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## Implementation of a Safe Patient Handling Program

### ***What is a Safe Patient Handling Program?***

It is the utilization of patient handling devices used to lift/transfer and reposition patients to prevent musculoskeletal injuries to the front-line healthcare provider.

### ***With a safe patient handling program, what types of patient handling devices are used?***

Liko, Inc. is the manufacturer of the mechanical lifts purchased by WFUBMC. These devices will lift/transfer and reposition patients who are totally dependent, as well as those patients who need assistance from a seated to a standing position. Slide boards, slide sheets, and air mats will be utilized for lateral transfers.

### ***What training will caregivers receive on the Safe Patient Handling Program?***

All caregivers providing care to our patients will be provided an overview of the program with the internet training module and then will complete a hands-on skills training/return demonstration session to validate their competency. The internet training module is available under the "Training and Education" section on the infiNet, and hands-on skills training will be conducted from August 14-24.

### ***Who will be providing the training for the Safe Patient Handling Program?***

Professional nurses employed by Prevent, Inc., a company that has implemented their program "Get a Lift!®" in 600+ healthcare facilities in the US.

### ***Did we trial this equipment?***

Yes. Various patient handling devices were piloted on 6R-IMC, 8N, 4AE, and 4C-ICU.

### ***Comments from staff on pilot units:***

"I love the lift program; it saved my back! Lifts actually make patients feel better because they think the equipment is made for them. Patients trust the lift more than the people lifting them."

*April Neal, CNAII, 8N*

"The lifts are very safe and easy to maneuver. Patients want to take them home."

*Tammy Armstrong, CNAII, 4AE*

"I like the lift program because it reduces nurses' risk of injury. I'd rather use the lift than hurt my back, and it doesn't take long to get the lift."

*Rachel Barnard, RN, BSN, 4AE*

"It [Safe Patient Handling Program] does not take any more time. It's what we need to do to save our backs."

*Meji Crawford, RN, BSN, CMSRN, 8N*

# Painting Teeth at Downtown Health Plaza

*Donna Bell, RN, CPN, Pediatric Clinic, DHP*



The pediatric nurses at Downtown Health Plaza do many things with their smallest patients, but their newest activity is painting teeth, better known as dental fluoride varnishing. Fluoride varnish is a temporary protective coating that helps prevent new cavities and helps stop cavities that have already started.

The program is called “Into the Mouths of Babes” and is part of the North Carolina Division of Public Health.

The first fluoride varnish is applied when the first primary teeth erupt, usually about six months of age. To receive maximum benefits, fluoride varnish needs to be applied four to six times. This number of applications has been shown to result in approximately 40% fewer dental treatment needs. Presently, pediatric Medicaid patients can receive fluoride varnishing every 60 days until they are 3 ½ years old.

Each child receives an oral screening by the pediatric resident, and the parent receives both written and verbal education in either English or Spanish. The fluoride varnish can then be applied to the teeth with a small paint brush. The varnish dries quickly, leaving a dull finish. This is brushed away the next day, leaving the fluoride protection.

In Europe, where fluoride varnishing has been in use for over twenty five years, it has been shown to reduce cavities by twenty five to forty percent.

Tooth decay is the most common chronic disease in children that does not “heal” itself, and antibiotics offer no protection against dental caries. In North Carolina, an estimated forty percent of children will have tooth decay when they enter kindergarten. Most of these are special needs children or are from low income families.

The fluoride varnish program started at Downtown Health Plaza on 1/31/2007, and 407 treatments have been provided so far. The children are greatly benefiting from this service, and Downtown Health Plaza has received about \$22,000 from Medicaid in return for these procedures.

It’s a win-win program for all.

# Coping with Care Giving

*A. Patricia Johnson, RN, MA.Ed., MA  
Chief Nursing Officer  
Vice President, Operations*



As I reflect on all the changes that have occurred through the years within nursing practice, the most important in my mind is the return to the emphasis on the ‘caring’ aspect of this profession. Nurse leaders have identified that the “core of the work of nursing in the future is knowledge and caring” and that “our knowledge and care provided are grounded in the relationship with our patients/clients/populations”. However, in years past, we often encouraged nurses to keep an emotional distance from their patients. “Don’t get too involved” was used to ‘protect’ nurses from burnout. It is a mistake to think that caring is the cause of burnout. While we do need to keep a healthy work life balance, we also need to ensure that our patients receive care and compassion from our highly competent nurses.

Jean Watson, a nursing theorist, has developed a nursing theory based on ‘Caring’. As we educate new nurses and orient those coming to work at our hospital, we are encouraging the nurses to incorporate ‘caring’ practices into our work. With the depth of knowledge and technical expertise required, it is no wonder that new nurses have truly focused on becoming clinical experts. The lack of attention to the caring component is not intentional but does require additional support and mentoring.

The Nursing Department has embarked on changing how we provide care at the bedside by utilizing Koloroutis’ Relationship Based Care as our model. In this professional practice model, Koloroutis states that developing a relationship with the patient and the family is a key concept. Hence this model is also referred to the “Patient Centered Model”. Koloroutis also states that additionally we must also care for ourselves and our team. One example of caring for ourselves is taking a much needed rest break with a team member providing patient coverage. We are not in this alone!

Nursing stands out in the literature as a highly stressful profession. Coping with professional care giving is certainly influenced by the complexity of healthcare today. The increasing responsibilities for nurses can at times be overwhelming. If nurses are to embrace these caring practices, the work environment may need to be redesigned to support these changes. To accomplish this, the hospital is utilizing the care delivery system from all avenues. It is our goal to provide a work environment that will allow our nurses to practice this new patient centered model of care. I am very excited about this new model of care and invite all of you to learn more about it and above all....take care of yourselves.

A handwritten signature in black ink that reads "A. Patricia Johnson". The signature is written in a cursive, flowing style.

# Do You Have Cultural or Religious Preferences?

Anne Stapleton, RN, BSN  
Patient Education Coordinator

To develop a plan of care that meets the individualized needs of patients and their families, you, the healthcare provider, must conduct an assessment. The assessment should include not only medical history, symptoms, and physical findings, but should also include information about the patient's health beliefs, behaviors, religious preferences, support systems, cultural factors, etc. This article will identify some questions you can ask to elicit cultural beliefs, values, and customs that may impact your patient's health practices, as well as identify factors that may help or interfere with your plan of care. The questions will guide you to answer, "Do you have cultural or religious preferences?"

## **Overview**

Culture is a set of beliefs, traditions, and behaviors that are learned and shared by members of a group. All people of the same group, such as nurses or members in a family, do not behave or believe the same. Culture makes each of us unique. For this reason, we must determine the patient and family's cultural and religious preferences to individualize the plan for the patient's health care.

## **Beginning the Assessment**

During an assessment interview, use a conversational style and open-ended questions. As with all subjective data, it is best to document the patient's own words as much as possible. A few examples of questions you can ask are listed below. Choose the ones that are appropriate for your desired outcomes. These questions can be spread over time and asked as you gain more rapport with your patient.

If you use an interpreter, look at the patient, not the interpreter, as you ask the questions and get the responses. While it is important to show interest and warmth during the interview, being too friendly may be considered intrusive. Showing respect is central to building a relationship and rapport. One way you can show respect and concern is to ask the patient what name he/she wishes to be used during your communications. Follow the patient's lead regarding eye contact; making eye contact is a form of disrespect with authority figures in some cultures. Limit the use of gestures such as the OK sign, thumbs up, etc., as these have different meanings to various groups. Handshakes, patting heads, etc. may not be acceptable in some cultures.

## **Assessment Questions**

You might start your assessment interview with a statement such as: "I am interested in learning more about you. May I ask you a few questions?" Then proceed with your questions.

What name do you want us to call you?  
Will you be comfortable if we touch you during tests, exams?  
What types of things do you and your family do to stay healthy?

(Continued on Page 5)

## Do You Have Cultural...,cont.

What types of remedies, medicines, herbs, or foods do you use to treat illnesses?  
Tell me about your experiences with health workers, such as doctors or nurses, and when you believe you should contact them.  
What does being sick or ill mean to you?  
What do you fear about your sickness?  
Do you have folk healers in your culture? If so, how do you use them?  
Does your faith, religion, customs have views or practices regarding healthcare we need to know about?  
Who makes the important [healthcare] decisions for family? Who else is involved in making decisions?  
What do you think caused your problem?  
Why do you think it started when it did?  
What kind of treatment do you think you should receive?  
What results do you hope to receive?  
What is important in life to you?  
Who in the family/community gives you health advice?  
What does your condition/illness mean to you?  
What have you done for this condition?  
Explain about the types of food you eat, how it is prepared, who cooks it, at what times, and with whom you eat your meals. Does your diet change during certain times (menstruation, pregnancy, religious holidays)?  
How do you keep track of taking medicines? Keeping appointments?  
What transportation will you use to go to medical appointments? Get your prescriptions?

### **Individualizing the Plan of Care**

Incorporate the responses you receive during your assessment into your plan of care.

If family or extended family is involved in making decisions, put in the plan of care to include them in discussions. If possible, time the conferences and educational sessions when members can be in attendance. You may need to be flexible with visiting hours. Early involvement of key people in the patient's life can improve outcomes.

Compromise when you can; respect that the patient may use alternative therapies. If the alternatives are not contraindicated for their health, try to incorporate the faith healer, the folk remedies, prayer groups, other alternative therapies into the plan of care.

Identify expectations or misconceptions the patient has for the disease process – describe how you plan to clarify misconceptions.

Base the plan of care and interventions on the patient's preferences and values.

Be creative and find ways to adapt the plan if you identify social and environmental factors that may interfere with compliance. You may encounter responses such as the family's needs coming before the patient's needs, no transportation for follow-up appointments, or being overweight perceived as a sign of affluence or beauty.

*(Continued on Page 6)*

# Do You Have Cultural...,cont.

## **Conclusion**

Obtaining a good cultural assessment will help you learn more about the patient and establish rapport and trust. Then your plan of care and interventions can be directed at the patient's unique needs.

Your patient will appreciate your interest in his/her culture and will benefit from your efforts to incorporate that knowledge into his plan of care. Be open to learning about various cultural customs and then you, too, will be enriched with your new knowledge.

## **References**

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University of Massachusetts Medical School Office of Community Programs. (2004). *Physician Toolkit: Curriculum Resources to Implement Cross-Cultural Clinical Practice Guidelines for Medicaid Practitioners*. Sections IV, V, VI. Retrieved June 13, 2007 from [www.omhrc.gov/assets/pdf/checked/toolkit.pdf](http://www.omhrc.gov/assets/pdf/checked/toolkit.pdf)



*Do not be too moral. You may cheat yourself out of much life. Aim above morality. Be not simply good; be good for something.*

~ Henry David Thoreau, Author (1817-1862) ~

# Nurses in the Journeys Program Plan on Leaving Legacies

*Phyllis Knight-Brown, RN, MSN  
Nursing Staff Development*

On April 17, 2007, the Journeys Program session focused on patient outcomes, principles of leadership, and career path development. Maureen Sintich, Senior Nursing Operations Director, spoke with the nurse resident about career goals, plans for meeting the career goals, and portfolio development. Maureen talked about leaving a legacy in nursing and shared how a close family member left a legacy in nursing for her. The nurse residents were asked to share in writing the legacy they would like to leave. Below is a sampling of the legacies our future nurse leaders plan to leave:

I will leave a legacy by:

- \* Always keeping a positive attitude and having a smile on my face.
- \* Influencing individuals' lives to increase their knowledge and enrich their lives.
- \* Developing programs to help kids with special needs live happy, healthy lives and reach the goals they want to achieve.
- \* Leaving money for scholarship to nursing students.
- \* Becoming a pediatric nurse practitioner and providing the best possible care for my patients.
- \* Demonstrating patience and a positive attitude even with the most difficult patients.
- \* Doing my best at work and going above and beyond the "normal" call of duty in every aspect of my job. I will always seek to learn new things and help others achieve their very best.
- \* Being the founder of the S.U.P.E.R Wellness Center which will educate the community on healthcare issues and physically, mentally, and spiritually help the community get in shape.



# Clinical Teaching Associate Program: A Great Partnership Continues

*Phyllis Knight-Brown, RN, MSN  
Nursing Staff Development*

The current nursing shortage, a well known fact, is predicted to extend into the next decade. Not surprisingly, this shortage also transfers into nursing faculty shortages, as schools of nursing attempt to meet increasing demands with a shrinking workforce. Local schools of nursing report similar trends and point to their current waiting lists of applicants vying for limited spaces.

Addressing this problem locally, North Carolina Baptist Hospital's (NCBH) Department of Nursing partnered with Northwest Area Health Education Centers (NWAHEC), Forsyth Medical Center (FMC), Winston-Salem State University (WSSU), and Forsyth Technical Community College (FTCC) to implement the new role of Clinical Teaching Associates (CTAs). CTAs are selected baccalaureate-prepared nurses who have completed 48 hours of classroom and clinical training, preparing them to serve as clinical nursing instructors for WSSU and FTCC. Since 2003, a total of 36 NCBH nurses from various locations in our hospital have participated.

The CTA program allows nurses interested in teaching an opportunity to serve in the clinical instructor role without giving up full-time benefits or salary. The program has increased the number of student clinical rotations supervised by our nurses (CTAs) within our facility. In doing so, the number of students exposed to our staff and practice environments has provided greater opportunities for nursing recruitment. Furthermore, local schools of nursing have benefited through improved enrollment numbers and decreases in student attrition.

These NCBH nurses were the most recent participants of the April CTA preparation course: Marcella Cherry (8RT), David Fair (IMC), Melinda Foster (11RT), & Jeffrey Gray Haynes (11RT). We thank these nurses and all the others who have served previously as CTAs. Their time and commitment are making contributions to NCBH efforts in recruiting and retaining nurses.

If you would like more information about this class, please contact Phyllis Knight-Brown (6-4412) or Stacy Thomson (6-9164) in Nursing Staff Education.



*The great aim of education is not knowledge but action.*

~ Herbert Spencer, English philosopher (1820-1903) ~

# Relationship Based Care: Through the Eyes of a Staff Nurse

*Carol Tilley, RN, 8 Reynolds*

Through the years at NCBH, nursing has drastically changed - from one staff nurse having 12 to 14 patients with one nursing assistant for the entire floor TO one staff nurse and one nursing assistant sharing the responsibilities for 4 to 5 patients during times when fully staffed. The majority of us feel that this is absolutely wonderful!

As with any job, nurses and nursing assistants experience illness and emergencies, requiring them to call in sick to work. This potentially adds to the workload of the staff nurses and nursing assistants, increasing responsibilities to 5 to 6 patients. But, we are still not complaining!

When a patient is admitted to our floor (8 Reynolds), he/she becomes the center of attention. The assigned RN and NA immediately get the patient and family involved in care - from immediate concerns related to patient care to assisting the patient to take medications on time - whatever works best for the patient.

Nursing staff, along with the patient and family, set daily goals. Because patients and families are involved in their own care, it places them in control of their situation, assuring the patient that he/she is the main focus. It also provides the patient with the encouragement to work toward getting better soon. This initiative has resulted in decreased patient days.

While most patients encourage support and involvement from their family members, there are a few who either do not have family or choose not to have family involvement. Of course, we respect this decision.

Hourly rounds are completed on all patients by either the RN or the NA (or sometimes both). Patients are given the opportunity to complete the "Three Ps" - pain, position, and potty. They are also offered snacks twice a day, between 1400 and 1500, and then again between 2000 and 2100. At the change of each shift, nurses give report at each patient's bedside. This allows the patient time to express concerns. Both of these initiatives have decreased the use of call bells.

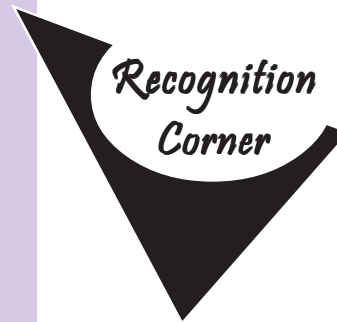
The nursing assistants have expressed how much they like Relationship Based Care because it allows them to utilize skills, such as placing urinary catheters and wound care. In return, this has encouraged some of the nursing assistants to attend nursing school.

This model gives me time to really get to know my patients and families, and I feel that patient care is no longer like an assembly line. After giving bedside report, it feels great to not be absolutely exhausted from work and also to know that staff, patients, and families are well taken care of.

The Relationship Based Care Model involves everyone - managers, caseworkers, doctors, secretaries, and all of the nursing staff. I feel very fortunate to work with such a great team because we have developed such a special relationship.

**EDITOR'S NOTE:** 8 Reynolds' patient satisfaction scores last quarter were 100%.

**Congratulations!**



### **Publications**

Schreier, T. (2007). Casting stones. *Nursing Spectrum: Southeastern Edition*, May/June, 30.

Ross, A. and Crumpler, J. (2007). The impact of an evidence-based practice education program on the role of oral care in the prevention of ventilator-associated pneumonia. *Intensive and Critical Care Nursing*, 23(3), 132-136.

Chilson, T.B., Fowler, J., Craven, D.P., and Smith, J. (2007). Peristomal rehabilitation utilizing NPWT [Abstract]. *Journal of Wound, Ostomy and Continence Nursing*, 34(3S), S7.

### **Posters/Presentations**

Amelia Ross, RN, MSN, CNS, Pulmonary, and Amanda Goad, RN, Mobility Team, presented a poster "Mobility Protocol Reduces Hospital Length of Stay Independent of Baseline Body Mass Index" at AACN's National Teaching Institute in Atlanta, GA.

Kim Benson, RN, Clinical Informatics, in conjunction with Carol Curran, RN, GE Healthcare, has been awarded a full scholarship to present "Effect of Bar Code Medication Administration" at the 2007 Summer Institute of Nursing Informatics Conference in Baltimore, MD.

An abstract "Implementation of Relationship Based Care in a Complex Healthcare Setting" by Deborah Krueger, RN, MSN, CNRN, UM, 5AE, has been accepted for a podium presentation at the 11th Annual Magnet Conference in Atlanta, GA, in October, 2007.

Beth Hubbartt, RN, MSN, CRRN, presented a poster "Conducting Focus Groups for Practice Decisions" at three nursing education forums - University of North Carolina - Greensboro, Winston-Salem State University, and Rehab Nursing at Carolina Beach.

### **Special Issues**

Candace Bowman, RN, AUM, 4A-ICU, was quoted in the May 7 *Advance for Nurses* magazine's editorial related to her nomination for Best Nursing Team. The quote said, "In November 2005, we lost 60 percent of our staff and census became full, and the unit pulled together and worked overtime and long hours."

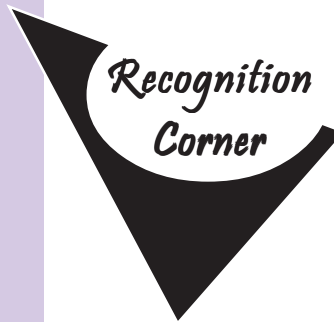
Carol Watters, EdD, APRN, BC, CNS, Orthopaedics, was chosen to receive the Nan Hilt Writers Award from the 2006 Editorial Board of Orthopaedic Nursing.

Megan Montgomery, RN, BSN, 4B-ICU, was featured in "On a mission: Nurse received higher calling to minister in Honduras" in the Spring 2007 *Nursing in NC: Western Edition*.

Deborah Krueger, RN, MSN, CNRN, UM, 5AE, received her MSN with a specialization in leadership/management from Walden University.

Misty Barrier, RN, MSN, completed the MSN-Nurse Practitioner program at University of North Carolina - Charlotte.

Rachel Mabe, RN, BMT, completed the Oncology Certified Nurse exam from the Oncology Nursing Certification Corporation.



**Special Issues, cont.**

Willa M. Abbott, RN, MSN, Director, Surgical Services Academy, has been appointed to the Vytex Technical Advisory Board at Vytex Corporation. She will consult on product development and marketing of a new natural rubber latex with low antigenic protein levels. Her appointment was listed in the May 7 *Advance for Nurses* magazine.

**Certified Pediatric Nurse**

Carrie Terwilliger  
Dawn Banks  
Donna Bell  
Gail Justus  
Gina Idol  
Heather Freeman  
Katherine Kruppenbach  
Mary Rutledge  
Stacy Snow

**Geriatric Resource Nurse**

Sarah Dralle  
Monica Frazier  
Cheryl Greene  
Carol Hill  
Cathy Hill  
Marie Horton  
Kimberly Hughart  
Debbie Joyner  
Erin Judge  
Mary McCall  
Christine Roach  
Leslie Shoaf  
Kendra Smith  
Zeb Templeton  
Denise Westendorf  
Patty Williams



**BCLS-I**

Janice Petroff  
Andrea Mikolaitis

**ACLS-I**

Dana Nichols

**PALS-I**

Crystal Rouse



**TNCC**

Dorinda Anderson  
Melissa Brawley  
Emily Draughn  
Shawn Foy  
John Hayes  
Pam Hinson  
Melinda Jenkins  
Cara Martin  
Lona McKnight  
Patricia Millner  
Tony Raymond

*Recognition  
Corner*

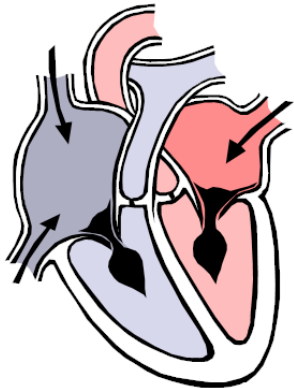
P = Provider  
R = Refresher  
I = Instructor

**ACLS-R**

Christy Loveall  
Amy Graham  
Tusha Eaton  
Mechelle Mumford  
Leslie Wagner  
Cynthia Brown  
Lawanda Page  
Sandy Rickard  
Kathy Wells-Kiser  
Shirley Richardson  
Wendy Butcher  
Cindy Willard  
Christine Hastings  
Miranda Edwards  
Jewel Reaves  
Sharon Young  
Michelle Limbacher  
Elizabeth Todd  
Gary Webster  
David Fair  
Ruth Bauserman  
Patty Murray  
Beth Willis  
Lisa Smith  
John Mikolaitis  
Cynthia Wall  
Drema Britt  
Julie Gilbert-Kasper  
Sheila Foster  
Deborah Budensiek  
Stacy Rountree  
Dawn Hayes  
Patricia Brenner  
Laura Weaver

**PALS-P**

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Shannon Blanton  
Elizabeth Goodman  
Laura Weaver  
Naomi Addison  
Kelly Yarnell  
Linda Ross  
Maria Vicario  
Jewel Reaves  
Amber Berger  
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Kristen Sanders  
Teresa Brady  
Candice Everidge  
Beverly Branch  
Traci Huff  
Donna Hopkins  
Karen Spillman  
Deborah Budensiek  
Sheila Foster  
Samantha Ziglar  
Karla Koehler



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Janice Petroff  
Stacey Baker  
Janice Woodruff  
Heidi McGuire  
Nakishia Coleman  
Rolanda Cathcart  
Deborah Brown

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Dawn Hayes  
April Roberson  
Lauren Leppert  
Lisa Wilkins  
Alaina Cruise  
Donna Shelor  
Charlene Kramer  
Sherri Capizzani  
Wendy Chaplin  
Mary Adkins  
Patti Haste  
Timothy Overby