STANFORD NURSING NEWS Quarterly

Stanford HEALTH CARE
STANFORD MEDICINE

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NEW DOCTORS&NURSES IN THE HOUSE

STANFORD MEDICAL YOUTH SCIENCES PROGRAM STUDENTS SPEND ANOTHER SUMMER

June 22nd saw 24 high school students in the hospital. Doubling as surgical techs, RT assistants, and unit secretaries, these able young people scrubbed up and got stuck in.

Two Students went to D1. They had never been exposed the working side of a hospital and just soaked up every new experience. Manager Martha Berrier notes "It's fun to watch them learn and grow. They really appreciate the time we spend with them, and it shows". D1 nurses reported "both our students came in wanting to be Pediatricians… one left wanting to be a Cardiologist instead!"

The OR has hosted SMYSP students for 24 years. They initially took two students and have expanded to

five. Manager, Sheryl Michelson enjoys "having a high school student experience 'our world' and see things through new eyes. It is also a learning experience for our staff. They feel energized by the students' questions, their excitement when they see a surgery or master a new challenge. We feel obligated to grow the "next generation" of health care providers. C1 nurses loved being able to introduce aspects of nursing that excited them new nurses. A student said "it was such a beautiful experience speaking to some elderly patients. It touched our hearts as much as I hope it did for the patients".

If you are interested in hosting SMYSP students next year, please contact Dr. Judith Ned at jned@stanford.edu.

This Month in Nursing History

August 4th marks the centennial of the start of the first world war 1914 - 1918

The most unlikely candidates for army nurses could read as follows: Mairi Chisolm, motorcycle racer; Agatha Christie, Crime Novelist; and Amelia Earhart, Aviatrix.

Mairi Chisholm raced motorcycles in her early teens. At 18 she rode her motorcycle 136 miles from Dorset to London to become a dispatch rider for the Women's Emergency Corps. Chisolm was spotted making an artful hairpin turn in city traffic and was recruited for the 'Flying Ambulance Corps' in Belgium. This entailed picking up wounded soldiers from the battlefront and ferrying them back to the field hospital while avoiding explosions, bomb craters and mustard gas. Chisolm and her friend Elsie Knocker decided that they could save more men if there was a closer (therefore more dangerous) dressing station and set about starting their own. No longer affiliated with the Red Cross, they secured their own funding and supplies. They seconded a vacant cellar one hundred yards from the front, which suffered from bomb blasts, and falling ceilings. The next three years were spent tending horrific injuries in an overcrowded former wine cellar. It was these home grown "common sense" remedies led by nurses that contributed to the modern casualty triage system.

Knocker and Chisholm in the "converted" Ambulance, Pervyse, Belgium, c. 1916

Of the nurses profiled here, only Agatha Christie was already trained as a home help nurse in 1914. She was immediately put to work in the small hospital near her seaside home in Tor. The transformation of small community hospital to military ran dressing station for combat infantry must have been shocking. Although she preferred nursing, Christie later said that it was her two year assignment in the pharmacy that gave her the knowledge to poison off her characters with such accuracy.

Amelia Earhart left college just one semester before finishing her degree to join the VAD (Voluntary Aid Detachment). After visiting her sister in Canada, Amelia took a course in Red Cross First Aid then enlisted as a nurse's aide at Spadina Military Hospital in Toronto. She cared for soldiers from mid-1917 to the end of the war in November of 1918. The Canadians and Americans sent their boys home from Europe with shattered limbs which did not fare well from 30 days at sea. Although she was not on the battle lines like Chisholm, she was deeply affected by what she saw.

Inside this issue

From The Center for Education and Professional Development Team

Certification is a mark of excellence and a distinguished way to pursue professional development. At the same time, it attests to your knowledge, experience and commitment to your profession as a nurse.

Certification Courses at the CE Center

CCRN (Critical Care RN Certification) Review Course

The course focus is on disease recognition, assessment pointers, interpretation of critical diagnostic values, and priority interventions. The AACN clinical synergy model, test questions, and test-taking strategies are integrated throughout the three sessions. Coursework is current, evidence-based, and highly interactive, with high-quality computer graphics and a detailed outline to minimize the need for note taking.

CCRN Review: Session I: Oct. 15, 2014
CCRN Review Session II: Oct. 22, 2014
CCRN Review Session III: Oct. 29, 2014

For general information regarding CCRN Certification: www.aacn.org

Medical-Surgical Nurse Certification Review Course

This certification review course is intended for clinical nurses practicing in adult medical/surgical units. The course will cover all body systems, physiology, pathophysiology, assessment strategies, and treatment options for common medical and surgical care patients. Pharmacological management will be included within each system reviewed. The course will benefit nurses with medical/surgical experience who need or want a clinical update and review of the latest best practice. It can also serve as a review for nurses preparing to take the ANCC or AMSNA certification exam. The sessions are recommended for nurses with at least one year of clinical experience.

Two Days, November 11, & 12, 2014.

For general information regarding RN-BC certification: http://www.nursecredentialing.org/Medical-SurgicalNursing

For general information regarding CMSRN certification: www.msncb.org

Connect

Ashley Elder, RN, has a Q&A session with Nancy Lee about being a nurse, a CNO and a car enthusiast

Q. *What called to you about the nursing profession/ what was it that had you choose this career?*

A. I wasn't 'called to nursing' like some people. I was a music major and got a bachelor's degree in music and I wasn't very good. I loved it but I couldn't support myself. My mom was a nurse and it worked well for her with having a family and she loved it and I thought "I'll try that." I know that's not a typical CNO story. But I can talk about why I'm still in it? Why I love what I do? I think I have the best job in the universe. I like to be able to talk to my patients; I like to be able to take care of my patients. Not just to be

episodic, and as nurses-we get to do that. Now I get to help almost 2,000 people make a difference in patients and families lives. That's what I get to do. It's my job to help my nurses take care of patients. And to help them be the best nurse they possibly can.

Q. *Could you describe a typical day as CNO ?*

A. I don't really have "typical" days. Every single day I "get out"- we call it GEMBA which is Japanese term that comes from LEAN that means going to where the work occurs. Work doesn't occur here (referring to our meeting location), this is where we talk. The work is where the healthcare provider interfaces with the patient and family so that's where we as nursing leaders need to be.

Q. *What is your favorite thing about your job?*

A. Helping staff solve a problem and helping managers get to a solution. When I go out on the nursing floor usually my focus is the nurses themselves because your focus is the patients, my focus is you. But I'm still a nurse so I love sitting and talking to the patients.

Q. *What would you be doing if you weren't in your current position?*

A. I'm a pediatric nurse by background; I'm not an adult care nurse. When I made the switch from pediatrics to adults I actually worked on a surgical floor, this was before nursing ratios. We had 10 patients, it was a nurse aid and myself and we had 10 post-surgical patients. As a peds nurse I like to hold my patients, I don't think a 59-year-old man who is post-proctectomy wants me to hold him. So the pieces that make me a nurse are a little different. If I was to retire and work part time as a frontline nurse I would work as a clinical coordinator in pediatrics someplace. I also think the clinical educator role that we have here at SHC is a nice blend as well. You have time where you're out of the count and doing really great educational training but you also still have time at the bedside.

Q. *Is there a nurse in your career that you admire ?*

A. There has been one nurse who has been a role model for me. He was the regional VP for nursing in the VA system for the western region. He was one of my faculty when I was in graduate school. He exemplifies that perfect mix of having a "foot in both camps." He could stay connected with what's happening in the patient universe while making sure nurses had a voice at the board table that was respected and well understood. And that is how I try to do what I do. That is really important to me, to figure out that balance because if all of you don't know who I am then that's a problem but if board of directors doesn't know who I am, that's a big problem too. That balance is so important and Ron really exemplified that.

Q. *What kind of car do you drive?*

A. I have a Chevrolet Volt, its electric with gas assist- so I have to plug my little car in. I get about 48 miles on electric before it switches over to gas. So overall I get about 88 miles per gallon- (not bad!). But I also get the perk of driving in the carpool lane. I would call myself an Eco-sound person. At my house we are obsessed with recycling and reducing waste.

Before my Volt I had a Prius. The Prius was the first non-sports car I've had. I've had cars like a Datsun 280Z my whole life. My first car was a 1600 Datsun double overhead cam with twin carburetors- that was before fuel injection- I've always loved sports cars! My dad wanted boys and ended up with 4 girls. So he taught us girls about cars. He believed we shouldn't learn how to drive a car until we could change a tire and the oil in our cars. Both of which I haven't done in decades- it's hard on your fingernails!

When I was young my dad, his friend, and I used to enter competitions where you had to change out an engine. You would race to see how fast you could take an engine out of a VW bug and put a new engine in. Our time was about 2 hours and 45 minutes, but we never won.

Ask the Executive

"New" Director of Clinical Operations, Sharon Hampton, MSN, RN, CAPA

Although new to the Director role here, Sharon Hampton is actually a returning Stanford Nurse Alumni. She was most recently employed as a Nurse Manager at MD Anderson Cancer Center in Houston, Texas. Now she is back to fill a Director of Clinical Operations role for Cardiovascular, Dialysis and Medical Oncology units .

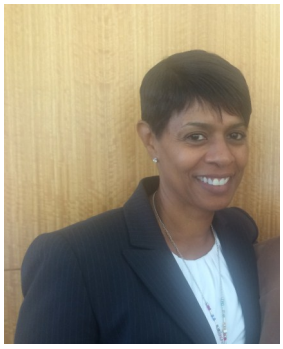
She initially wanted to be a biology teacher, but her mother was a Unit Secretary at Stanford on West 2B and informed her that she was going to be a nurse. Of course, mother knows best and "it turned out to be the best decision 'we' ever made".

Sharon began her nursing career, as a nursing assistant here in 1986, and graduated from nursing school in 1988. As a new graduate she worked on F1/F2 (OB/GYN-GYN Oncology, Post-Partum, High Risk Anti-Partum & Newborn Nursery). In 1995 she was accepted into the critical care float pool and transitioned into the main PACU in 1998.

2006 saw a move to Texas and for the position of Nurse Manager at MD Anderson Cancer Center over the pre/post outpatient surgical services, Interventional Radiology Recovery, 23 hours Observation Unit as well as the clinic Rapid Response Team and the Code Blue Team.

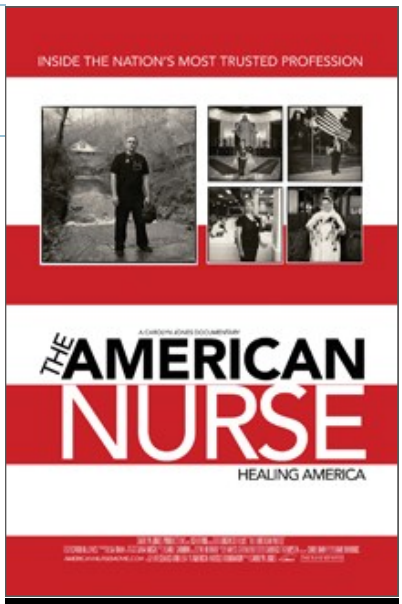
Her mission in coming back - "I hope to continue to improve on the spirit of excellence that Wendy Foad has perpetuated. The Magnet Model of Transformation Leadership, Structural Empowerment, Exemplary Professional Practice, New Knowledge, Innovation and Improvements and Empirical Quality Results is right up my alley.

I support professional certification and Professional development at all levels. I also really want to work with my team to make nursing history. I believe that we are well on our way to making excellence in practice our standard for care".



When asked "what do you want nurses to know about you?" she replies **"**I want nurses to know that I am a nurse leader that walks the walk. I will support, guide and mentor at every opportunity. I believe that together we can change the face of health care one positive outcome at a time".

Welcome Back, Sharon!



Movie Night

Lucile Packard Children's Auditorium

Tuesday, **September 23**, 2014 at 7:30 PM
Thursday, **September 25**, 2014 at 7:30 PM

Registration - CE Center Website

Make a Match

Belinda Lovo RN

On the BMT unit one of the challenges is to get patients up and walking. These patients are often in a lot of pain, deconditioned due to intense transplant regimen and are unable to leave the unit due to their immunocompromised status.

Belinda Lovo, RN and PT Christine Mamawag came up with an idea called "Walking 4 Strength". The idea is to support patients to walk the perimeter of the unit 11 times, which equals 1/2 mile.

There is a lap counter at the nurses station in the form of a flip chart for logging laps that patients, family and staff use to help keep track of the number of circuits walked. Upon completing a few laps patients are then given a red silicon bracelet that reads "SHCWalk4Strength".

Studies show that early ambulation can shorten hospital stays. The goal of this program is to promote physical activity during a patient's hospital stay. Many nurses on E1 have since have adapted this practice to their 12 hour shift. Patients who participate are excited and determined to walk despite how bad they may feel.

One patient said, "To me the *walk 4 strength* program was much more important to me than any prize. It was about showing this disease in my body that I was here first and I'm going to be here after it. No matter what, I was going to beat this thing in the long run".

This only happens with the encouragement from the nurses on E1 who provide the best quality care to improve patient outcomes.

Caritas Days

Jovy Borja, BSN, RN

What makes my heart sing? An "eternal" attitude of gratitude for receiving the scholarship to attend the 4th Annual Caritas Consortium; Honoring Health, Healing and Wholeness sponsored by Kaiser Permanente Northern California, June 2-June 4, 2014.

Jovy Borja, BSN, RN and Dr. Jean Watson

There was abundance of healthy foods; lively music and dancing; meditation for stress reduction; networking; exhibits of arts, crafts, and posters on the Caritas Processes by presenters from different hospitals; multidisciplinary speakers on diverse topics on burn-out, palliative care, and many more; as well as heart warming patient panel interactions.

The highlight was the mesmerizing talk by the legendary, Dr. Jean Watson on "Heart Alignment". It has given me new insights, perspectives, and inspiration relevant to my nursing profession as I have come to share the search for meaning and wholeness of being with others. I was thrilled to meet her! I have many milestones to make to be like her, but I can adapt her caring model in my daily practice to make a difference in the lives of my patients and fellow nurses. I am a part of a greater whole, and it is up to me to design the tonality of the environment in whatever role I assume.

The experience increased caring consciousness of myself as a person/nurse and of people/patients in connecting as human beings. As a result, it transcends to an authentic heart-centered caring potentiating healing of mind-body and spirit in self and others. I learned from Jean Watson's Caring Theory that this is called, "Transpersonal Caring Relationship" occurring in caring occasions or moments. The inter-weaving of the idea in the fabric of health care can be the future of nursing.

Transfer Center Nurses want you to know...

Judith Barnes, RN

When I tell people I work as a nurse in the Transfer Center, I often get the question "What does the Transfer Center do?"

The Transfer Center (TC) facilitates transfers patients from outside hospitals to Stanford and LPCH Stanford Children's Health who need advanced specialty care in a tertiary academic medical center. We're part of the organization's outreach to support the health and medical needs of the community.

The TC is part of Clinical Inpatient Access. The Roomers, Crisis Nurses, Administrative Nursing Supervisors and Life Flight Nurses are the other components of Clinical Inpatient Access.

The TC is open 24 hours a day, 7 days a week, and 365 days per year, staffed with Communication Specialists and Registered Nurses. We get patients from all over the US and international patients from all over the world.

The 16 RN's who work in the TC come from a variety of clinical backgrounds, including Adult Critical Care, Pediatric and Neonatal Critical Care, Emergency Room, Maternal Health and Obstetrics, Case Management, Cardiology and Cardiothoracic Surgery , Trauma, and Medical Surgical nursing.

When a patient needs to be transferred, the outside hospital calls the Stanford TC. We connect our physician with the outside hospital physician for a clinical discussion to determine if there is a clinical service Stanford or LPCH has to offer that would benefit the patient.

Once the Stanford/LPCH physician determines the patient is appropriate for transfer, the Transfer Center RN (TCRN) gets clinical nursing report from the nurse caring for the patient in the outside hospital. For non-emergent transfers, the financial counselor assists with financial screening to assure we're not putting the patient or family at financial risk.

The TCRN works with the nursing supervisor to secure the appropriate bed and with the Stanford or LPCH physician to determine that the patient is stable for transfer. The TCRN then keeps the nursing unit and receiving physician aware of when the patient will arrive on the Stanford nursing unit and passes along pertinent clinical information. If the patient is critically ill and needs to get to Stanford or LPCH quickly, we work with the Life Flight staff to send Life Flight to transport the patient.

The role of the TC Nurse requires a broad range of clinical knowledge, as the TCRN's work with physicians from all of Stanford and LPCH clinical services. Transfers from a long distance or for critically ill patient require a high level of coordination and communication. At times, we have multiple emergent calls coming in at the same time, so triage and organizational skills and a calm demeanor are essential skills.

It's rewarding to know you were part of the effort to bring a patient to Stanford or LPCH to receive the specialized care that potentially makes a real difference in that patient's outcome and can positively affect their quality of life.

Recommended Reading

A Testament of Youth by Vera Brittain, is acclaimed for its description of the impact of World War One on the lives of women who served as nurses.

NURSING GRAND ROUNDS

Take place on the 1st Wednesday of the month in LPCH Auditorium.

Refreshments at 3:00pm.
Presentation 3:30pm - 4:30pm.
Complimentary admission,
CA BRN 1 CE hour.

September 3, Research Council

October 1, Social Media Etiquette

November 5, Trauma Nursing

December 3, How to Spearhead a Multi-disciplinary Team to reduce Average Length of Stay.

Call for Authors

Something you'd like to see covered? Want to write an article? Brag about your colleagues?

Drop us a line at

RnNewsletter@stanfordmed.org

Diffusics Information and Updates

Harmandeep Madra, BSN, RN and Theresa Latchford MSN, RN, CNS

Experience	Potential Cause	Tips for Success
Get initial blood return then stops /Blowing veins	Catheter tip not completely in vein; Double venipuncture (thru and thru)	Lower the insertion angle and slightly advance the entire unit after initial flashback. Maintain traction on the skin during advancement Push the catheter forward through the skin; don't pull back on the needle
Initial catheter push off the needle is hard. Catheter is difficult to advance	Seal not released prior to insertion Not pushing catheter forward first	Release seal prior to insertion Use the pad of index finger on push tab Position other fingers on bumps of finger grips Grip finger grips lightly Push the catheter forward through the skin; rather than pulling back on the needle Use hooding technique or two-handed advancement
Pain/leaking at insertion site	Stabilization not adequate	Stabilize the catheter system to avoid movement at the insertion site Allow prepping agent to completely dry Ensure clear hub, where catheter connects isn't pushed too far into the skin
Blood backing up into port	Inadequate flushing	Flush with a pulsatile (push/pause) technique
Dull/painful insertion	Catheter tip over needle bevel	Push the colored stabilization platform and finger grips snugly together.