9.3 Demonstrate how direct care nurses use available professional standards, literature and research findings to support control over nursing practice, independent decision-making and assertiveness/leadership in patient care management and practice. Provide evidence from multiple patient care settings within the organization.

As described in Force 5.5, the Patient Care Delivery Model at MGH fosters an environment of care that places the authority, responsibility, and accountability for the nursing care of patients and families directly with the Registered Nurse at the bedside. Direct care nurses use their knowledge to support independent decision-making and to manage practice in a way that improves outcomes for their patients and families.

Following are examples demonstrating how nurses exert control over their practice and how the organization recognizes nurses for providing exemplary care to patients and their families.

**Same Day Surgical Unit (SDSU) Resource Nurse Role**

In the transient holding area of the SDSU, patients are assessed for preparedness and readiness for their surgical procedure by the entire perioperative team. This multidisciplinary team includes Staff Nurses working in the resource role, Circulating Nurses, Anesthesiologists, Surgeons, Patient Care Associates, and Admitting Staff. They work together to facilitate patient flow and optimal patient care. The following is a narrative from a Staff Nurse describing how the use of standards has supported her practice as she has assumed a leadership role as a Resource Nurse for the unit.

“As the Resource Nurse in the transient holding area, I often rely on professional standards and current literature to support our current practice and patient care. A simple example of this would be recently when I witnessed a Surgical Resident dry shaving a patient’s abdomen with a razor in our transient holding area preoperatively prior to surgery. I explained to the resident that research data proposes using a clipper instead of a razor to decrease the incidence of surgical site infections. I informed him that the Association of Peri-Operative Nurses (AORN), JCAHO and American College of Surgeons have been working on a National Quality Partnership called Surgical Care Improvement Project (SCIP) that has demonstrated that appropriate hair removal with clipping hair has decreased surgical site infections. I told him that MGH participates in this National initiative known as SCIP and the perioperative team had adopted the appropriate surgical hair removal process of clipping hair with clippers. He said he was interested in learning more about this initiative, and I provided him a copy of our Clipper Policy, which I was able to access via our Policy and Procedure Manual online.

E. Walsh RN, BSN, Staff Nurse SDSU
Endoscopy Unit, Blake 4 and Charles River Plaza

Staff Nurses in the Endoscopy Unit use the Practice Guidelines, Position Statements and Professional Practice Standards put forth by the Society of Gastroenterology Nurses and Associates (SGNA) to support their practice. For example, SGNA Standards guide Staff Nurse decision-making when making patient assignments. Staff Nurses on the unit follow the SGNA Standard for Minimum Registered Nurse Staffing for Patient Care in the Gastrointestinal Endoscopy Unit that describes minimum staffing in an endoscopy unit to include one RN in the pre-procedure and post-procedure areas, as well as one RN in each procedure room.

Staffing is also described in the SGNA’s “Statement on the Use of Sedation and Analgesia in the Gastrointestinal Endoscopy Setting” which states that during moderate sedation, the Registered Nurse monitoring the patient may assist with minor, interruptible tasks once the patient’s level of sedation/analgesia and vital signs have stabilized.” However, it is the position of the SGNA that “a second nurse or associate is required to assist the physician with those procedures that are complicated either by the severity of the patient’s illness and/or the complex technical requirements associated with advanced diagnostic and therapeutic procedures.” The Staff Nurses, with the Nursing Director, in the Endoscopy Unit used this guideline to advocate for staffing changes that supported two nurses be present for complicated procedures or when the patient requires deep sedation; such as when an ERCP is performed. This is now the standard staffing practice in the unit.

Nurses in the Endoscopy Unit also use the SGNA guidelines to support the documentation of their practice. During the 2006 Endoscopy Unit annual retreat, the staff set a goal to improve compliance with documentation. To address the issues, Staff Nurses formed a committee and revised the nursing flow sheet to follow the SGNA Guidelines for Documentation in the Gastrointestinal Endoscopy Setting.

Post Anesthesia Care Unit (PACU)

The PACU follows the professional standards that have been set by the American Society of Peri-Anesthesia Nurses (ASPAN). According to ASPAN, “the standards integrate principles of evidence based practice through a thorough literature review and update of references and resources. They also reflect changing healthcare environments that include various levels of care, a variety of environments of practice and emerging patient safety issues.” There are eight Standards of Peri-Anesthesia Practice: Patient Rights; Environment of Care; Staffing and Personnel Management; Performance Improvement; Research; Assessment;
Planning and Implementation; and Evaluation. In addition, there are three ASPAN Clinical Practice Guidelines:

- Pain and Comfort;
- Prevention of Unplanned Perioperative Hypothermia; and
- Prevention and/or Treatment of Postoperative Nausea and Vomiting and Post-discharge Nausea and Vomiting in Adult Patients.

Although the PACU practice guidelines are consistent with the standards set forth by ASPAN and JCAHO, this year the PACU Practice Committee (attachment 9.3.a) is currently reviewing and revising each of its practice guidelines to assure compliance with current standards. In the final phase of this project, a website for the guidelines will be developed to give Staff Nurses and all direct care providers access to the guidelines right at the patient's bedside. Minutes from the Practice Committee meetings (attachment 9.3.b) reflect how Staff Nurses actively integrate professional standards into practice.

Additionally, Staff Nurses in the PACU use the ASPAN Pain and Comfort Clinical Guideline© in conjunction with the MGH pain assessment guidelines to assess pain on their patients in the post-operative period. Based on the clinical assessment of their patients, nurses in the PACU felt patients were not getting adequate relief from post-operative pain because they did not fully understand the use patient controlled analgesia (PCA) and epidural pain management. In response, as described in Force 6.27, the PATA-PACU Pain Task Force developed two patient education pamphlets, How to Use a PCA Pump to Control your Pain After Surgery and Epidural: A Choice for Surgical Pain Control, to help educate patients on methods of pain management prior to their surgical procedures.

Wound Care Resource Nurse - General Medicine, Bigelow 9

Staff Nurses attended wound care classes described in Force 8.6 to learn current and best practices in wound care management. Staff Nurses gained experience in managing wound care using evidence-based practice that is supported by current literature and research. After completing the Wound Care Education Program, Staff Nurses, with the support of the Clinical Nurse Specialist, have now assumed leadership roles on the unit assisting their peers in assessing wounds and suggesting treatment options for improved patient outcomes. Attachment 9.3.c is a Caring Headlines article describing the Wound Care Education Program for Staff Nurses.
Mallinckrodt General Clinical Research Unit (GCRC), White 13

On the GCRC, Protocol Nurses take the lead in planning, implementing, and evaluating all aspects of the research protocols in collaboration with the Principal Investigator and other research team members. It is their responsibility to operationalize studies by researching and reviewing the literature upon which each study is based. When a protocol is ready to start, the Protocol Nurse educates her colleagues to the science, literature, and other findings needed to understand and independently execute the protocol.

Additionally, Protocol Nurses in the GCRC conduct their own research to support and improve their practice environment. In doing so, they found that older models of blood sparing lines were clotting frequently, which raised the possibility of pushing clots into the patient’s vein. As a result of this work, they contacted a medical equipment representative to help them design a new blood sparing line to support their practice. The outcome of this research was presented in the 2007 Nursing Research Day poster session during the Nurses Week Celebration (attachment 9.3.d).

Main Operating Rooms

The Staff Nurses in the Main Operating Room use professional practice standards put forth by the Association of Peri Operative Nurses (AORN) Standards, Recommended Practices and Guidelines to support their practice. Standards related to safety training requirements for the use of lasers is one example of how the operating room nurses use AORN standards to guide independent practice.

Laser safety is very important patient and employee safety issue in the operating room environment. In order to practice independently, all Staff Nurses are trained on laser protocols, policies and procedures. Training includes: basic laser safety and training on specifics types of lasers, viewing an AORN video and reading AORN articles about lasers. Once these three requirements have been completed, each nurse must pass a post-test to demonstrate understanding and competency. The nurse is then precepted by another competent laser person to receive hands-on training experience with the laser. Attachment 9.3.e is the OR Laser Credentialing Policy outlining these requirements. Once credentialed, all OR nursing staff working in services that use the laser complete a laser safety component as part of their annual competency review.
Cardiac Step Down Unit, Ellison 10

Using guidelines from the Health and Human Services National Quality Measures for Heart Failure, Staff Nurses with the support of their Clinical Nurse Specialist received funding from a Making a Difference Grant to purchase water pitchers with volume markings to be used in conjunction with fluid conversion charts and post education questionnaires as visual aides to support their patient education program for heart failure management. This will be described in detail in Force 11.9.

Another example from the unit is the development of the Mind/Body Groups for patients and families. A master’s prepared Staff Nurse on the unit developed this pilot program to teach patients and their families the practice of using the Relaxation Response as a way to reduce stress during hospitalization. Knowing that stress, a risk factor for many acute and chronic diseases, including cardiovascular disease, is not typically addressed as part of conventional medical treatment, she proposed introducing the Relaxation Response to the patients on her unit.

The Relaxation Response is an abdominal breathing pattern, performed with the use of repetition and focus. This breathing pattern, performed twice a day for approximately 10-20 minutes, has been shown to be effective in reducing stress and improving health. It is based on the work of Dr. Herbert Benson, a Boston cardiologist and founder of the Mind/Body Medical Institute, who first identified stress as a strong risk factor of disease and developed the Relaxation Response as a method of focused breathing to counteract the pathophysiology of stress. Dr. Benson has done over thirty years of research in this area and has measured improvements in hypertension, cardiac arrhythmias, anxiety, depression, insomnia, premenstrual syndrome, infertility, general well being and pain.

Two Staff Nurses lead the Mind/Body Group twice a week for patients and family members in the unit’s “Healing Garden”, a room specially designed with elements of nature, light and life. The groups started in 2005 as a six-month pilot, using funds from a Making a Difference Grant. During the pilot, the twice weekly averaged 5.2 patients per session with each session lasting 20 to 30 minutes. Feedback from patients was extremely positive. Many of the participants were greatly appreciative of the opportunity to learn such an exercise, which can help them in their daily lives. Patients reported that they “love it (the breathing exercises)”, “it really helps me to relax”, “I can do this twice a day…at work or in traffic or waiting in a line”, “I want my wife to come and learn this” etc. Many patients reported improvements in their ability to sleep, calm themselves or to cope with
issues in their lives. Frequently at the end of the group, participants verbalized how they can fit this into their lives and how the participants supported one another.

An unexpected outcome of the pilot was that as Staff Nurses were being trained in the Relaxation Response for their patients, they began to recognize the personal benefits gained from experiencing the technique themselves. Since the onset of this project, Staff Nurses as well as other members of the team; such as Social Workers, Case Managers, Chaplains, Physical Therapists and Nursing Support Staff, have been trained in the Relaxation Response. This has served a dual purpose for the staff involved, helping to improve their own health, while they help their patients manage stress more effectively.
PACU Practice Committee Membership

Joyce Saturley, RN, MS – Staff Nurse (Chair)

Committee Members

Scott Ciesielski, RN – Nursing Director
Paula Clay, RN – Staff Nurse
Nancy Connolly, RN – Staff Nurse
Diane Herald, RN – Staff Nurse
Marjorie Jordan, RN – Staff Nurse
Janet Kimbrough, RN – Staff Nurse*
Deirdre Lamusta, RN – Staff Nurse
Judith Lynch, RN – Staff Nurse
Julie McCarthy, RN – Staff Nurse

*Advanced Clinician
MINUTES: PACU PRACTICE COMMITTEE  February and March 2007  (7:15 am – 9 am)

Members: Deidre, Diane H., Jane K., Joyce, Julie M., Laura, Margie, Nancy, Paula, Scott, Susan B.

DISCUSSION:

February meeting:
1. The ASPAN standards for temperature measurement, pain and nausea were reviewed. A place must be added to the PACU sheet for these items.
   a. Temperature:
      - Should be checked on adm, q30 min until normal thermia
      - Temp 96.8 to leave PACU
      - Bear hugger for 96
      - Q2H on normathermia =96.8
      - Thermal comfort must be assessed with the temperature – y/n (yes – comfortable, n- not comfortable)
   b. Pain:
      - Assess adm, disch. And q30min
      - Goal 4 and under unless document reason for exception
      - Document PCA teaching in the nurses note
   c. Nausea:
      - Assess adm., disch., and q30min
      - Note intra-op anti-emetics, if none and pt has risk factors, confer with PACU anesthesiologist regarding administration of preventative anti-emetic
      - Write nurses note if medication given with response
      - Document y/n
2. Other:
   a. If taking PO fluids, document amt
   b. Blood loss over 500cc, document blood bank sample and any set up

March meeting:
   The new ASPAN standards book was reviewed. There have been some substantive changes to the overall standard of care. Much discussion ensued. It was decided that before we develop templates for special procedures we should bring the basic standard of care up to date with the current ASPAN standards. Joyce organized current ASPAN information in notebooks for each member. What should be in your notebook: Standards, Clinical Practice Guidelines, Resources, and Position Statements. Each member should have received a notebook with the inserts and should have the current MGH PACU standards (from Karen). In addition, standards are overall mission statements – Scott will write them. We will write clinical practice guidelines. Please let me know if you are missing anything. (Joyce 508-380-1876)

TO DO:
1. Hold on template development.
2. Review the current MGH PACU Standards.
3. Review the new ASPAN information.
4. Reconcile the #2 & #3. Some have suggested that we write by section – pre-adm requirements, admission, PACU stay, and discharge guidelines – but do it the way you think that it should be.
5. Send your document to me by April 2nd.

NEXT MEETING, APRIL 5TH, 7:15, BURR 2
Bringing specialized wound-care education to all patient care units

—by Virginia Capasso, RN, clinical nurse specialist

For the past 17 months, the Clinical Nurse Specialist (CNS) Wound Care Task Force has worked to educate and empower unit-based clinical nurse specialists and staff nurses to deliver contemporary, evidence-based wound care throughout the hospital 24 hours a day, seven days a week. Some early outcomes of the task force include a section for wound assessment on the new general care patient flow sheet and development of a comprehensive wound care education program.

The field for wound assessment on the general care patient flow sheet consists of 13 parameters to assess a wide variety of wounds. Parameters are derived from the 17-item Pressure Sore Status Tool (PSSST), which was developed and tested by Dr. Barbara Bates-Jensen of the University of Southern California, School of Nursing. Parameters include location, shape, size (length, width, depth), type, characteristics of the skin along the margin of the wound, as well as other characteristics. A systematic approach to wound assessment allows detection of dramatic or gradual progress toward healing or deterioration in a wound bed.

Phase I of the Wound Care Education Program will be launched this month and consists of programmed instruction related to wound cleansing, assessment, and documentation. Phase I is earmarked for newly-hired nurses, but will be completed by all current nursing staff.

Phase II of the Wound Care Education Program will be a two-day comprehensive nursing continuing education program. Morning sessions will feature didactic presentations by CNS experts on topics pertinent to general wound care and care of high-risk and high-frequency wounds, such as pressure ulcers, vascular ulcers, atypical wounds, burns, and radiation injuries. Afternoon sessions will focus on description of wounds, selecting appropriate treatments for wounds, and applying specialty dressings, such as multi-layer compression dressings and vacuum-assisted closure (VAC) dressings.

Above, Jill Pecco, RN, clinical nurse specialist, demonstrates application of the VAC dressing. Below left, participant applies “Lima’s boot.” At right, participants practice application of VAC dressing.
Attachment 9.3.c continued

The program was tested by 60 enthusiastic clinical nurse specialists and nurse practitioners in November 2001. The inaugural program for nursing staff was offered on January 11 and 18, 2006. Response has been overwhelmingly positive. Nurses seek educational offerings that provide an introductory level of specialty knowledge and skills so they can troubleshoot wound and skin-care issues on their units.

Phase II will be offered four more times in 2006:
- Wednesday, March 1, and Wednesday, March 8
- Wednesday, June 7, and Wednesday, June 14
- Friday, September 8, and Wednesday, September 13
- Wednesday, November 1, and Wednesday, November 8

Registration is limited to 50 people per session. To register, call the Knight Center for Clinical & Professional Development (76-3111).

For more information about the Wound Care Education Program, contact Virginia Capasso, APRN, co-chair of the CNS Wound Care Task Force.

CNS Wound Care Task Force
2004-2005
- Virginia Capasso, APRN, co-chair
- Joanne Impoldi, APRN, co-chair
- Ann Martin, ARNI, co-chair
- Theresa Cantarino Evans, ARNP
- Jacqueline Collins, RN
- Erin Cox, ARNP
- Victor Dussault, RN
- Joan Gallagher, ARNP
- Susan Garaghan, RN
- Catherine Giffith, ARNP
- Deborah E. Hagen, RN
- Marion Jeffries, ARNP
- Susan Kilroy, RN
- Cynthia Lasala, RN
- Madeleine O'Hagan, RN
- Jill Pedo, RN
- Marion Phripp, RN
- Susan Rengraves, RN

Practice makes perfect!

Above: Clinical nurse specialists, Joanne Impoldi, RN (left) and Virginia Capasso, RN, during the didactic portion of the Wound Care Education Program. Below: Participants display their newfound skills after practicing dressing-application techniques.
TITLE: LASER SAFETY POLICY

LEVEL OF PERSONNEL: RN, ST, Laser Safety Officer (LSO) and Video/laser Tech

DESIGNATED CLINICAL AREAS: MOR, SDSU

APPLICABLE POLICY STATEMENTS:

1. The laser will be operated and the environment managed in a manner to provide maximum safety to patients and all personnel.
2. The nursing staff member responsible for operating the laser must have successfully completed the MGH credentialing process. (See policy: Credentialing of Nursing Staff Operating Lasers).
3. The nurse operator may be replaced by another person associated with and under the direct supervision of the credentialed staff physician using the laser for treatment. In this case, the circulating nurse is responsible for the safety of the environment in which the laser is used.
4. All staff physicians utilizing lasers must be credentialed for the specific wavelength being used.
   • The exception is that non-credentialed staff physicians and surgical residents may use a laser under direct supervision of a surgeon credentialed for that specific laser.
   • A list of medical staff and the wavelength they have been approved for is available on each laser, in the policy book at each OR control desk, and online at http://phsweb47.mgh.harvard.edu/dop/ then click on “laser privileges” bar. Credentials are granted and the list maintained by a physician in the Office of Gastroenterology (currently Dr. Norm Nishioka).
   • It is the responsibility of the circulating nurse to verify the laser user’s credentials if they are in question.
5. Safety practices specific to each laser as outlined on the laser protocol sheet will be adhered to for each procedure in which the laser is used. A sample of each protocol sheet is attached.
6. All OR nursing staff working in services that use the laser will complete a laser safety component as part of their annual competency reviews.
EQUIPMENT: laser, laser key, laser warning signs, laser safety glasses, fire extinguisher, smoke evacuator, high filtration masks, water or saline, laser protocol sheet.

NURSING ACTIONS:

GENERAL SAFETY

1. Protocols specific to the laser used will be reviewed and followed for each laser case.
2. All lasers should be tested prior to the procedure.
3. Access to the room in which a laser is being used should be limited to necessary personnel.
4. Laser keys will be stored in a locked box when the laser is not in use.
5. Appropriate warning signs with the type and wavelength of the laser being used will be posted at the entrances to the operating room.
6. Eyewear specific to the laser and wavelength in use will be available at the doors to the operating room in which a laser is in use.
7. All lasers must have a "stand by" mode and remain in that mode when powered up but not actively in use. Newer lasers also have a "kill switch" that can be activated in the event of a problem occurring.
8. The laser-credentialed physician is responsible for prescribing the setting and lens sizes used with the laser.
9. The person controlling the laser delivery device should always control the laser pedal.
10. Tips of laser fibers should be covered with moistened sponge or towel when not in use.
11. The circulating nurse will document all required information in the Perioperative Nursing record.

SPECIAL CONSIDERATIONS:

- It is recommended that the laser pedal be the only one available at the field when a laser is in use.

This documentation should include the type of laser with its identification number, the wavelength, setting, type of tissue, and safety measures taken.
12. The laser operator will complete the laser log sheet for all cases in which the laser is set up, even if it was not used.

13. Surgical masks capable of filtering 0.1 micron particles will be available outside the OR where a laser is being used.

**EYE SAFETY:**

1. Employees will have a baseline eye exam prior to any potential exposure to laser radiation.

2. All windows in a laser room should be covered with opaque material placed from the inside of the room.

3. All personnel in the room will obtain and use appropriate eye protection. It is each individual’s responsibility to check that the eyewear covers the laser wavelength being used, prior to the laser being fired.

4. Patient’s eyes will be taped closed or protected with moistened eye pads or wear wavelength specific eyewear. Metal eye protectors should be used if the laser is being fired in the immediate proximity to the eyes. If lubricant is used, it should be a non-petroleum based substance.

5. The laser user need not wear safety glasses if the laser is coupled to a microscope and the uses is looking though an eyepiece or when an eye safety filter is coupled to an endoscope.

- Clear glass doors and frosted doors are not laser safe and need to be covered with an opaque material placed from the inside of the room.

- Examine eyewear for cracks or scratches. Glasses must be clearly marked for the wavelength being used and ocular density.

- Because of the possibility of a fiber breaking, it is recommended that everyone in the room wear safety glasses.
FIRE SAFETY:

1. An adequate amount of saline or water should be available at the operative field to extinguish a fire.
2. The laser operator should have immediate access to a fire extinguisher and be familiar with its operation.
3. The surgical field should be covered with wet towels. Flammable items such as gauze sponges should be moistened to avoid accidental burns or ignition of the surgical drapes.
4. The anesthesiologist is responsible for choosing an appropriate endotracheal tube to protect the airway if the laser surgery is to take place near the tube.
5. Flammable anesthetic gases should not be used when the laser is in use.
6. During perineal cases methane gas may be expelled and possibly ignite. Lubricated packing should be placed in the rectum prior to laser use.
7. Betadine, Hibiclens, Lugo’s and Shiller’s stain, acetic acid and toluene blue absorb infrared radiation. They will be vaporized by a laser beam causing a burn if not allowed to dry fully.
8. Prep solutions containing alcohol are flammable and should be allowed to dry fully before the laser is activated.

ELECTRICAL and CHEMICAL SAFETY

1. Check cords and plugs for fraying, cracks or breaks. If any found, have them repaired prior to using the laser.
2. Keep the environment in which the laser is being used dry.
3. Check biomed sticker on laser for

- Packing may be gauze or tampon lubricated with a non-petroleum substance. Flag the string of the tampon with a hemostat.
routine maintenance every six months.

4. Some lasers have toxic fluids as an active medium. If an unusual appearing or smelling fluid is discovered near the machine, notify the laser safety officer or the biomed department.

Do not use the laser until it is checked.

PLUME MANAGEMENT

1. A high flow smoke evacuator should be used during plume producing procedures.

2. Use disposable filters for the evacuator that are capable of trapping particles of 0.1 micron size.

3. Change smoke evacuator filters according to manufacture’s recommendations or sooner if an odor is detected. Use standard precautions when changing the filter.

4. Change smoke evacuator tubing after each procedure.

5. Operate the smoke evacuator at the highest setting for optimal smoke evacuation.

6. Keep the smoke evacuator suction inlet an effective distance from the site of smoke generation.

7. Utilize protective surgical masks capable of filtering 0.1 micron particles during plume generating procedures.

8. Do not use wall suction unless it is equipped with plume filtering devices capable of preventing clogging of the vacuum system.

- Usually within 2 centimeters
- Even when a smoke evacuator is being used
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