



Strategies

FOR NURSE MANAGERS

Evidence-based practice

Debating the evidence: A hospital sparks an argument to get nurses engaged



Continuing Education | Learning Objectives

After reading this article, you will be able to:

- ▶ Describe how Montgomery Regional Hospital (MRH) educated and inspired nurses about evidence-based practice
- ▶ Discuss the format used by MRH to hold a debate
- ▶ Identify the topics debated by MRH

by Lisa Wade, RNC, BSN, CTL

When nurses hear the word “research,” they often run in the opposite direction. Even the definition of evidence-based practice (EBP) can be intimidating for bedside nurses: “A practice that involves making clinical decisions on the best available evidence, with an

emphasis on evidence from disciplined research” (Polit and Beck, 2008).

Nurses have a duty to be current in their practice to ensure best patient outcomes. In addition, one of the central focuses of the ANCC Magnet Recognition Program® (MRP) is that facilities follow evidence-based nursing practice.

Therefore, any hospital on the journey to MRP designation must ensure that its culture is focused on EBP and that nurses are engaged and excited. It was with this aim that Montgomery Regional Hospital (MRH) in Blacksburg, VA, tried an innovative debate format to educate and inspire its nurses.

I began to think of other fun ways to approach evidence-based practice education. I had recently watched the movie *The Great Debaters* and began to ponder the idea of debating the evidence.

Sowing the seeds of an idea

I attended the ANCC’s annual MRP conference in October 2008 in Salt Lake City and had the privilege of sitting in on many great informative sessions. I was particularly impressed with the session about how to engage staff nurses in EBP, presented by nurses from The University of Alabama. The session described how the hospital used a court and trial format to discuss EBP issues, which seemed engaging and fun.

This inspired me to start thinking about ways my facility could engage staff nurses. Although the court format was appealing, it would require approximately 15 people for the court, including a judge, a foreman, two attorneys, nine jurors, and two to four witnesses. This was a problem because Montgomery Regional is a much smaller facility than The University of Alabama, thereby

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HCPPro

Debating the evidence

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limiting our personnel resources. I began to think of other fun ways to approach EBP education. I had recently watched the movie *The Great Debaters* and began to ponder the idea of debating the evidence.

I presented my idea to the research council, the professional practice council, and the nursing leadership council and received unanimous support to proceed with planning "MRH Nurses Debate the Evidence for Nurses Week 2009."

Stirring the pot

One of the first steps was to identify a debate style to be used by those arguing their case. I performed a literature search and identified several styles: team policy, Lincoln-Douglas, National Debate Tournament, Cross Examination Debate Association, and Parliamentary. After thoroughly reviewing each style, I presented a summation of the styles

to the three councils with a recommendation, which was accepted, that we use the team policy format because it is the oldest, and probably the most popular, of all debate formats.

In this format, two debaters speak in support of the topic, also known as the affirmative side, and two debaters speak against the topic, called the negative side. Each debater receives eight minutes to present his or her case. A speaker from the affirmative side presents first, followed by a speaker from the negative side, then the second affirmative speaker, and finally the last negative speaker.

Once everyone has presented, each debater gets another three- to four-minute slot for rebuttal, this time starting with a negative presenter, followed by an affirmative, and so on.

Three judges are required to hear the speeches and determine a winning side. In this format, only seven people are needed for a single debate session.


We decided to allot between one hour and one hour and a half for each session, which allowed for presentation time and a question-and-answer session with the audience. Because the time needed for presentation was much less than originally planned with the court format, we realized we could potentially present more topics.

Picking an argument

A call for hot topics was presented to each council, and the topics selected for debate were:

- Family presence during resuscitation
- Lidocaine administration prior to peripheral IV starts
- Preferential treatment for the aging workforce

The retention and recruitment council is responsible for the primary planning of Nurses Week activities, and a collaborative effort identified the best day to hold the debate. Once the day was chosen, we had to figure out what times during the day would enable the most people to attend. We considered change of shift, lunch, and afternoon lulls. We decided to start with family presence

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at 8 a.m., followed by lidocaine administration at 2 p.m. and the aging workforce at 5 p.m.

A hospitalwide e-mail was sent calling for volunteers to conduct the debate and announcing the topics of discussion. Debaters were asked to have interest in the topic and be willing to speak in front of a crowd but were not required to have any previous debate experience.

To reduce anxiety among those interested in debating, the research council performed literature searches on the chosen topics and provided volunteers with the resulting top three articles. Besides decreasing nerves, this ensured that each debater received the same literature for his or her selected topic. We also gave everyone the format and time expectations well in advance.

Since I was serving as the chair/moderator for the debates, I planned a group meeting the day before the scheduled debates to review the format and time limits, as well as to answer any questions in an effort to alleviate any lingering fears.

We created objectives for each session so the audience would have a guide to the expectations of the debates. A standard evaluation form was also presented so the audience could evaluate the sessions and provide suggestions for improvement. The first session was audiotaped for later transcription, and the remaining two sessions were videotaped for viewing by staff members who were unable to attend.

Let the debates begin

We recruited the same three judges for all sessions:

- ▶ **Loressa Cole, RN, BSN, MBA**, chief nursing officer
- ▶ **Ellen Linkenhoker, RN, BSN, MSN**, market MRP coordinator
- ▶ **Kimberly F. Carter, PhD, RN**, from Radford (VA) University, who serves as a research consultant at MRH

After listening to each debate, the judges felt each topic presented an opportunity for research at our facility.

Attendance was good and included areas of the hospital other than nursing. Each attendee was asked to complete an evaluation at the end of the session, in which

we received written confirmation that the debate format worked to educate nurses and get them interested in EBP. Written comments included:

- ▶ “Great job! This definitely provided food for thought.”
- ▶ “The presenters were very well versed in their subject of choice.”
- ▶ “When I came in, I was thinking one way, but when I left, my thoughts had changed totally based on the information presented.”
- ▶ “Do we have to wait a whole year before we do this again?”

Outline for next time

The first “MRH Nurses Debate the Evidence for Nurses Week” was a huge success. Plans have already begun for a 2010 debate week; we intend to make improvements to next year’s discussion based on what we learned through our experience this year.

One lesson learned is the need for a timer. In one session, one of the presenters went over the allotted eight minutes and spoke for 20 minutes. Another consideration would be to hold a presentation practice session prior to the formal presentation day.

Although the injection of humor into the presentations created a lighter environment, it would be useful to have an opportunity to provide debaters with training on the appropriateness of humor in this type of presentation.

For next year, we may consider the possibility of presenting the information on more than one day.

Even though we used hospitalwide e-mail and word of mouth for advertising, we recognized the need for more in-depth advertising to generate excitement. Tying the debates into literature searches also provides opportunities for education on EBP. ■

Reference

Polit, D., and Beck, C. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*, Eighth Edition. Philadelphia: Lippincott Williams and Wilkins.

Source

Adapted from **HCPPro’s Advisor** to the ANCC Magnet Recognition Program®, November 2009, HCPPro, Inc.

Staff development

Simulation learning modalities: Going beyond the basics



Continuing Education | Learning Objectives

After reading this article, you will be able to:

- ▶ Describe various simulation modalities
- ▶ Identify strengths and weaknesses of several simulation modalities

The phrase “simulation modalities” may conjure up a variety of images. For example, some think of a sophisticated training mannequin that produces computer-generated EKG printouts, responds to intubation efforts, and virtually behaves in ways similar to an actual patient. Others may think of an IV arm used solely for learning how to start IVs.

The point is, there is a wide range of simulation modalities and a vast potential for providing education via simulation.

One innovative educator has made simulation her area of expertise. **Mary Holtschneider, RN, BSN, BC, MPA, NREMT-P**, director of nursing practice and education at the North Carolina Nurses Association in Raleigh, is the National Nursing Staff Development Organization’s (NNSDO) liaison to the Society for Simulation in Healthcare’s Simulation Alliance Task Force. The task force members are working to develop scenarios, standards, and techniques for simulation use (NNSDO, 2008).

“There are so many people jumping on the simulation bandwagon that it’s becoming increasingly important

to identify the various types of simulation and attempt to establish standards for their use,” says Holtschneider. “This way, optimal education outcomes are promoted.”

Low-fidelity simulation modalities

Low-fidelity simulations are described as those that feel the least real to the learner (Holtschneider, 2009; Mt. Hood Community College, 2009). These simulations can be paper- or computer-based and are generally static models that allow for very little learner interaction within the simulation.

Examples include computer- or paper-based tasks, mannequins that do not have the capability for providing feedback (e.g., a Resusci Anne that only offers computer printouts evaluating the accuracy of breaths and compressions), or an IV arm that allows students to practice IV insertion techniques without feedback devices (Holtschneider, Mt. Hood Community College).

Low-fidelity simulation modalities are relatively easy to implement and transport and less expensive to implement than more sophisticated modalities. However, they are the least real of the modalities and, therefore, do not provide learners with the experience or the feeling of actually working in real-life settings.

High-fidelity simulation modalities

Also referred to as high-fidelity human patient simulators (HPS), “[high-fidelity simulation modalities are] often the first thing people think about when we say simulation,” says Holtschneider.

When using an HPS, educators can implement a variety of scenarios that they can tape and play back for debriefing or guided reflection, as well as create blended simulations, incorporating actors assuming the role of patients with low-fidelity task trainers.

HPS is usually dependent on some type of computerized mannequin that allows the re-creation of the physical patient in a realistic physical clinical environment

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(Stanford, 2009a). Examples of HPS include the following (Holtschneider; Stanford, 2009a):

- ▶ IV start training using computer interactive devices that allow the learner to see veins, arteries, muscle, nerves, and bones as underlying structures
- ▶ Mannequins that breathe and stop breathing spontaneously, allowing learners to evaluate the effectiveness of their intubation techniques or how well they are bagging a patient
- ▶ Actual or real-time displays of algorithms on EKG, oxygen saturation, and photo-realistic 3-D interactive graphics based on real patients

Mannequin-based simulators have become increasingly common in areas such as the operating room, ED, and critical care units, where life-threatening situations that require recognition and treatment often occur.

Some simulators can even mimic the effects of various drugs, track the distribution of the drug in the body, and determine the exact effects that a specific amount of the drug will have on the human body (Stanford, 2009a).

The costs associated with these types of simulation generally increase with the level of sophistication of the simulator. Complex simulators may also be more of a challenge to set up and transport than more simple simulation techniques. However, the level of realism introduced by high-fidelity simulation modalities truly brings the learner into an interactive, genuine work environment.

Standardized patient educators

A tactic that adds to the high-fidelity simulation modalities is the use of standardized patient educators (SP). SPs are educators who are specially trained to portray patients, family members, and, at times, even members of the hospital staff.

They are actors, but “really educators at heart,” says Holtschneider.

Using SPs lets learners engage in mock conversations with patients, deal with family members who are

frightened and questioning, and cope with colleagues who may not be acting professionally.

The Association for Standardized Patient Educators (ASPE) is an international organization for professionals in the field of SP methodology. Its goals are to (ASPE, 2009):

- ▶ Enhance the professional growth and development of its members
- ▶ Advance SP research and related scholarly activities
- ▶ Establish standards of practice
- ▶ Foster patient-centered care

SPs are used in a variety of academic settings, such as medical and nursing schools. In addition, their use is now becoming more common in clinical environments because they add another dimension of reality. However, they also add to the cost. Organizations hiring these educators must screen them carefully and hire only those persons qualified to assume such roles.

Serious gaming

The term “serious gaming” involves the use of video game technology to add another dimension to the learning process. Learners function within specific rules and guidelines while playing interactive computer-based games.

These games generally present a complex healthcare situation (e.g., multiple casualties from a terrorist attack arriving at an ED) that requires the learner to intervene appropriately.

Although the game format is viewed as a fun way to learn, the games offer deadly serious scenarios. Serious gaming is an increasingly popular training mechanism. There are even conferences on the use of this technology, such as the Games for Health Conference, which was held in Boston in June (Games for Health, 2009).

Video and computer games can be developed fairly quickly and can simulate functional entities in various clinical settings. However, they can be expensive to develop, and learners must have appropriate training in

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their use. In addition, they require the availability of adequate equipment for learners (Holtschneider).

Desktop simulations and virtual worlds

Desktop simulations and virtual worlds can be run on a desktop computer and only need a screen, mouse, and audio inputs and outputs. The learner can view data, see the patient via animation, perform diagnostic or treatment interventions, and interact with the patient by typing or, in some cases, actually speaking with the patient.

An advanced approach to this type of simulation allows several participants to participate in a virtual world simultaneously. Learners can interact with each other, the patient, and others in this world. A distinct advantage of this type of simulation is the ability to interact with various healthcare team members as well as the patient and family (Stanford, 2009b).

Virtual reality and visualization

Virtual reality is a computer-generated world that allows the learner or group of learners to experience various stimuli, often in a 3-D presentation (Holtschneider; Stanford, 2009c).

Learners typically wear head-mounted displays to receive visual and auditory cues. They can interact in the computer-generated world from various sites or be in

a physical space in which they can interact with others (Holtschneider).

Virtual reality is a rapidly developing field and is one of the few mediums to give learners the best approximation of a true sense of realism. However, the creation of a complex virtual patient and treatment setting that will provide the most thorough and detailed training experience can be time-consuming and expensive. It requires a complete computer model of the patient environment; a way to track visual, audio, and touch fields; adequate hardware for all sensory modalities; and hardware to compute all models, track inputs, and produce outputs in real time (Stanford, 2009c).

This overview of simulation modalities shows that the word "simulation" refers to several teaching methods, from the simple to the complex. These variations, as well as the differences in complexity, make it important to have standards and guidelines in place for their optimal use and best possible learner outcomes. ■

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Adapted from **The Staff Educator**, November 2009, HCPro, Inc.

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Infection control

Educating visitors about isolation precautions

Visitor education will help control transmission, especially during flu season



Continuing Education | Learning Objectives

After reading this article, you will be able to:

- ▶ Describe visitor policies that comply with infection control best practices
- ▶ Justify the importance of visitor education
- ▶ Indicate what personal protective equipment visitors should wear for patients with isolation precautions

With Joint Commission standards requiring patient and visitor education on healthcare-associated infections (HAI), coupled with the emergence of H1N1, hospital visitation policies have become a hot topic for infection prevention.

Although the CDC and OSHA offer guidelines for employees caring for patients under isolation precautions, neither agency gives concrete recommendations for visitors who will be in the same room as the patients. Depending on the nature of the interaction with the patient, employees will wear gloves, isolation gowns, surgical masks, or N95 respirators. However, because visitors are not typically providing care, isolation gowns and gloves are largely unnecessary, says **Terry Burger, BSN, RN, CIC, CNA, BC**, director of infection prevention and control at Lehigh Valley Hospital in Allentown, PA.

"If a visitor is going to go in the room and visit with a loved one and will not be touching everything, touching their wounds, or touching any open or draining secretions, from our perspective, it is not imperative that they sit there during their visit in isolation with [personal protective equipment (PPE)]," Burger says. Instead, educating visitors about isolation precautions allows them to fully understand their role in preventing infections.

Protecting other patients

Burger says because most visitors are healthy, she is far more concerned about transmitting infections to

other patients in the hospital who may have compromised immune systems. Rather than forcing everyone to wear PPE at Lehigh, it's more important to educate visitors on proper hand hygiene and restrict them from visiting other patients in the hospital.

"It's not like because they kiss them they now have MRSA," Burger says. "What we really instruct them to do is [practice] good hand hygiene. If they are going to be touching their loved one, then they have to make sure they are washing their hands before they go to the cafeteria or they go to the gift shop or anywhere else."

For patients who are on droplet precautions, such as influenza or meningitis, visitors are offered PPE. For tuberculosis patients, visitors are required to wear an N95 respirator. "In terms of contact, we're a little bit more lenient with that," Burger says. "By and large, most [visitors] have been around these [patients] day in and day out. What we are much more adamant about is that they not leave that patient and go to another patient room."

Communicating with the visitor

Many visitors who walk into a medical facility may not be aware of the precautions a friend or family member is under or understand why those precautions are in place. The most important thing is to educate them on infection control policies and have PPE available for them, says **Patty Burns, BSN, RN, CIC**, infection control coordinator at St. Elizabeth Medical Center in Edgewood, KY. "We talk to them about how it is transmitted, how they want to stand back and not be right in front of the patient, and definitely to use hand hygiene when they leave," Burns says. "Also, when they themselves have any sort of respiratory illness, they should not be visiting."

Burns says infection preventionists at St. Elizabeth educate nurses, and the nurses educate visitors and gauge

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Infection control

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each situation. If the visitor is a family member who has been around the patient consistently at home, he or she is probably already aware of the precautions.

“If it’s a husband and wife situation and they have been living in the same house, and now all of a sudden the person is in isolation, it seems kind of silly to make the person put a mask on,” Burns says. “So we talk to them about the risks, do [they] want [a surgical] mask and how to deal with that. It comes down to communication with the visitor.”

Preventing flu transmission

With the addition of H1N1 to seasonal flu, visitor education and protection has become even more important. Burger and Burns use appropriate signage that prompt visitors to wear a surgical mask if they are coughing or sneezing and to use hand sanitizer whenever possible.

Burns says the Greater Cincinnati Health Council has worked with surrounding hospitals so that all 40 facilities

in the area are using the same signs. Hospital visitors are used to seeing these signs not only in medical facilities, but also on the local news, so they are aware of the precautions as soon as they walk in.

“We have hand sanitizer everywhere, and now we have those cough etiquette stations [at every entrance] with a lot of education right there telling them how to cough [and] how to use tissues,” Burger says. “And they are filled with tissues, hand sanitizer, and surgical masks.”

Burns says staff members have strictly enforced a year-round policy prohibiting visitors under 14. “I say it is [because of H1N1], but it is actually our visiting rule 365 days a year, but we usually don’t stress it or go as far with enforcement,” she says.

St. Elizabeth has signs in the waiting room that ask visitors to restrict children under 14 from visiting loved ones. Recently, the hospital has also posted stop signs that strictly prohibit children from going beyond certain points of the hospital. Staff members are enforcing these guidelines now that H1N1 is prominent. “In our community right now, H1N1 is widespread and it has been for three weeks, so chances are many people do have it and shouldn’t be visiting, so we’ve been stressing that a lot,” Burns says.

Areas of importance

In many facilities, you won’t find visitors completely dressed in gowns, masks, and gloves because they are not providing care. However, **Terry Burger, BSN, RN, CIC, CNA, BC**, director of infection prevention and control at Lehigh Valley Hospital in Allentown, PA, says there are a few situations in which infection control policies should follow escalated precautions:

- **The burn unit.** Patients in this unit are under very strict precautions because they are far more susceptible to infections. In this case, visitor personal protective equipment is strictly enforced.
- **The neonatal ICU (NICU).** Isolation patients in the NICU are treated with more precautions because of their susceptibility, Burger says.
- **Direct patient contact.** Visitors will sometimes help care for the patient, particularly if the patient is a child; a family member may bathe him or her. Visitors should follow the same protocols as healthcare workers.

Joint Commission compliance

Designing a visitor education plan for isolation precautions and for flu season also satisfies Joint Commission requirements to provide education to patients and their families about HAI transmission. Using signs that educate visitors about the flu as they walk into your facility and having nurses talk with visitors and patients about proper precautions would fulfill some of those requirements, says Burns. “The Joint Commission just wants to make sure patients and their families are receiving the information they need, and this is a perfect example of the fact that we need to share information with them,” she says. ■

Source

Adapted from **Briefings on Infection Control**, December 2009, HCPro, Inc.

Quality improvement

Joint Commission's role in internal quality data



Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Discuss The Joint Commission and quality data collection

In a world where consumers can collect encyclopedic knowledge on a car or home electronics purchase, the need for usable, measurable quality data grows every day, particularly in healthcare.

More regulatory and other organizations are focusing on quality data collection, **Stephanie Iorio, RN, CPHQ, CPC**, said during her presentation, "The Impact of Quality Data on the External Environment," given at September's National Association for Healthcare Quality conference, which was held in Grapevine, TX.

Current themes in quality measurement include an absence of standardization of measures and data element definitions, a need to harmonize measures across healthcare settings, a growing demand for measures of efficiency, and use of administrative and other electronic data. There has also been a movement toward "episodes of care," Iorio said.

Other themes that are currently hot in quality measurement include:

- Measuring the quality of data, particularly data that are self-reported
- Pay for reporting and pay for performance
- Process versus outcomes measures

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- Patient privacy and confidentiality
- The growing role of consumers

"Are we measuring the right processes?" said Iorio.

There are more than half a dozen regulatory or reporting agencies that are tracking quality data in the acute care setting—not just CMS

"Are we measuring the right processes? ... Today you can find out more about a TV you want to purchase than about your own healthcare online."

—Stephanie Iorio, RN, CPHQ, CPC

and The Joint Commission, but also such staples as the National Quality Forum, the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, Leapfrog, and HealthGrades. But despite this, "today you can find out more about a TV you want

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What is ORYX?

ORYX measurement requirements are intended to support Joint Commission–accredited organizations in their quality improvement efforts. Performance measures supplement and help guide the standards-based survey process by:

- Providing a more targeted basis for the regular accreditation survey
- Continuously monitoring actual performance
- Guiding and stimulating continuous improvement in healthcare organizations

Some accredited organizations are required to submit performance measurement data on a specified minimum number of measure sets or noncore measures, as appropriate, to The Joint Commission through a Joint Commission–listed ORYX vendor (also known as performance measurement systems). Data collected or submitted to The Joint Commission are reviewed during the on-site survey.

Quality improvement

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to purchase than about your own healthcare online," said Iorio.

The crux of quality is data, she said. Data analysis reveals a great deal about quality and patient safety. Reviewing data can show trends in appropriateness of care, variations in practice and outcomes, and resource utilization. Movement away from manual chart reviews, which are time- and resource-intensive, to the electronic record has revolutionized the availability and usefulness of administrative data, Iorio noted.

The Joint Commission

So where does The Joint Commission play into all this? This year, ORYX reporting required four measure sets. Additional measure sets are in development, and measures are being reworked for capture through the electronic health record system. Also beginning this year, The Joint Commission considered introducing

paired mandatory reporting requirements—that is, certain measures that would be tied together in required reporting. For example, if your facility reports cardiac care measures, either myocardial infarction or heart failure measures would also be required. Similarly, surgical services measures would mean Surgical Care Improvement Project infections would also need to be reported.

Most hospitals would meet the remainder of reporting requirements by choosing to report some combination of nursing-sensitive, pneumonia, children's asthma care, and pregnancy measures, said Iorio.

Iorio pointed out the law of diminishing returns here: "If you've been reporting on the same measures [for some time], how many times can you do so before you max out on your potential?" she said. ■

Source

Adapted from **Briefings on The Joint Commission**, November 2009, HCPro, Inc.

Current measure sets

How do the existing measure sets stack up? The following indicates how existing measure sets are looked at currently, as well as when upcoming changes are expected to be implemented.

Venous thromboembolism (VTE) measures

- Joint Commission only
- Implemented with October 2009 discharges
- Applicable to all inpatient discharges, including minors without VTE, with Princ Dx VTE, and with other Dx VTE

Perinatal care measures

- Joint Commission only
- Expected implementation date: April 2010 discharges
- Endorsed by the National Quality Foundation—based on current scientific evidence
- Looks at domains of care: assessment and screening, prematurity, infant feeding, and continuity and transition

Stroke measures

- Joint Commission only
- Implemented with October 2009 discharges
- Applicable to all stroke patients but required by primary stroke centers
- Includes ischemic and hemorrhagic strokes

ED measures

- Joint Commission and CMS consider these measures informational
- An implementation date has not yet been established
- Looks at the following ED concepts: patient wait time, overcrowding, boarding, and diversions

Nursing-sensitive measures

- Joint Commission only
- Expected implementation date: April 2010 discharges
- Looks at multiple data sources: clinical abstraction, event reporting, administrative, workforce, and surveys

HIPAA compliance

Hospitals not the place for social networking sites

Covered entities and business associates can protect themselves against the dangers of unsecured social networking Web sites by taking a hard stance against them, experts advise. Social networking sites, such as Facebook and Twitter, are examples of another new technology that presents a risk to protected health information (PHI).

It's not common—although it's possible—for health-care workers to use these sites to intentionally and maliciously violate patient privacy laws.

More often, healthcare workers sign on during breaks or when they are off work and vent about their day with friends without realizing that they are sharing identifiable information and violating HIPAA.

"These professionals are well educated, but that doesn't mean they are savvy with security," says **Chris Apgar, CISSP**, president of Apgar & Associates, LLC, in Portland, OR. The finality of disclosures on these Web sites is what makes the situation so dangerous, Apgar says. "Once you put something out there, it's out there, and it's never coming back," he says.

Banning these Web sites from the hospital network is one strategy that many organizations use, Apgar says.

Spring Harbor Hospital in Westbrook, ME, bans access to Web sites such as Facebook on facility computers, says **Chris Simons, RHIS**, who serves as the facility's privacy officer and director of HIMS. "We also include it in orientation as a no-no," Simons says. "We have had some issues with staff on Facebook saying inappropriate things about their managers and have addressed that."

St. Dominic Jackson (MS) Memorial Hospital similarly has banned access to social networking sites on all hospital-owned computers and laptops, says **Dena Boggan, CPC, CMC, CCP**, the hospital's HIPAA privacy/security officer.

Boggan sends weekly HIPAA tips to all employees. Immediately after initiating the ban, she sent a tip that described the dangers of blogging about work experiences, especially healthcare events, on social networking sites.

Continually reminding staff members is important because they don't always understand the dangers that seemingly harmless posts and entries may present, says Boggan. "These are cautious reminders to be very aware that although it may be your personal site, the Internet has eyes everywhere," she says.

Rhonda Edgecomb, RHIT, CHP, chief privacy officer at Community Health and Counseling Services in Bangor, ME, doesn't see social networking sites as a concern within her organization. But she understands how problematic they can be.

As a member of a social networking site, Edgecomb has read inappropriate postings by peers who work in healthcare settings. "They refer somewhat vaguely to cases that they worked on, and I have a huge issue with that," she says.

Similarly, access to personal e-mail accounts is just as dangerous for many reasons, and organizations are beginning to ban this practice as well.

A physician who logs on to a personal Yahoo! Mail account to send him- or herself a list of patients to access at home is one example of inappropriate use, Apgar says. That's a breach of a lot of information, he explains. The hospital network may be encrypted, but the information won't be encrypted once the physician opens the e-mail at home.

Some organizations may hesitate to block Web mail from the hospital network because it also would block access to the Web mail's search engines, such as Google and Yahoo!, which staff members use daily. However, blocking specific Web addresses for e-mail accounts while maintaining access to search engines is possible, Apgar says. Discuss this option with your information technology department. It's another way for providers to protect themselves. ■

Source

Adapted from **Briefings on HIPAA**, November 2009, HCPro, Inc.

Tip of the month

Healthy work environments boost nurse retention

Although we are in the midst of great financial challenges, do not let this mislead you regarding retention. Do not lose focus on retention because you feel there are less job opportunities available for your staff.

We may have a temporary ease in the number of openings, but the projections do not look good for the future.

Estimates are that there will be more than 250,000 nurse vacancies by 2025. To retain the nurses you have, you need to build or maintain healthy work environments.

The American Association of Critical Care Nurses (AACN) has done an outstanding job of publishing standards that guide organizations through establishing and sustaining an atmosphere where nurses thrive.

AACN focuses on six areas:

- Skilled communication
- True collaboration
- Effective decision-making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership

You can order the AACN standards through its Web site at www.aacn.org. ■

Reference

American Association of Critical Care Nurses (2005). "AACN Standards for Establishing and Sustaining Healthy Work Environments." *American Journal of Critical Care* 14: 187–197.


Buerhaus, P., et al. (2009). "The Recent Surge in Nurse Employment: Causes and Implications." *Health Affairs* 28(4): w657–w668.

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