

STANFORD NURSE



VOL 26, NO. 1

STANFORD HOSPITAL AND CLINICS

SPRING 2006

THE POWER OF
DIVERSITY

A GROWING SPECIALTY:
FERTILITY NURSING AND
THE REI CLINIC

10 TIPS TO PREVENT
INFECTION

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Stanford Nurse is published by the Division of Patient Care Services. It is distributed to the Stanford nursing and medical communities, selected individuals, schools, organizations, and professional journals. Address correspondence to: Editor, *Stanford Nurse*, Center for Education and Professional Development, 300 Pasteur Drive, MC 5534, Stanford, CA 94305-5534. *Stanford Nurse* is indexed in the Cumulative Index to Nursing & Allied Health Literature.

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On the cover: Hirut Truneh, RN, BSN,
Assistant Patient Care Manager, Unit C2

From the Chief Nursing Officer

CINDY DAY, RN, MS, CNAA, VICE PRESIDENT FOR PATIENT CARE, CHIEF NURSING OFFICER



As we celebrate our profession during Nurseweek, I continue to learn and grow from you, the nurses at Stanford. The excellence and innovation you bring to our profession is a constant source of inspiration to me.

Nursing is growing in leaps and bounds at Stanford. We are expanding our work in evidence-based practice and discovering new ways to share this important work with all nurses. We have shared our knowledge and research with the larger nursing community through our participation in Nursing Research Day in San Francisco and with the Advisory Board that distributes this information throughout the country. I hope you will enjoy and learn from those examples shared in this edition of *Stanford Nurse*.

As we continue to develop nursing at Stanford, I thank each and every one of you this Nurseweek for your practice excellence, your commitment to our patients, and your support of Stanford Nursing. I look forward to seeing you and celebrating our profession during this special week.

Cindy Day



Scenes from last year's Nurseweek.



A Growing Specialty

Fertility Nursing and the REI Clinic

TERRI ALFREDSON, MS, RN
REI CLINIC MANAGER

"It wasn't supposed to be this hard."
"I didn't realize it could be so difficult to have a baby." "Why didn't someone warn me that getting pregnant after forty was not guaranteed?" These are just some of the more common remarks heard daily at the Stanford Hospital & Clinics REI (Reproductive Endocrinology and Infertility) Clinic.

REI nurse Mey Ling Leon, RN, with Elizabeth Blong and her daughter Evelyn.

Increasingly, women and couples are delaying childbearing for a variety of reasons — a desire for advanced education, financial stability, a committed relationship, or a combination of factors. Since the advent of reliable oral contraceptives there has been more emphasis on delaying procreation and very little attention focused on the fact that pregnancy rates are significantly lower and miscarriage rates are significantly higher for women after 40. The surfeit of celebrities having babies in their 40s creates an illusion that fertility can be extended indefinitely.

Many reasons, one result

Age-associated fertility problems are not the only reason people consult a reproductive endocrinologist. Nearly 40 percent of couples seeking assistance with fertility have some form of male factor involved. Others have little difficulty conceiving, but experience recurrent miscarriages. Cancer survival has increased dramatically, leading to women hoping to cryopreserve (freeze) their oocytes (eggs) or embryos before beginning radiation or chemotherapy that will render them infertile.

Couples in which the male partner is facing fertility-threatening treatment also come hoping to preserve

sperm or embryos for future pregnancies. Imagine having to cope with a diagnosed malignancy and begin fertility preservation therapy at the same time.

While it is estimated that 10 percent of couples in their childbearing years experience some form of infertility, many do not seek consultation and an even smaller number actually begin treatment.

Among the most commonly listed reasons for not seeking consultation and treatment are feelings of isolation — a sense that no one else has experienced this problem. Just having to ask for help with fertility can be incredibly stressful. Almost a third of the patients who schedule appointments at our center do not follow through, finding it too emotionally draining to discuss such personal issues.

There may also be discordance between the partners — one may be ready and willing to pursue evaluation and treatment while the other is hesitant or even overtly resistant. Other barriers to treatment include

“The patience and skill of the nurse meeting with the couple at this first appointment sets the tone for all future interactions.”

the time and cost involved. Fertility evaluation and treatment is costly and timing is often dictated by the woman’s menstrual cycle, making it difficult to plan for time away from work. Many employers do not purchase fertility treatment insurance or they provide only limited coverage with significant limitations.

A challenging journey

What determines whether and where a couple will seek fertility treatment? Patients may choose from a variety of providers and commonly select the practice based upon first impressions. From the initial intake call to the final discharge, the clinical and clerical staff must listen and respond professionally and compassionately, and earn the respect of the patient or couple. Given the amount of information provided at the initial consultation, this is not an easy task. The evaluation is often invasive and embarrassing for both partners. The patience and skill of the nurse meeting with the couple at this first appointment sets the tone for all future interactions. Assessing the couple’s readiness to learn and their will-

ingness to proceed is critical. *Are they just shopping for advice? Are they both ready to pursue treatment? Have they had a difficult experience with another practice? Would they benefit from a session with our psychological support coordinator? Do they need more time to process the information and discuss their wishes with each other?*

Ethical issues may also arise, relating to the use of donor gametes or if genetic or chromosomal disorders have been identified. Consultations with maternal-fetal medicine or other physicians may be recommended prior to proceeding with treatment. Timing may be critical if chemotherapy or radiation is scheduled to begin soon. Pre-Implantation Genetic Diagnosis may be under consideration, requiring additional discussion, consents, and collaboration with the embryologist and the facility performing the diagnostic testing.

The nurse meeting with the couple must juggle multiple options and constraints while calmly explaining complex physiology and pharmacology.

A complex process

Once the physician and couple have agreed upon a plan, the nurse coordinates every step of the process,

from patient education sessions regarding medications and treatment to diagnostic testing, clinic appointments, consents, symptom management, referrals to insurance coordinators and other medical specialists, response to treatment, and, ultimately, communication regarding the outcome of treatment.

An educated estimation of the onset of the menstrual period forms the basis for all subsequent evaluation and treatment. When the menstrual period does not conform to the estimate, the team must collaborate quickly with the patient to determine how to proceed. Since menstrual periods and ovulation do not recognize weekends or holidays, staff must be present daily to address critical timing issues.

Fertility treatment generally involves the subcutaneous injection of medication, up to three injections a day, for 10 or more consecutive days. Nurses select the medication delivery system for the drugs prescribed by the physician, either individual vials or injector pens, depending upon the doses and individual patient assessment. Detailed schedules of medications, appointments, blood tests, and consults are crafted for each patient or couple. When the services of a urologist is required for the



Terri Alfredson, MS, RN, counsels a patient in the REI clinic.

male partner, schedules and instructions become even more complicated, requiring exceptional communication, organization, and documentation skills on the part of the nurse. Finally, the nurse calls the patient to report the results of the pregnancy test after treatment — helping patients cope with both positive and negative outcomes.

Forging close bonds

The frequent contact between patients and nursing staff, often over the course of several months, fosters strong bonds. Former patients continue to send holiday cards and

pictures years after their treatment ends. When treatment is successful, the entire staff celebrates with the family; when it is not, we grieve together.

Our REI nurses and staff have been known to go to extraordinary lengths to care for our patients; for instance,

meeting a patient late in the evening to administer injections, investigating and contacting all-night pharmacies for the patient who loses or contaminates a dose, or rooming a patient in her “lucky” exam room. We assist patients with appeals to their insurance companies, decorate the clinic with

holiday and seasonal themes, and embroider exam table stirrups with seasonal icons to make the environment more welcoming.

Certainly fertility treatment does not always result in the birth of a child. One indicator of the skill of the staff is the satisfaction expressed by those patients who do not leave with a child, but feel gratitude for the care and compassion we provided or comfort in the knowledge that we have helped them do everything possible.

Fertility nursing is not an easy specialty to learn or practice, but it offers so many opportunities to combine cognitive, psychological, research, and communication skills that it has a host of committed devotees. SN

“Imagine having to cope with a diagnosed malignancy and begin fertility preservation therapy at the same time.”

Follow the Blue River

Stanford Hospital & Clinics and Lucile Packard Children's Hospital Create a Pediatric Emergency Department

BY PAULA MILLER, RN, CCRN, AND COLLEEN O'CONNOR, MS, CCLS
EDUCATORS/COORDINATORS FOR PEDIATRIC SERVICES, EMERGENCY DEPARTMENT

When you arrive at the Stanford Emergency Department, nothing immediately appears to be different. But a closer look reveals the pediatric nurse triage area decorated with a child-friendly decor to welcome children to the ED.

Following triage, children and their families follow the "blue river" that opens up to a new, brightly-lit, and colorful pediatric waiting room. Packed with toys, games, new iMac computers, and a big screen television that can play movies for children, the pediatric waiting room offers a comforting, child-friendly environment.

Together, Stanford Hospital & Clinics and Lucile Packard Children's Hospital have created a new Pediatric Emergency Department unit within our existing Emergency Department. The area was designed to provide as positive an experience as possible for the children and their families who must visit our ED. The most special thing about this 24-hour facility is less visible, however: the

pediatric specialists, from physicians and nurses to a child life specialist, who have been assembled to tend to all the medical problems that afflict children from around the Bay Area.

Over the past two and a half years we have hired and trained 12 pediatric nurses for our ED. These men and women, along with all of the excellent nurses who work in the ED, have taken on the challenge of improving the way we deliver care to our pediatric patients. To that end, we have held classes and refresher courses for all of the ED nursing staff to update their pediatric skills. We have also instituted Annual Pediatric Skills Days for the ED nursing staff to help keep them abreast of the latest pediatric evidence-based practice.

Our main goal for the new Pediatric ED is to care for the entire family. Once we place the patient in a room we encourage the family to take toys to the room, play on the computer, and get comfortable in the space. This allows the nurses and the pediatricians to get a better feel for the child within his or her family setting. Children are much more likely than adults to be bewildered, anxious, and stressed when brought to the Emergency Department.

We are now able to reduce a child's anxiety through play and distractions such as movies and games, allowing us to get a more accurate exam and ultimately leading us more quickly to the appropriate plan of care.

The Pediatric Emergency Department is a testament to the commitment of Stanford Hospital & Clinics, Lucile Packard Children's Hospital, and the community to provide the very best care to sick and frightened children. [SN](#)



Colleen O'Connor gives a young patient a preview of a CAT scan by playing with a model designed just for children.

ABCD:

Above and Beyond the Call of Duty

BY SUSAN D. NEKIMKEN, RN, MPA, CMSRN
PATIENT CARE SERVICES MANAGER, D & E GROUND

All over the hospital, in every unit and on every floor, you'll find staff going out of their way to fulfill a patient's special need, offer comfort to a patient's family, or thoughtfully mentor a colleague.

On D & E Ground Units, we're acknowledging such actions with our "ABCD" (Above and Beyond the Call of Duty) awards that pay tribute to a

staff member's special contribution with a pin, a certificate, and a written description. We also make formal presentations during report time so that everyone can share in honoring the recipient. In our conference room, a poster showcases the honorees' photographs along with the stories of their deeds. Below are just a few examples of these small but welcome acts of kindness.

When **only** a hamburger will do

When **Lolita Asignacion**, the Resource Nurse on EGR, was called to assist with a code that lasted 45 minutes, lunchtime had come and gone by the time she was finished. When she went to check on her other patients, she found that one patient had not received his lunch tray because a neutropenic sign was on his door and the tray was returned to dietary services inadvertently.



By the time Lolita reached dietary services it was almost 2 pm, and the only food available was a turkey or egg salad sandwich – neither of which appealed to the patient. What he really craved was a hamburger. So Lolita gave some money from her own pocket to one of her peers and asked that she buy a hamburger from the cafeteria. When Lolita arrived with the hamburger, the patient was thrilled. He offered to pay Lolita when his wife came to visit, but she refused payment, saying that his satisfaction was payment enough. Thanks to Lolita and her commitment to patient service!



The comfort of a warm gesture

As a nurse approached the front desk, **Rohini Prasad** was overheard answering a patient’s call light. A minute later, the nurse noticed Rohini on her way into that patient’s room with a warm blanket. She covered the patient with the warm blanket, and then went back to her work. Rohini consistently exemplifies the meaning of teamwork. Indeed, if we all went about our day with the same enthusiasm, warmth, and caring that Rohini demonstrates, wouldn’t it be wonderful? Thank you, Rohini, for all the things you do for us!

A prescription for caring



When **Milton Prado** was asked by one of our nurses to help a Spanish-speaking patient and the patient’s family by translating some important discharge instructions, Milton patiently interacted with the family, which greatly helped to alleviate their anxiety as they left the hospital. After they were gone, however,

the nurse realized that she had forgotten to give the patient the triplicate prescription the doctor had written. Milton knew the patient had an appointment in the clinic, so he picked up the prescription and ran with it to the clinic to make sure the patient would have it. The grateful nurse was overheard telling Milton, “You rock!” We would all like to echo that sentiment and more. Thank you, Milton, for all of your special care for all of us and for our patients.

Untangling a complex procedure



The husband of a patient called **Maria Faulve-Montojo** to tell her that he didn’t understand how to manage the tubing on his wife’s feeding tube (she had just been discharged from D/E Ground the previous weekend). After trying unsuccessfully for 20 minutes to explain the apparatus to him over the phone, Maria asked him for directions to his home, promising to stop by on her way home from work. Maria did just that, demonstrating the feeding procedure to the patient’s husband, who was then able to do it himself. He was very grateful – and so are we. Thanks to Maria for her commitment to nursing!

An angel at your service



Prosi Angel had graciously accepted responsibility for taking a volunteer under her wing every Tuesday evening. Wendy, who aspires to be a nurse, had volunteered on D/E Ground to get some in-patient experience, and she was lucky enough to be mentored

by Prosi. When Wendy was getting ready to leave the Bay Area in order to attend school in Kansas, she called a manager to express her appreciation for her experience with Prosi, noting that Prosi had treated her to dinner and given her a Stanford mug as a going-away gift. Wendy was very grateful for her experience and especially appreciated Prosi’s warm, sincere kindness. We know that Wendy will always remember her positive experience at Stanford because of Prosi. Thank you Prosi from all of your friends on D/E Ground!

Oral Care for Mucositis

BY D. KATHRYN TIERNEY, RN, PhD
ONCOLOGY CLINICAL NURSE SPECIALIST
BLOOD AND MARROW TRANSPLANT PROGRAM

Oral mucositis is an inflammation of the oral mucosa often leading to ulceration, bleeding, and secondary infections.

It results from the direct effects of cytotoxic therapies on the oral mucosa, as well as indirect damage secondary to inflammation in the setting of neutropenia and the presence of pathogenic microorganisms in the oral cavity.¹ The incidence of oral mucositis is influenced by the type and dose of antineoplastic therapy administered as well as patient-related factors such as age, oral health, and underlying disease.²

Cause and effect

The preparative regimen for ablative blood or marrow transplantation (BMT) consists of high doses of combination

chemotherapy with or without total body irradiation. This high dose therapy is associated with a significant risk for the development of oral mucositis. Greater than 70 percent of BMT recipients experience clinically significant mucositis.³ The sequelae of oral mucositis includes pain, dysgeusia, dehydration, malnutrition, difficulty communicating, and decreased quality of life. Potentially pathogenic organisms found in the oral cavity include fungi and bacteria¹. Once the oral mucosa is damaged, the patient is at significant risk for local and systemic infections. Sonis (2004) sites the following health and financial implications of mucositis in BMT recipients: increased days with fever and longer hospital stay, increased use of narcotic analgesics and parenteral nutrition, and a higher risk of systemic infections.⁴

D. Kathryn Tierney, RN, PhD, and her team designed a new, more effective oral care regimen intended to prevent mucositis.



Table 1: Steps to Evidence-based Practice Change in Oral Care

1	Literature review
2	Develop a new oral care regimen and plan for monitoring the practice change
3	Discuss new oral care regimen with infectious disease specialist and BMT attending with an expertise in mucositis
4	Present findings of literature review and new oral care regimen to all of the BMT attending physicians
5	Disseminate new oral care regimen to nursing staff
6	Set an implementation date
7	Evaluation

A laborious routine

The oral care regimen utilized for many years consisted of a combination of agents designed to reduce the oral flora with the goal of decreasing the risk of systemic infections secondary to microorganisms from the oral cavity. The oral care regimen performed six times per day consisted of:

- 1) Rinsing the mouth with sterile water containing sodium bicarbonate.
- 2) Gently cleaning the oral cavity and teeth with a toothette.
- 3) Rinsing the mouth with sterile water containing sodium bicarbonate.
- 4) Use of a topical antifungal agent, typically clotrimazole troches that were left in the mouth until dissolved. The alternative was to use nystatin oral suspension, which was swished around the oral cavity and then expectorated.
- 5) Waiting 15 minutes.
- 6) Rinsing the mouth with Peridex®, a chlorhexidine gluco-

nate mouthwash with reported antibacterial and antifungal properties.

This was a cumbersome regimen and patient adherence was highly variable. Common patient complaints were that the clotrimazole troches left a chalky taste and feeling in the mouth, Peridex® often caused burning pain, and the toothettes had an unpleasant taste.

A new approach

Table 1 outlines the steps to an evidence-based oral care regimen. To start, a UCSF graduate nursing student working with the BMT clinical nurse specialist performed an extensive literature review on the prevention of oral mucositis in cancer patients. The summary of findings indicated that no one product proved superior to any other product in the prevention of oral mucositis¹. Evaluation of these studies is confounded by the heterogeneity of study samples, antineoplastic therapies, and the various strategies for administering the many agents investigated. However, findings indicated that the most important aspect of oral care was not the product used but a systematic regimen of mouth care⁵. Based on this finding, we believed a simpler oral care regimen would result in increased patient adherence.

From six steps to two steps

The new oral care regimen was reduced to a two-step process. Step one included rinsing the mouth with normal saline followed by step two, a gentle cleaning with a soft “baby” toothbrush 4-6 times per day. The need for a thorough dental exam and cleaning 2-4 weeks prior to transplantation is also emphasized, as this strategy has been shown to reduce the incidence of mucositis¹. The monitoring plan consisted of a monthly review of positive blood cultures and feedback from patients and nursing staff.

This simplified two-step plan was first presented to Dr. Ginna Laport, a BMT attending physician with expertise in mucositis, and Dr. Wes Brown, an infectious disease specialist. With their approval, the BMT clinical nurse specialist presented the plan to the entire physician staff of the BMT program. At this meeting, one attending physician remained very concerned about the lack of antifungal prophylaxis. To assuage that concern, the following modification to the oral care regimen was added: If the assessment of the oral cavity revealed what appeared to be thrush, a fungal swab from the suspicious area was sent to the microbiology lab for evaluation. Simultaneously, the patient would begin using clotrima-

zole troches for seven days while waiting for culture results. If results indicated an oral fungal infection, the clotrimazole troches continued; if the results were negative the clotrimazole troches were discontinued.

Staff preparation for this change in procedure consisted of inservice training and email notification. The change was implemented on October 1, 2004. The immediate feedback from both patients and staff was that the regimen was much easier, and therefore patient adherence increased. An unexpected finding reported by the nursing staff was that there was less nausea and emesis. (The previous oral care regimen often caused nausea, increasing the likelihood of emesis, and this was reduced with the more palatable normal saline rinses.) There has been no increase in positive blood cultures with organisms from the oral flora.

There were a few details that needed fine tuning after implementation. For example, how often would a new toothbrush be needed and how would the outpatients make normal saline? Additionally, all BMT patient education materials needed to be revised to reflect the new oral care regimen. We are pleased with the outcomes and, by all measures, this evidence-based practice change has been a success. [SN](#)

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Analyzing Complications of IV Therapy

A study of patients on D1

BY JIM STOTTS RN, MS

ASSISTANT DIRECTOR FOR PRACTICE AND EDUCATION
ACTING CNS FOR CARDIOLOGY

The impetus to evaluate complications of IV therapy originated from episodic observations of cellulitis in IV sites in arrhythmia patients returning for their follow-up appointments, and occasional discoveries of continuous infusions flowing through IV sites that were either reddened, swollen, or leaking.

Working from a tool used by Lucile Packard Children's Hospital, we developed an IV History Tracking Form to collect specifics about each IV site: what and how many medications were administered, site location, catheter size, number of flushes, duration of use, and reason for discontinuance. We then sorted, tallied, and analyzed data from over 125 patients and 300 IV sites to reveal interesting trends. Nearly 100 percent of patients who received peripheral infusions of Amiodarone, patients who received other specific medications such as KCL, Ca++ gluconate, and Cefazolin, and sites with multiple medications were all associated with complications. The observations we made during data collection indicated a need to educate staff to recognize IV complications and enforce IV standards of practice.

We also developed an audit tool with instructions for giving feedback when deviations from standards are identified. Future plans are to educate and coach staff on recognizing and documenting IV sites with complications, and updating existing policies to standardize nomenclature of complications and decision guides for selecting appropriate IV site based on type and duration of therapy. [SN](#)

10 Tips to Prevent Infections

An Innovative Educational Tool

BY DEBRA JOHNSON, BSN, RN, CIC
INFECTION CONTROL AND EPIDEMIOLOGY DEPARTMENT

Effective infection control starts with effective education. In the setting of a busy academic medical center like Stanford Hospital & Clinics (SHC), communicating infection control education to all staff requires a variety of methods.

Because standard notices, documents, and lectures don't always engage staff and may fail to convey essential information, the real challenge is finding an innovative method that does. A self-study module developed at Barnes-Jewish Hospital in St. Louis reduced the ventilator-associated pneumonia rate from 12.6 to 5.7 per 1,000 patient days.¹

A new approach

In late 2003, while preparing for the 2004 Joint Commission accreditation survey, the members of the Infection Control and Epidemiology Department (Sasha Madison, MPH, CIC, Pat Rutherford, BSN, RN, CIC, and myself) along with Ellen Jo Baron, PhD, Director of the Microbiology Lab, discussed how we could use new and innovative methods to present infection control information, especially the message of hand hygiene. Our goal was to find an educational approach that would reach a large number of staff at any given time without necessarily requiring an instructor, and to communicate the message in a compelling way.

Knowing that many of the interns and residents use personal digital assistants (PDA's), we brainstormed about ways to "beam" information to them, but felt we needed a broader approach that would reach all staff, not just those with PDA's. Dr. Baron suggested we apply for a mini grant available from SUMMIT (Stanford University Medical Media and Information Technologies) for developing educational programs using technology.



Debra Johnson, BSN, RN, CIC, and members of the Infection Control and Epidemiology Department and Microbiology Lab developed a creative approach to preventing infection.

Using this grant, we developed an interactive, computer-based educational tool in collaboration with SUMMIT Virtual Labs at Stanford University, the SHC Infection Control Department, and Dr. Baron. Under the direction of Camillan Huang, PhD, from SUMMIT, we developed a CD blending media, technology, and educational principles. The title, “10 Tips to Prevent Infection,” offers a subtle reminder of the cornerstone of all infection control programs: hand hygiene. The first screen shows two hands facing the viewer. The word “PROTECTION,” which appears above each finger, is used to guide the user to a different screen for each important infection control concept. For example, the “N” is used to reinforce the concept that no artificial nails are to be worn by health care providers. This interactive module combines solid teaching methods with a variety of multimedia methods like animation, interactive games, video, and self-assessment quizzes — providing students with content that is available anytime for self-paced study and assessment.

A perfect “10”

10 Tips to Prevent Infection was completed in 2004 and unveiled at the Patient Safety Fair where participants were asked to run through the tutorial and complete an evalua-

tion. The evaluations were overwhelmingly positive. The CD was then tested in the new employee orientation conducted weekly at Stanford for all new hires. Since the program was instituted, the infection control portion of new employee orientation has garnered excellent evaluations and has been well received by the nursing staff orientation classes. It has also been used at infection control education classes for vari-

ous departments including Housekeeping, Life Flight, New Grad Orientation, and Stanford Medical Youth Services. Copies of the CD are now available for staff and have been placed in the health library, making them available to the public. The module can also be downloaded off the Web for use by anyone.²

The evidence for infection control education is clear; we

know it works. And just as important as the content are the tools we use to impart the information. As we move forward with the use of technology in our practice, we hope that “10 Tips” can be a model for new methods of education. [SN](#)

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“Our goal was to find an educational approach that would reach a large number of staff at any given time without necessarily requiring an instructor, and to communicate the message in a compelling way.”

A Balance of Work and Play



KAY SPAROLINI, a staff nurse in the Cath Lab, grew up in Carmel and has played golf off and on since childhood. She plays tournament golf as a 16 year member of the Shoreline Women's Group in Mountain View. Kay has a reputation in the Cath Lab for being able to outplay any of last year's cardiovascular fellows and is looking to keep that reputation alive this year.

JUNE TILTON is a staff nurse on E3 and another avid golfer who finds the time to play three times a week. She plays for two women's groups at Poplar Creek in San Mateo and at the Green Hills Country Club in Millbrae. She took first place in a low net tournament for Green Hills last summer.



LYNN MARIE MURPHY is a staff nurse on NICU. Lynn Marie has combined her enthusiasm for healthy living and passion for yoga by becoming a certified instructor for Therapeutic Yoga. She's been on yoga retreats to Costa Rica, Bali and most recently Rishikesh, India.



KATHY HICKMAN, RN, MSN, Project Manager, always wanted to learn how to ride horses as a child, but never really had the opportunity. A few years ago she decided to give it a try. Kathy says, "Although I take lessons with people who have had experience from childhood and excel faster than I do, I still love being around horses and riding. I am so focused when I ride, nothing else can enter my consciousness which is so freeing. It is just you and the horse."

The Power of Diversity

Three cultures, three perspectives, one vision

When Hirut Truneh, BSN, RN, first saw a disposable syringe, she couldn't get over the waste it represented. "In Ethiopia we do so much with so little," she says. "When you grow up in a very poor country, it's hard to get used to the abundance we have here."

Now the assistant manager on C2 Unit, Hirut has come to appreciate disposable syringes and the many other conventions of Western medicine we take for granted. Yet despite her long residence in the United States (she left Ethiopia to attend college in Boston when she was 18), she still finds herself marveling at all of the conveniences we don't even think about. "How can Americans complain about having to do laundry?" she laughs. "At home, every Thursday was laundry day: one person scrubbed the clothes by hand in the bathtub, another wrung them out, another hung them to dry. Here we just toss them in the Whirlpool."

Crossing the language barrier

But what Hirut brings to her nursing practice from her native culture gives her

insight into the diversity of needs and expectations patients from different cultures may have.

Angela Lee, RN, a staff nurse on D3 Unit, agrees. She was born and raised in Hong Kong but, like Hirut, came to the United States to go to school – both high school and college, in her case. She observes, for instance, that while she generally prefers to use Stanford's excellent interpreter services rather than translate for Chinese-speaking patients herself, there are ways in which her language and nursing skills can complement each other, allowing her to forge a special bond with patients.

She recalls: "There was one elderly patient who spoke very little English but, like me, spoke Cantonese. I learned that there were



Hirut Truneh, RN, BSN, Assistant Patient Care Manager, Unit C2

many things he was worried about upon discharge, such as how he would do his grocery shopping and how he could lift a pot of water to make rice for himself." An interpreter could have translated his concerns but not helped him to formulate a plan for living independently again, while a nurse who did not speak his language could not have communicated with him at all. Simply being able to talk with someone in his own language, and know that he was being heard, proved to be a great comfort.

Gennette Olalia, a staff nurse in the Emergency Department, believes that her sensitivity to the needs of non-native English speakers is one of the advantages she offers her patients. Originally from the Philippines, Gennette studied nursing before moving to the United States with her husband. She reflects: "Older Filipinos generally appreciate you talking with them in their native language. Yet I was once asked to translate for an elderly Filipino patient who became upset when

the doctor felt he needed a translator, because he did speak English. I think it's important to remember that immigrants, in particular, are often proud of their ability to speak English, and don't want to be treated as foreigners."

Family matters

The customs associated with illness and the way family members relate to a relative who is sick vary from culture to culture as well. In Chinese culture, for instance, people are typically reluctant to talk about death, Angela says. "So they may hang back for fear of getting too close to a family member who is dying. As nurses, we may push them to get closer than they feel comfortable. I think it's

because we venerate the elderly, and feel a responsibility to take care of them. So natural as it is, we view it as a shame to let a parent, in particular, die."

In the Philippines, however, families typically stay very close to patients, Gennette notes. "They almost always bring family with them to the hospital, and it's very important for nurses and doctors to recognize the significance of family in the recovery process." For instance, the family typically stays with the patient, sleeping at the hospital and helping the patient with tasks like bathing and dressing. "And since there are fewer nurses in Philippine hospitals than in the U.S. hospitals, they actually play a vital role."



Angela Lee RN, BSN, staff nurse on D3



Gennette Olalia, RN, BSN, CEN, staff nurse, Emergency Department

As Gennette points out, this may be a foreign concept in American hospitals, but we have already instituted this custom to some extent. At Lucile Packard Children's Hospital, for instance, parents can spend the night with their children, while in labor and delivery, spouses and partners may stay with a new mother and child for the night.

This also reflects Hirut's experiences as a child in Ethiopia, at the clinic where her mother, who was a nurse midwife, worked. "Often," she remembers, "a family member would simply spread out a blanket on a bench in the hallway and sleep there to stay close

to the patient." She goes on: "When you're sick, we consider it to be your greatest time of need. So when family members visit and stay close to the patient, it's a sign of care."

"My mission is to understand where people are coming from," Hirut says, "and to be sensitive to the different expectations people from different cultures may have."

On a lighter note, she says, one of the benefits of diversity is that with so many different cultures represented by the staff on C2 – from Ethiopia to Columbia to Poland to Kenya – "potlucks are always wonderful!" [SN](#)

Professional Certification

A Report from B3

BY JULIE TISNADO, MSN, RN, CNRN

In the fall of 2004, the B3 Unit Council decided that professional certification was the logical next step in increasing clinical expertise and promoting the professional practice of our neuroscience nurses. As a result, one of our goals for 2005 was to achieve certification of 30% of staff nurses eligible to take the examination (eligibility requires two years experience in neuroscience nursing).

Stepping up to the challenge

The first step was to identify potential barriers. As we discussed this in staff meetings, two things became clear. The time commitment for preparation and fear of failing the exam were major detractors for everyone, including me. However, as manager of the unit, I decided it was necessary to embrace the challenge — even at the risk of failing. After much discussion and assurance of support, eight senior staff nurses decided to take the exam.

We received overwhelming support from the neurosurgery faculty and clinic staff. Several attending physicians and clinical

nurse coordinators agreed to present a key topic every other Monday during the three months preceding the exam. We scheduled the sessions late in the afternoon so that all involved could easily attend. The B3 unit educator, Joy Ryan, videotaped each lecture so that the content was available to anyone who missed a session. The Department of Neurosurgery paid for textbooks to minimize out-of-pocket expenses for staff. Journal articles, sample tests, and other materials that seemed pertinent were distributed.

Essential planning and preparation

During the final six weeks of preparation, two of the neurosurgery residents agreed to facilitate weekly review sessions. This proved to be beneficial for a variety of reasons. First, it gave the staff an opportunity to ask questions or receive a more in-depth explanation of a topic they were struggling with. Second, it was an eye opening experience for the residents to understand the complexity of the content we were expected to know. They began to compare

our sample questions with the types of questions they were asked on Board exams. Third, a real sense of camaraderie, team spirit, and mutual respect developed.

Since we had more than the five requisite applicants, we were able to hold the exam at Stanford. The familiar environment made it a little less stressful. Upon completion, all of the staff, including the resident physicians, were invited to a special lunch provided by the Department of Neurosurgery. We were all glad to have the exam behind us, though none of us believed we had passed.

Cause for celebration

The eight- to ten-week wait for results was exasperating. Finally, one by one, each of us received a letter informing us of a passing or failing score. Seven of the eight nurses passed the exam. The excitement was palpable; a high that lasted several weeks.

We celebrated our success with a special recognition lunch hosted by Cindy Day, Chief Nursing Officer and Vice President of Patient

Care Services, and Debra Grant, Associate Director of Nursing. Lawrence Shuer, Chief of Staff, and Gary Steinberg, Chair of the Department of Neurosurgery, also attended. The nurses were acknowledged in the Fall 2005 issue of *Stanford Nurse* magazine and a special plaque with the names of those who passed now hangs on the unit.

The success of those who passed spurred more interest on the Unit. In October, 2005, eight more staff nurses took the exam. Five of those achieved a passing score. We utilized the same process, only this time, the newly certified nurses were a constant source of support and encouragement for their colleagues. Our original goal was for 30 percent of our eligible staff to become certified; we have already reached 55 percent.

I am very proud to say that we have definitely raised the bar for clinical excellence on B3. We will continue to utilize the process we have put in place for the future. Our new goal is to achieve and hopefully maintain 100 percent certification. [SN](#)

In Recognition of...

CONFERENCE PRESENTATIONS

Carrie Jeffries, RN, ANP-C, MS, MPH, AACRN, AAHIVS: "Managing HIV for the Long Haul: Naïve to Highly Experienced," National Association of Nurses in AIDS Care Annual Meeting, Orlando, FL, November 2005.

Carrie Jeffries, RN, ANP-C, MS, MPH, AACRN, AAHIVS: Key Note Speaker "Anti-Retrovirals and Hepatotoxicity," First Annual Missouri HIV/AIDS Clinical Forum, Columbia, MO, October 2005.

Julie Krieger, RN, BSN, MHA, CNA, BC, and Susan Nekimken, RN, MPA, CMSRN: Poster Presentation – "Improving Patient and Staff Satisfaction in an Oncology Overflow Patient Population," Association of California Nurse Leaders, Los Angeles, CA, February 5 – February 8, 2006.

D. Kathryn Tierney, RN, PhD: "Sexuality After Hematopoietic Cell Transplantation: An Important Quality of Life Issue," American Society of Blood and Marrow Transplantation Annual Conference, Honolulu, HI, February 19, 2006

D. Kathryn Tierney, RN, PhD: "Sexuality After Cancer: A Survivor's Issue," Duke University Medical Center Hematology Conference, Asheville, NC, April 7, 2006.

APPOINTMENTS

Carrie Jeffries, RN, ANP-C, MS, MPH, AACRN, AAHIVS: President Elect, HIV/AIDS Nursing Certification Board, 2005 – Present.

CERTIFICATES

Judy Barnes, RN, BSN, MPA: Passed the American Case Management Association Exam, October, 2005.

Linda Bracken, RN, EdM, MPA, CNA: Passed the ANCC Nursing Administration Certification Exam, October, 2005.

Cynthia Basa, RN, BSN, CNRN: Passed the Certification Exam for Neuroscience Nursing, October, 2005.

Davinder Bhatia, RN, MSN, CNRN: Passed the Certification Exam for Neuroscience Nursing, October, 2005.

Hazel Cabral, RN, BSN, CNRN: Passed the Certification Exam for Neuroscience Nursing, October, 2005.

Cecilia Cadet, RN, MPA, CNA: Passed the ANCC Nursing Administration Certification Exam, October, 2005.

Andrheena Chua, RN, BSN, CNRN: Passed the Certification Exam for Neuroscience Nursing, October, 2005.

Randy Cobar, RN, CRRN: Passed the Certified Rehabilitation Registered Nurse Exam, December, 2005.

Terri Gordon-Gamble, RN, MSN, CNA: Passed the ANCC Nursing Administration Certification Exam, October, 2005.

Debra Grant, RN, MBA, CNA: Passed the ANCC Nursing Administration Certification Exam, October, 2005.

Beverley Grenz, BA, ASN, CMSRN: Passed the Nursing Certification Exam, Academy of Medical-Surgical Nurses, October 2005.

Will Gressman, RN, MS, MPA: Passed the American Case Management Association Exam, March, 2006.

Christa Groen, RN, BSN: Passed the American Case Management Association Exam, October, 2005.

Julie Krieger, RN, BSN, MHA, CNA, BC: Passed the ANCC Nursing Administration Certification Exam, October, 2005.

Tess Lazzareschi, RN, BSN, CRRN: Passed the Certified Rehabilitation Registered Nurse Exam, December, 2005.

Becky Lee, RN, CGRN: Passed the Certified Gastroenterology Nurse Exam, October, 2005.

Birgit Massion, RN, CGRN: Passed the Certified Gastroenterology Nurse Exam, October, 2005.

Julie Maughan, RN, BSN: Passed the American Case Management Association Exam, November, 2005.

Jeanne McGrane, RN, MSN, MBA, CNA: Passed the ANCC Nursing Administration Certification Exam, October, 2005.

Joan Mersch, RN, MS, CNA: Passed the ANCC Nursing Administration Certification Exam, October, 2005.

Joyce Montemayor, RN, BSN, CNRN: Passed the Certification Exam for Neuroscience Nursing, October, 2005.

Ida Nichols, RN, CGRN: Passed the Certified Gastroenterology Nurse Exam, October, 2005.

Heidi Peirce, RN, BC: Passed the ANCC Psychiatric/Mental Health Nursing Exam, October 2005.

Fernando Reyes, RN, CRRN: Passed the Certified Rehabilitation Registered Nurse Exam, December, 2005.

Margie Saenz, RN, BSN: Passed the American Case Management Association Exam, December, 2005.

Maria Sandoval, RN, BC: Passed the ANCC Psychiatric/Mental Health Nursing Exam, October 2005.

Leitha Sangermano, RN, MS, CNA: Passed the ANCC Nursing Administration Certification Exam, October, 2005.

Linda Schoenstein, RN, BSN: Passed the American Case Management Association Exam, October, 2005.

Maj Smith, RN, BSN, MSA: Passed the American Case Management Association Exam, November, 2005.

Robinetta Wheeler, RN, MS, PhD, BC: Passed the ANCC Psychiatric/Mental Health Nursing Exam, October 2005.

ARTICLES & PUBLICATIONS

Kathy Grimley-Baker, RN: "You Never Know What Will Happen," Chapter 37 in *Ordinary Miracles in Nursing*, Patricia Winstead-Fry and Deborah Labovitz Publishers.

DEGREES

Carolina Perez, RN, BSN: Bachelors Degree in Nursing, San Francisco State University, December 2005.

D. Kathryn Tierney, RN, PhD: Doctor of Philosophy in Nursing, University of California, San Francisco, March 2006.

AWARDS

Beverley D. Tobias, RN, MBA, COHN-S, CCM, FAAOHN: Award of Appreciation, American National Standards Association, January 28, 2006.

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