the presenting symptoms, and experienced an improved quality of life as demonstrated by a 19% decrease in total distress scores.

CONCLUSION/IMPLICATION: Expert pain and symptom management are critical aspects of comprehensive care for cancer patients. Availability of palliative care programs must be expanded, and research studies must be developed to expand the body of knowledge and provide evidence-based care. An advanced practice nurse has the most appropriate skills to direct and coordinate all clinical, educational, research, and administrative functions of a Palliative Care program in order to relieve patient and family suffering and improve quality of life.

Equal Access to Health Care

Malikah Taylor, RN

In March of 2010, President Obama signed a major piece of domestic policy reform. The Patient Protection and Affordable Care Act coupled with the Health Care and Reconciliation Act of 2010 will insure healthcare services for 95% of Americans by 2014. This new legislation will introduce major market reforms including banning exclusions for pre-existing medical conditions, closing the current Medicare Part D prescription drug coverage gap, providing a number of government subsidized medical insurance policies for low income families, decreasing taxes, and imposing fines on employers who do not provide health insurance (What's in Health Care Bill? Take a Dose, 2010, CBS NEWS). But what is the plan to overcome the health disparities that have created an insurmountable barrier to health care access?

Studies show that 1 in 3 residents in the United States (U.S.) identifies as a member of a minority group. Health disparities reflect biases and stereotyping in the health care system and are not just a consequence of socioeconomic, education, or insurance status (Russel, 2009). Minority groups can have varying genetic dispositions to chronic illnesses, and when paired with environmental effects of inner city living and minimal access to quality care, the combination can lead to disastrous health outcomes. The uninsured obtain little to no preventive care and they receive less treatment for their disease processes, which often results in higher mortality rates.

Adequate healthcare has many benefits. For instance, the treatment of children in the early stages of development may reduce the risk of acquiring chronic illnesses (Russel, 2009).

The United States military conducted two studies to determine if disparities would decrease or diminish in the face of uninterrupted access to health care. In a study of adult soldiers admitted to military hospitals, the differences seemed to cease to exist after adjustments for risk factors were made (Meyers, 2008). However, a second study concluded that despite medical coverage there were distinct negative differences in asthma prevalence, treatment, and outcomes in children of enlisted military based on race (Stewart, 2010).

The insurance industry business boomed when healthcare shifted from private non-profit funding to pre-pay for profit funding resulting in the current trend of single payer and employer based policies with co-pays and deductibles, as well as the Medicare/Medicaid programs. Racial, ethnic and socioeconomic variances have consistently been a barrier to health care. In the 1950s, African Americans lawfully paid taxes yet were denied access to adequate medical care (Jones, 2010). Instead of eliminating disparities, the United States has added sexual orientation, mental illness, immigration, disability and addiction to the list of discrepancies. Equal access to health care means it is available, appropriate, and affordable (Castanares, 2010).

Availability of primary and specialty care physicians, as well as community-based programs are key to practicing preventative medicine. Patients living and working in overpopulated inner city areas have limited healthcare choices: overcrowded emergency departments or a few local offices or clinics, most of which have limited hours. The result is poor access to care for working adults and their children. Those living in more rural areas similarly

Table 1 Benefits of Healthcare Reform

Employees	Those who cannot afford premiums can use allotted funds to purchase insurance at the Health Insurance Exchange
Low income population	Increased Medicare & Medicaid coverage Complete reimbursement for primary care
Middle Class Business Owners	Will receive tax cuts and credits to help provide insurance for employees
Pre-existing conditions	Insurance companies will no longer be able to deny coverage to those with pre-existing medical conditions. Children are covered now. Adults will be covered by 2014.
Senior Citizens	Early retiree insurance; more long term care options; rebates for Medicare D prescription coverage gap; discounted prescriptions.
Uninsured Upper Class	Can chose either basic coverage or pay a fee that offsets the cost of care for uninsured Americans
Young Adults	Dependent children will be covered on their parents' policy up to age 26

have scarce resources which are typically spread out for miles. Multiple locations accessible by public transportation, flexible office hours, and timely referrals for patients that require extensive treatment for chronic illnesses are needed to redirect patient flow to outpatient services. With increased access, diseases can then be diagnosed in a timely manner and treated before the onset of emergent complications. The result is a decrease in lengthy hospital stays and emergency rooms visits.

Health care should be appropriate for the community it services. Close consideration needs to be paid to trends and variations of the surrounding population and their linguistic capabilities. Health care organizations ought to make attempts to employ multicultural and multi-disciplined professionals that mirror the population being served. Diversity in the staff providing care can decrease the fear associated with seeking healthcare and mistrust of healthcare workers. Additionally, if care givers are aware of barriers to treatment, alternatives can be explored to avoid non-compliance and prevent progression of disease. An effort to streamline patient-provider communication allows for early reporting of changes in condition, early detection of illness, and can increase health literacy. This will help instill the importance of preventive care in the entire community. The federal government has recognized the importance of these concepts and offers grants and scholarships to minority students seeking careers in health care.

Affordability of health care affects every class system in the United States. As policy premiums and out-of-pocket costs increase there will be more and more Americans with little to no health insurance. Emergency departments and urgent care centers are currently flooded with patients that misuse the health care system to obtain primary care services or treatment of exacerbated chronic illnesses that may require hospital admissions, expensive medications, complex procedures while increasing exposure to nosocomial infections. Insurance companies only reimburse a percentage of hospital charges leaving the institutions to absorb the balance if the patient is unable to pay. These financial hazards result in hospital and physician networks closing their doors further decreasing the availability of the care in impoverished areas. A universal healthcare plan is the best option to provide basic healthcare with the option to expand coverage and have its cost subsidized to ensure access to the care.

> The new healthcare legislation will not be fully implemented until 2014 and the mandates will be slowly put into practice over the next few years. The bill appears to have addressed most of the major concerns and in theory should be able to benefit every American.

There are a variety of universal healthcare systems throughout the world, all with limitations cited as pitfalls by those in the US who have concerns about the new healthcare plan. Countries with some form of a universal system have no financial barriers to healthcare or health disparities and no one is denied access to basic healthcare. France and the United Kingdom have mandatory national health systems, with capitated public plans funded by taxation. Europeans utilize both public and private healthcare institutions that operate independently of each other. One drawback to this system is the lack of physician collaboration across institutions leading to restricted access to specialty care. The wealthier population in these European countries may access specialty care seamlessly for conditions that are not considered to be life threatening by purchasing a private or secondary insurance policy. By contrast, the US has the most expensive healthcare system in the world that is only available to only 40% of its population, and has yielded higher rates of mortality compared to other developed nations (Gusmano, 2009).

Our nation's inability to control the cost of technologic advances and prescription drugs in addition to the failure to adequately collect for services rendered has contributed to the current economic crisis. The implementation of a universal health plan has been supported by physician groups that feel pressured to avoid procedures, consultations, and costly meds because of restraints imposed by peer-review organizations (Himmelstein, 1989). These physician groups believe that a single-payer system would resolve some of the problems of cost, access, and fairness of

healthcare resource distribution (University of Maine Bureau of Labor Education, 2001).

The new healthcare legislation will not be fully implemented until 2014 and the mandates will be slowly put into practice over the next few years. The bill appears to have addressed most of the major concerns and in theory should be able to benefit every American.

The future of healthcare in the U.S. changes with the implementation of this legislation. Accountable Care Organizations made up of primary and specialty care providers will now coordinate patient care. States are being encouraged to create their own state health insurance compacts. Hospitals and insurance companies alike will be investigated for Medicare and Medicaid fraud. Private insurance premiums will be reviewed for price increases ensuring that 80% of premiums are spent on the benefits or quality improvement measures. Medical records will be monitored by mandated electronic documentation and bundled billing. In 2014, there will be an increased focus on preventive care and use of community-based resources. Facilities and physicians providing quality care will receive higher rates of reimbursement. Payment will be based on the quality of care given and not on patient volume. Grants will be offered to encourage implementing alternatives to traditional medical malpractice litigation. Lastly, all federal health programs are now required to collect and report racial, ethnic, and linguistic data to the secretary of Health & Human Services to help identify and decrease disparities (U.S. Department of Health and Human Services, 2010).

Healthcare barriers created by health disparities affect every American regardless of race, gender or socioeconomic status. The harsh reality of this discrimination is millions of Americans are prevented from receiving necessary, preventive outpatient care. This cycle will continue until health care is available, appropriate, and affordable for all. The United States Healthcare System is currently under reconstruction and the reforms will be implemented in their entirety in 2014. However, the federal deficit and overall cost of providing basic healthcare are proving to be major barriers to the implementation of this law and make it unlikely that 100% of the population in this country will receive healthcare services.

Email comments to **Taylor-Malikah@cooperhealth.edu**

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Breathe Easy When Caring For a Patient with a Chest Tube

Michelle Hackett, RN-BC

Whether you are a trauma nurse caring for a patient with a penetrating chest wound; an ICU nurse with a patient that has a pleural effusion; a cardiac nurse caring for a patient that just had open heart surgery; an oncology nurse caring for a post-pneumonectomy patient; or a pediatric nurse taking care of a preemie with a collapsed lung; you will likely, at some point in your career, encounter a patient with a chest tube. For many nurses, chest tube care is a task performed on a routine basis, but for other nurses it is a skill that is used infrequently.

Chest tubes are inserted to treat any condition that can cause the lung to collapse such as pneumothorax, hemothorax, pleural effusion, chylothorax, and empyema (Coughlin & Parchinsky, 2006; Pruitt, 2007; Rajaraman, D., Hoque, H., & Davies, T., 2010). Inserted in the pleural space of the lung, chest tubes work by restoring the normal negative pressure within the pleural space, lost by presence of blood, air, or fluid, to re-inflate the lung and restore normal ventilation (Coughlin & Parchinsky, 2006; Romano & Mercado, 2006). Chest tubes are made of clear plastic and have multiple side holes to facilitate drainage and contain a radiopaque strip to aid in visualization on radiography (Pruitt, 2007). Long gone are the days of multiple glass bottles bubbling at the bedside. Today's chest tubes are connected to a plastic, multi chamber, single unit that facilitates gravity or suction assisted drainage. The most commonly used models are the Pleur-evac® and Atrium™ (Rushing, 2007).

Chest tubes are often inserted and sutured in place at the bedside by a physician using local anesthesia; however they can also be inserted in the operating room or by interventional radiologist (Coughlin & Parchinsky, 2006; Pruitt, 2007; Rajaraman, et al., 2010). In any nursing specialty, it is the nurse's responsibility to ensure that the needed equipment is available for the sterile procedure (Coughlin & Parchinsky, 2006; Rushing, 2007; Teleflex Medical Incorporated (TMI), 2010).

Nursing responsibilities prior to chest tube insertion include performing a respiratory assessment; collecting baseline vital signs; pre-medicating the patient with sedatives and/or analgesics as ordered and providing emotional support to the patient (see Table 1). Pre-procedure the nurse is responsible to make sure the patient is correctly identified using two patient identifiers and a time out is performed to confirm correct site for chest tube placement. Additionally, the nurse should check that informed consent for the procedure has been completed (Pruitt, 2007; Romano & Mercado, 2006). While it is the doctor's responsibility to obtain consent, it is also the nurse's responsibility to ensure that consent has been obtained prior to the procedure.

Once the procedure has begun, continue to provide emotional support, and assist in properly positioning the patient. Advocate for your patient by ensuring that everyone present maintains a sterile field. Observe the patient for any signs of respiratory distress. Provide supplemental oxygen if necessary. Re-medicate the patient and assist the physician as required (Coughlin & Parchinsky, 2006; Pruitt, 2007; Romano & Mercado, 2006).

After the chest tube is inserted, be sure to document time, date, and placement site. Note how well the patient tolerated the procedure, medications administered, and dressing type. Record drainage amount, type, and color; physical assessment data; whether tube is to water seal or wall suction, and whether patient is on room air or supplemental oxygen (Romano & Mercado, 2006). A chest x-ray will be ordered to confirm placement (Coughlin & Parchinsky, 2006; Pruitt, 2007). The nurse also documents all patient-family education provided (Pruitt, 2007).

Once the chest tube is in and placement confirmed, the RN assesses the patient for adequate oxygenation, and monitors for complications by taking the following precautions:

- Keep a spare Vaseline® gauze pack at the bedside in case of emergency (Coughlin & Parchinsky, 2006; Pruitt, 2007).
- Provide supplemental oxygen as ordered and encourage the non-ventilated patient to use the incentive spirometer 6-10 times per hour. An easy guideline for the patient to follow is to use the spirometer every time a television commercial comes on.
- Elevate the head of the bed in high Fowlers or semi-Fowlers to promote drainage of air and fluid from lungs and maximum lung expansion, unless contraindicated (Coughlin & Parchinsky, 2006; Rushing, 2007).
- Keep the patient comfortable by providing analgesics as needed; remember to monitor for respiratory depression (Pruitt, 2007).
- Monitor output in the chest drainage unit.
- Encourage the patient to get OOB and ambulate as soon as possible to prevent pneumonia and promote lung re-inflation (Rajaraman, et al., 2010; Romano & Mercado, 2006; Rushing, 2007).
- If the chest tube is ordered to be on wall suction, make sure that it is not disconnected for any reason unless ordered by the doctor. If the patient needs to leave the unit for testing, notify the physician first. The doctor will determine whether the benefit of the test outweighs the risk of disconnection of the chest tube.

Sometimes complications occur during chest tube insertions. A vessel or organ may be nicked leading to bleeding that may require emergency intervention

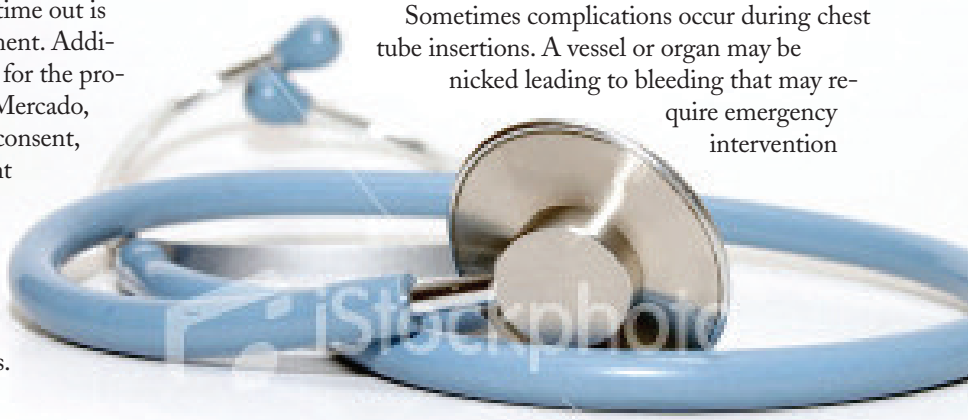

Table 1

Pre-Insertion	Intra-Procedure	Post-Procedure	Follow-up Care
Ensure informed consent	Assist in "time out"	Keep drainage system below chest level	Check for air leaks
Obtain CXR	Position the patient	Elevate head of bed as tolerated	Elevate head of bed as tolerated
Obtain baseline vital signs	Monitor vital signs	Monitor vital signs	Monitor vital signs and output; Notify physician of excessive drainage
Perform a respiratory assessment	Observe for signs of respiratory distress	Observe for respiratory distress; encourage deep breathing/IS	Assess respiratory status; Encourage deep breathing and incentive spirometry
Provide emotional support	Provide emotional support	Provide emotional support	Provide emotional support
Pre-medicate as ordered	Assist as needed	Ensure dressing and connections are secure	Ensure dressing and connections are secure
Gather supplies as needed	Maintain sterile field	Measure drainage hourly for the first 4 hours and every 8 hours	Maintain wall suction at all times as ordered. Replace drainage system prn
Document	Document	Document	Refill water seal and suction chambers as necessary
			Document

(Rajaraman, et al., 2010). Promptly report bloody drainage in excess of 200ml/hr in adults or > 5ml/kg/hr in children and anyone under 40kg. Monitor the patient for signs and symptoms of infection and report them to the physician as well. Notify the doctor of the presence of subcutaneous emphysema characterized by excessive edema in the face, neck and chest, and the distinctive sound like rice krispies or bubble wrap snapping underneath the skin when palpated (Coughlin & Parchinsky, 2006; Pruitt, 2007). Immediately inform the doctor of any signs or tracheal or mediastinal shift that may indicate a tension pneumothorax (Coughlin & Parchinsky, 2006). Dislodgement of the chest tube or the presence of clots should be reported without delay.

Check tubing and drainage canister for air leaks. Start at the patient and work your way down to the drainage unit. Make sure connections are attached securely to the patient and each other (Coughlin & Parchinsky, 2006; Pruitt, 2007, Romano & Mercado, 2006; TMI, 2010). Inspect the water seal/air leak chamber for bubbling to check for an air leak. Begin at the dressing and momentarily pinch the drainage tubing at 8-12 inch intervals. Each time you pinch, look at the water seal/air leak chamber. When you pinch between the source of the air leak and the water seal/air leak chamber, the bubbling will stop. If the bubbling stops near the dressing, the air leak is likely at the insertion site or the lung. Remove the chest tube dressing and inspect the site to ensure that the tube has not dislodged from the chest wall and no drainage holes are exposed. If you cannot see or hear any obvious leaks at the site, the leak is from the lung. Replace the dressing securely at the site. If the leak is in the tubing, replace the unit. Notify the doctor if air leaks are not corrected by the above actions or reoccur. Document the air leak and steps taken to correct it. The higher the number in the air leak chamber, the bigger the air leak (Rajaraman, et al., 2010; TMI, 2010).

Maintain the drainage system below the patient's chest level and encourage the ambulatory patient to do the same (Coughlin & Parchinsky, 2006; Pruitt, 2007; Romano & Mercado, 2006). Change the drainage unit when it is almost full or if it is knocked over to ensure accurate recording of output. The ONLY time that the tubing should be clamped is temporarily when changing the drainage canister or when checking for air leaks. The clamp should be released immediately thereafter to prevent a tension pneumothorax (Coughlin & Parchinsky, 2006; Pruitt, 2007; Romano & Mercado, 2006). A dislodged chest tube should not be reinserted at the insertion site; as this might introduce bacteria into the chest potentially leading to an infection or empyema. Instead, secure the site with sterile Vaseline® gauze to prevent air from entering the lung, call the physician immediately and get supplies ready for reinsertion (Coughlin & Parchinsky, 2006). Do not perform milking or stripping of a chest tube without an order as this may increase intrathoracic pressure and increases the chance of dislodging the tube from the chest wall (Lewis, et al., 2000; Romano & Mercado, 2006).

Replace water in the water seal and suction chambers of the drainage system as needed according to the manufacturer's instructions. Coil excess tubing on the bed next to the patient and make sure they are not lying on it. Keep dependent tubing in a straight line from the patient to the drainage device to prevent clogging and promote maximum drainage (Coughlin & Parchinsky, 2006; Pruitt, 2007; TMI, 2010). Measure drainage at least every 8 hours and mark the date and time at the current fluid level on the drainage chamber each shift. Be sure to check for tidaling (or fluctuations) in the water seal chamber that indicates patency and air removal from the lung. However, lack of tidaling may indicate re-inflation of the lung and time to remove chest tube (Coughlin & Parchinsky, 2006; Romano & Mercado, 2006; TMI, 2010). Table 1 details both immediate and routine nursing care to be done after a chest tube has been placed. Thorough and complete documentation cannot be stressed enough.

Serial chest x-rays are usually done daily while the chest tube is in place until x-rays reveal that all the blood, fluid, or air has been removed and the lung has re-expanded (Coughlin & Parchinsky, 2006). Indications for the removal of a chest tube include drainage less than or equal to 50ml over a twenty-four hour period, the patient demonstrates no respiratory distress; and fluctuation in the water seal chamber ceases (Coughlin & Parchinsky, 2006; Pruitt, 2007; TMI, 2010). When the chest tube is no longer needed, it is removed at the bedside by the doctor or advanced practice nurse (Coughlin & Parchinsky, 2006). Make sure there is a suture removal kit, petroleum gauze dressing, 4x4 dressings, and occlusive

(continued on page 14)

Walk, Don't Run! Patient Education for Total Joint Replacement

Lisa Moriarty, MSN, RN-BC, ONC, CNS

In the United States (US), 21 million adults have arthritis that is painful and disabling, negatively impacting their quality of life (CDC, 2010). Americans with osteoarthritis, the main diagnosis for total joint replacement, account for 7.3 million physicians' visits per year, a projected cost of $95 million due to medical costs, extended rehabilitation care, and lost wages (Navarro, 2002; Prouty et al., 2006; Steele et al., 2000). About 400,000 Americans each year decide on total joint replacement to decrease pain and improve mobility; and thus quality of life (AAOS, 2010).

Total joint replacement is a major operation because of its associated risks and complications. Empirical evidence supports that pre-operative education minimizes complications in the immediate postoperative period following a total joint arthroplasty (Steele, 2000; Turkowski, 2000, 2005). Positive outcomes include minimizing anxiety, reducing hospital length of stay, and lowering overall costs of care (McGregor, et al., 2004). Most nurses agree that increased knowledge of a disease process or condition may decrease anxiety in patients (Showalter, et al., 2000). At Cooper University Hospital (CUH), a variety of education resources are available for patients and families. Specifically, for joint replacement surgery, the patients are educated by a multidisciplinary team including: nurses, surgeons, anesthesiologists, inpatient and office staff, and physical and occupational therapists. In addition, CUH has a Patient and Family Education Center, available in the lobby of the hospital. The center is a dedicated educational resource with available staff to assist patients and families to learn as much as they can so they can be a partner in their own care.

Providing appropriate patient education helps achieve better patient outcomes. Education needs to be delivered with clarity, accuracy, similar content, (repeating the same information as often as is needed), including acknowledgement and evaluation of the literacy of the patient. When a patient hears different or confusing information, their anxiety increases, satisfaction with care decreases, and outcomes can be jeopardized. The educational goal is to consistently deliver the same information. This can only be accomplished by continuing staff education, team work, and allowing the staff to have ample time to educate the patient and family.

A review of literature demonstrates that nurses consider providing quality education to patients and families a priority. Patient education is one of the things that nurses believe they can do better than others. Nurses value time to talk to patients and provide education (Rodts, 2005). Additionally, Redmon (2005) emphasized the value and efficacy of teaching patients information that they are personally interested in and have the ability to understand.

Table 1 Joint Replacement Surgery Education Topics

Education Topics	Information to Include
Reasons to have surgery	Pain, decreased function, failed conservative treatment
Diagnosis	Degenerative joint disease, Rheumatoid arthritis, Avascular necrosis, Congenital abnormalities
Goals of surgery	Decrease pain, increase function, increase quality of life
What is a Total hip, knee, and shoulder replacement?	Normal joint, advanced disease, artificial joint (Show models and x-rays)
Preparation for surgery	Exercise, decrease weight, medical, dental clearance, infections cleared
Complications: Deep vein thrombosis, Pulmonary embolism, infection, pain, stiffness, pneumonia, loosening, wear, other medical problems	Walking, isometrics, anticoagulants, antibiotics, range of motion, incentive spirometry, excessive activity, side effects of narcotics
Pain Management, what is "multi-model" medications	Medications to take in the hospital and at home, combination of anti-inflamatories, acetaminophen, and narcotics
What happens day of surgery, day 1, day 2, day 3 after surgery	Details of care, i.e. catheters, drains, intravenous, pain, nausea, ice packs, hygiene, vaccines, pneumatic compression devices, etc.
Discharge Planning	Preparing your house ahead of time, discuss benefits of going home vs. rehab
What happens 1st 6 weeks at home	Incision care, when to call doctor, nurse, when to go to the ER, medications, pain, etc.
What to expect for the lifetime of the joint replacement	Activity, infection, follow up visits, questions, etc.

This is not a new concept. Mansour, et al (1983) stated: "The emphasis… is not on teaching but on how to help adults learn; …visual aids can be used effectively to augment health education by serving as a stimulus to attract and focus attention, causing ideas to flow, questions to form, and learning to begin."

Educational topics for patients undergoing joint replacement surgery include everything from indications for surgery to what happens after discharge *(see Table 1)*. Nurses and multidisciplinary team members have multiple venues to teach patients including: one-on-one, group classes, community education for prospective patients, or through former patients who can give personal perspectives of their experiences. The healthcare team providing the education can use anatomical bone models, artificial limbs and x-ray pictures as aids in addition to written information. The goals and benefits, as well as the complications of joint replacement surgery need to be delineated so patients have the information to make an informed decision regarding treatment options *(see Table 1)*.

Patient Education at CUH

The 2011 goals for CUH patient education for joint replacement patients reflect an enhanced approach, facilitated by the orthopedic nurse practioners (NPs). Patient classes are scheduled more frequently. Group classes allow for "patient and family" support, and sharing of experiences. Literature supports that listening to others concerns, questions, and the variety of perspectives may also decrease anxiety (Redmon, 2005). Group classes require that the monitor or teacher have an expertise in discerning when a situation is causing more anxiety, and then being able to steer the conversation towards a therapeutic outcome. The NPs are in a unique position to interact with these patients pre-operatively, during their hospitalization, and postoperatively (in office visits and telephone calls). The teaching will eventually be interdisciplinary, including the nursing unit personnel. Other goals include evaluations and data collection, possibly capturing outcomes such as decreased anxiety levels, increased patient satisfaction, and decreased complications. Staff needs to be informed of the content of all education so that they can review and reinforce material during the patients' hospitalization.

Additional education and resources are available to patients at Cooper thru the Cooper Bone and Joint web site, www.cooperhealth.org//cooper bone and joint, the Patient and Family Resource Center and community-based lectures given by Cooper surgeons. The Arthritis Foundation provides support groups, online and printed information for patients. The American Academy of Orthopaedic Surgeons provides comprehensive education and resources for patients, as does the National Association of Orthopaedic Nurses.

Patients undergoing joint replacement surgery have unique educational issues specific to their diagnosis and disability. The surgery for total joint replacement is not considered an "emergency". It is, however, extremely relevant to a person's well being and continued maintenance of health. These issues have a direct impact on those individuals and their families, and the community at large; affecting its economics, and sustainability (AAOS, 2010). Therefore, patient education can be an effective means to improve patient outcomes.

Email comments to **Moriarty-elizabeth@cooperhealth.edu**

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BREATH EASY *(continued from page 12)*

tape at the bedside (Coughlin & Parchinsky, 2006; Pruitt, 2007). Removal of a chest tube is far less painful than insertion. The patient may or may not need pain medication during removal; if so administer it at least ten minutes before removal (Pruitt, 2007; Romano & Mercado, 2006).

Once the chest tube is removed, remain diligent in your assessment to assure your patient does not demonstrate any respiratory distress as a result of premature removal (Coughlin & Parchinsky, 2006; Rushing, 2007). Be sure to obtain baseline vital signs, monitor pulse oximetry, and ensure that a post-removal chest x-ray is ordered and completed; see Table 1 on page 12 (Pruitt, 2007). By familiarizing yourself with the indications for and management of chest tubes nurses and our patients can breathe a sigh of relief that competent patient care will be provided.

Email comments to **Hackett-michelle@cooperhealth.edu**

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REFLECTIONS

Helping Patients Overcome Obstacles, One Day at A Time

Sarah Francis, RN, BSN

TSDU staff (left to right: Jen Forrest, Jamie Caswell, RN, Sarah Francis, RN, Victoria Johnson, RN and Waleska Medina)

Working as a part of Cooper's Trauma team can be very challenging yet humbling all at one time. From Trauma Admitting to Trauma Intensive Care Unit (TICU), Trauma Stepdown Unit (TSDU), and North 7, everyone is dedicated to provide optimal care for every patient. Many of the patients have experienced a traumatic incident that caused them to be hospitalized for weeks or even months at a time. A lengthy hospital stay can cause a great deal of stress on the patient and the family members. The staff throughout the trauma division is extremely observant of the many challenges that our patients and family members have to face. We are always trying to think of ways to lift their spirits up and maintain a positive outlook.

In the Spring of 2010, a young male was admitted to the TSDU. He was in an accident that caused severe trauma to his leg which was unable to be repaired leading to an amputation. While in the TSDU for several weeks the staff thought he had become depressed. One day when I went into his room I noticed that he was watching the first inning of the Phillies game and was looking even more upset than usual. When I asked him if he was feeling okay he told me that he and his friends had planned a big trip before his accident to go to that game together. So I called nutrition and had them send up a couple of hot dogs and went downstairs and got his favorite soda. Throughout the game some of the staff members went in and watched the game with him. We immediately saw that these small gestures were helping, he was starting to smile and laugh again. If we could have we would have gone to get him some Chickie and Pete's fries!! He did very well over the following days and was able to be transferred out to North 7. From there he was discharged to a rehabilitation center and progressed in his recovery.

The prolonged period of time that a patient has to stay within the Trauma units does not only affect the patient but their family members as well. During the flu outbreak we had a woman admitted after being in a car accident. This single mother of two young children had injuries that required observation in TSDU for several weeks. The children were staying with their grandparents while their mother was in the hospital. They were beginning to get very upset because they missed her but were unable to come onto the floor to visit her due to the flu outbreak. This caused her a great deal of stress, knowing that her children were so upset and there was nothing she could do to comfort them. The nurse taking care of her that day came up with the idea to have the grandparents come in with the children and meet us by the elevators on the main floor. By doing this the children would be allowed in the hospital but would not be exposed to other inpatients on the unit.

My colleague and I decided we would both take her down when they called to say they were there. All patients that are in an ICU setting have to travel with a nurse and maintained on a monitor whenever they leave the unit. In addition to the monitor we traveled with a multitude of equipment including a wound vac, PCA, oxygen, emergency equipment, and Total Sport bed. When we got off of the first floor elevators and saw her children waiting for her, we all had to hold back a tear. They were so happy to finally see that she was okay. We stayed a few minutes so that she could talk to them. In just a few short minutes they were all feeling a little better. In a few short days, she was able to be discharged from TSDU.

These scenarios are only two examples of the many things that the Trauma staff has done for their patients throughout the years. We have to overcome many of the challenging parts of our job such as being at the beside to tell a patient that the car he was driving killed both of his best friends. It is so rewarding to help someone move past the trauma they have gone through even if it for just a short period of time. It is also important to remember that anyone can be involved in a traumatic accident so I always try to imagine how I would want to be treated. As nurses and staff we are thanked countless times by patients and family members for what we do every day. I feel that there are times that we should be thanking the patients and family members for providing us with these humbling experiences.

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Professional News

DEGREES:

Rowena Ripa, RN, MSN, PCCN, Wilmington University

Lois Scipione, RN, MSN, Wilmington University

Jen Bombaro, RN, BSN–PCU, ACD, received her Bachelor of Science Nursing degree January 2011, Wilmington University

Helen Nichter, RN, MSN–PCU, ACD, received her Master of Science Nursing degree September 2010 and became Board Certified (APN-BC) December 2010, Felician College

Juanita L. Davis, RN, MSN, MBA, LaSalle University

Stacie Webster, RN, BSN, Felician College

CERTIFICATIONS:

Jen Groves, RN, CCRN, CEN, certified in Emergency Nursing

Cyndi Cornwell, RN, BSN, CCRN, CEN, certified in Emergency Nursing

Linda Gazzerro, RN, WOCN, passed National Wound, Ostomy, Continence Nursing 2010 recertification

Monica DeVito, RN, FN-CSA, licensed as Forensic Nurses and Certified in Sexual Assault (FN-CSA) by the State of New Jersey

Mary Silva, BSN, MBA, NE-BC, FN-CSA, licensed as Forensic Nurses and Certified in Sexual Assault (FN-CSA) by the State of New Jersey

PUBLICATIONS:

Linda Wicker, RN, MSN, "The Effect of Comprehensive Infection Control Measures on the Rate of Late-Onset Bloodstream Infections in the Very Low Birth-Weight Infants" was published March 2011 issue of the American Journal of Perinatology

ANNUAL CUH NURSING AWARDS:

The UC/CADV Award for Excellence in Cardiovascular Nursing Practice: . . . . . **Marilyn Yusay**
The Selma & Martin Hirsch Clinical Excellence Award (Staff): . . . . . **Jessie May Dotson**
Cooper Nursing Alumni Clinical Nurse Excellence Award: . . . . . **Kevin O'Brien**
Carol Tracy Compassion Award: . . . . . **Lisa McKeeby**
The Moorestown Auxiliary Memorial Award for Excellence in Geriatric Nursing Practice: . . . . . **Megan Staerk**
John Henry Kronenberger Memorial Award for Neonatal Nursing Practice: . . . . . **Cindy Garretson**
The Philip & Carole Norcross Award for Excellence in Nurse Leadership: . . . . . **Kathy Devine**
The Barbara & Jack Tarditi Family Award for Nurse Mentorship: . . . . . **Barbara Sproge**
The Barbara & Jack Tarditi Family Excellence Award for Nurse Research: . . . . . **Stacey Staman**
The Charlotte E. Tobiason Memorial Award for Excellence in Obstetrical Nursing Practice: . . . . . **Barbara Murphy**
The Philip & Carole Norcross Award for Excellence in Oncology Nursing Practice: . . . . . **Stephanie Jennings**
The Moorestown Auxiliary memorial Award for Excellence in Outpatient Nursing Practice: . . . . . **Maria Eastlack**
Ronald Bernardin Memorial Award for Pediatric Nursing Practice: . . . . . **Tammy Beringer**
Award for Excellence in Perioperative Nursing Practice: . . . . . **Patricia Spahn**
Award for Excellence in Perioperative Surgical Technology Practice: . . . . . **James Moffit**
The Lynn Nelson Memorial Award of Excellence: . . . . . **Gladys Pollock**
Excellence in Trauma Nursing Practice: . . . . . **Debbie Cannon**
The Barbara & Jack Tarditi Award for Excellence in Patient Care (Non-nurse): . . . . . **Luz Mercado**
Nurse of the Year: . . . . . **Debbie Cannon**

PRESENTATIONS:

Kathy Devine, RN, BSN, CCRN, Diane Floyd, RN, BSN, CCRN, Debra Williams, RN, MSN, CCRN, Stacey Staman, RN, MSN, CCRN, Greg Staman, RN, Rick Rohrbach, RN, FN, Ron Murphy, MICP, & Chris Taylor, MICP, Trauma Mastery Session – Trends in Trauma and Cardiovascular Nursing, sponsored by SEPA chapter AACN, Atlantic City Convention Center, March 2011

Kathy Devine, RN, BSN, CCRN, Diane Floyd, RN, BSN, CCRN, Stacey Staman, RN, MSN, CCRN, Greg Staman, RN, Rick Rohrbach, RN, FN, Ron Murphy, MICP, Chris Taylor, MICP & Cody Banks, EMT, Trauma Simulation: Trauma Alert… Are You Ready? – Trends in Trauma and Cardiovascular Nursing, sponsored by SEPA chapter AACN, Atlantic City Convention Center, March 2011

Don Everly RN MSN MBA CEN CPEN, "2010 BLS, ACLS, PALS Update: What's Hot and What's Not! at the 2011 NJENA Emergency Care Conference, March 18, 2011, Atlantic City, NJ.

Dominic Parone RN BSN CEN, "On Call and ready to Go: New Jersey Disaster Medical Assistance Team responds to Haiti" at the 2011 NJENA Emergency Care Conference, March 18, 2011, Atlantic City, NJ.

Mary Stauss RN MSN APN CEN, "New Frontiers in Emergency Nursing: A-Lines and CVPs in the ED" at 2011 NJENA Emergency Care Conference, March 18, 2011, Atlantic City, NJ.

APPOINTMENTS:

Dianne S Charsha RN, MSN, NEA-BC, NNP-BC was accepted into the 2011 Johnson & Johnson – Wharton Fellows Program in Management for Nurse Executives. She will be attending the program June 5–June 24.