What I Learned at NTI

This year, the American Association of Critical-Care Nurses (AACN) held the annual National Teaching Institute (NTI) in Boston, just one month after the bombings at the marathon. Being from Connecticut, it was great to be in my own backyard.

Chest Tube Dressings

The first thing I learned is that we finally have research examining outcomes in thoracic surgery patients with dry, sterile chest tube dressings. Nurse researchers at Massachusetts General Hospital examined records of all thoracic surgery patients who had chest tubes from 2005 to 2010 (n=4361) and a subset of 321 lung cancer patients who had lobectomy between January 2009 and December 2010. The thoracic surgery service stopped using petroleum gauze a decade ago.

Overall, there was a 3.1% incidence of air leak, with 8% in the cancer group. Wound infection rate was 0.48% in all patients and 0.3% in the cancer group. Neither air leaks nor wound infections were attributable to dressing materials. The researchers use and recommend a simple dry occlusive gauze dressing.1 We’ll be sure to let you know when this study is published.

Evidence-Based Practice Makes Dollars and Sense

Two sessions on evidence-based practice provided case studies on procedure changes driven by research reviews.2,3 One examined the frequency of temperature checks in PACU patients using a Bair Hugger. The PACU policy of 1 hour was supported even though the manufacturer recommendation was every 10 minutes (which was clearly impractical.) Another examined the relationship between bathing PICU patients and hospital acquired infections.3 A review of the literature together with a survey of hospitals that had reduced CLABSI to zero identified daily CHG (chlorhexidine gluconate) baths as the key variable. Implementing daily bathing with CHG wipes took the CLABSI rate in this hospital from above benchmark to zero.

Another speaker illustrated the difference between quality improvement and evidence-based practice by describing a project about postop respiratory care.4 Staff noticed all patients had incentive spirometers, but wondered if they were being used and if they made any difference in postop recovery. The quality improvement question is, “Are patients coughing and deep breathing?” The evidence-based practice question is, “Is there a difference between incentive spirometry and nurse-directed deep breathing on postoperative respiratory outcomes?” The project is now moving forward examining how to optimize outcomes while conserving nursing time and costs.

In addressing what nurses should keep and what we should throw away,3 speakers compared nurses who insist on hanging on to “the way we’ve always done it” to hoarders. Hoarding is related to stress. Often, these nurses are in unhealthy work environments, dealing with staffing issues and compassion fatigue, and bombarded with more information than they can process; a much more nuanced view than simply labeling them “resistant to change.”

Bringing Financial Management to the Bedside

Overflow attendance at two sessions on economics for bedside caregivers showed how relevant these issues are to our practice today. One session discussed AACN’s initiative “Clinical Scene Investigation,” designed to leverage the staff nurse’s expertise to enhance patient care and decrease hospital expenses.4 Speakers emphasized how important it is to invite hospital executives to clinical units so they can see what nurses actually do. Nurses should also know the organization’s strategic plan so they can align proposals to improve patient care with that plan. In presenting a change, specify “if you spend X, you’ll see Y in return” or “you’ll save X for every dollar invested.”

Here’s a quick way to apply this approach to analyze the potential financial benefit of the CLABSI intervention described earlier. AHRQ’s quality initiative on eliminating CLABSI reports average cost $70,696 with a range of $40,412 to $100,980.5 CHG wipe list price is $8.95 (Amazon.com). Assuming an 8 bed unit with 80% occupancy, you’ll need 2336 wipes for daily use for a year (8 beds x 365 days x 0.8). The wipes will cost $20,907 at list price. If only one CLABSI at the lowest cost is prevented, you will be able to say to administration, “If you invest $20,907, you will see $40,412 in return” or “We will save $1.93 for each dollar invested.” While a full analysis includes more factors, what administrator would argue with that kind of savings?

Lori Ewoldt, of the Mayo Clinic, packed a day’s worth of information into a session on healthcare finance.6 Key is to follow Medicare reimbursement and coverage changes because all other payers will follow suit. She discussed reimbursement, patient satisfaction, value-based purchasing, readmissions, and the Affordable Care Act. See On the Web for links to her valuable resources.

The Power of a Nursing Team

The last session was presented by nurses, a social worker and a physician who cared for the bombing victims at Brigham and Women’s Hospital.7 I was never more proud to be a nurse than I was listening to them talk about their experiences. The room filled with laughter and tears as they talked about the care of one patient in particular – J.C. – who was next to the second bomb when it went off. He did not lose a limb, but had significant hearing loss and serious burns made worse by the nails, wood, and BBs that were embedded in the burned tissue from the force of the blast. We followed his care from the ED to critical care and then intermediate care. The nurses and social workers talked about their challenges caring for people from a mass casualty event; managing family members, law enforcement, and visits from dignitaries while trying to protect everyone’s privacy –

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In the Literature

A Data Legacy

The current issue of *Nursing Economics*$ features the last article by the late Donna Diers, a pioneer in data-driven decision making in nursing, who died in February. The article, written with Yale colleagues, describes their approach to understanding how nursing units work by examining nursing data and combining it with a theory of organizational diagnosis. The theory states that in order to exist and be productive, groups must manage boundaries between themselves and whatever is outside. An “overbounded” unit, for example, is the military, in which the group must be cohesive with rigid rules because the outside is so hostile. An “underbounded” unit, on the other hand, is a rudderless ship with no direction at the mercy of outside forces. A detailed case study describes the analysis of a troubled unit and how the combination of objective and empirical data, nurses’ lived experiences, and applied theory not only identified key problems, but also provided the roadmap to solving them.


An Appetite for Comprehensive Nutrition Management

This month, the Alliance to Advance Patient Nutrition (www.malnutrition.com) released a call to action with publication of an interdisciplinary nutrition care model simultaneously published in *MEDSURG Nursing* and two nutrition journals. Based on six key principles, this comprehensive article provides nutrition care recommendations for key stakeholders (dietician, nurse, physician, hospital administrator) organized by principle; validated screening tools; and practices to support nutrition interventions. Principles are: create an institutional culture, redefine clinician roles, recognize and diagnose all at-risk patients, rapidly implement interventions with continued monitoring; communicate nutrition care plans; and develop discharge nutrition care and education plans. This comprehensive model pulls the research together and provides practical implementation plans. The Web site has even more resources to put these recommendations into action.


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including suspects. J.C.’s dressing change-related pain was particularly difficult for his nurses to handle. At the end of the session, we were introduced to another key member of the team — J.C. himself. He walked up on the stage to a standing ovation from a room filled with experienced critical care nurses who almost all had tears rolling down their cheeks. The stories were so vivid; we all could imagine ourselves in his nurses’ shoes. Seeing him walk up on stage unassisted was a triumph we all shared. He said he never much thought about nurses because he’d never needed one before. But he promised he will be our advocate for the rest of his life. What a message to cap off an inspiring, informative, and moving week.

Sources


On the World Wide Web

Here are resources from the 2013 NTI

Visit Atrium University (http://www.atriumu.com) and go to the Evidence Center to download the slides and references from the booth presentation Evidence-Based Care of Patients with Chest Tubes.

The AACN Clinical Scene Investigator Academy is online at http://tinyurl.com/nkx65k6. You can download information from the first cohort of projects there.

From the financial sessions:

Direct costs associated with healthcare-associated infections from CDC: http://cdc.gov/HAI/pdfs/ha/scott_costpaper.pdf

Why Medical Bills Are Killing Us, from Time magazine: http://healthland.time.com/why-medical-bills-are-killing-us/

Hospital Safety Scores: http://www.hospitalsafetyrace.org/

Commonwealth Fund Quality Improvement Resources for Health Care Professionals: http://www.whynotthebest.org/

Medicare Dismisses Hospitals’ Bonuses, Penalties Based on Quality: Article: http://tinyurl.com/buu5f9v Database: http://tinyurl.com/pekzc3k

These are resources from the Centers for Medicare and Medicaid Services: there is a wealth of open source data you can review to see where your organization scores and to assess against benchmark for a range of indicators

Hospital Quality Initiatives: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html

Hospital Readmission Reduction Data http://tinyurl.com/pfap9n5

Spending per Hospital Patient with Medicare http://tinyurl.com/ouz3jx

Medicare Provider Charge Data http://tinyurl.com/blv4cwqj

Medicare Hospital Total Performance Scores: http://www.medicare.gov/HospitalCompare/Data/VPB/total-performance-scores.aspx