

Nursing

PROGRESS NOTES

THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
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Genomics field explodes: Nurses respond

— by Wendy Lynn

“Explaining to patients their risk for developing cancer or developing a secondary cancer can be complicated,” says Joyce Dains, Dr. P.H., advanced practice nurse in the Cancer Prevention Center, and director of advanced practice nursing programs. “The clinical application is about the role of genomics in disease prevention, early diagnosis, treatment, drug selection and therapy.”

Dains, a cancer genetics educator, says when she sees a “red flag,” such as a family history that suggests an inherited risk, she refers the patient to a genetics counselor. “They do a multigenerational evaluation of the family history and can advise about genetic testing. Other than inherited risk, there are issues such as gene variation, changes in gene expression and the interaction of your environment with your genes - environmental exposure, diet and/or exercise issues and smoking. All cancer is genetic, but not all cancer is hereditary.”

A whole new world

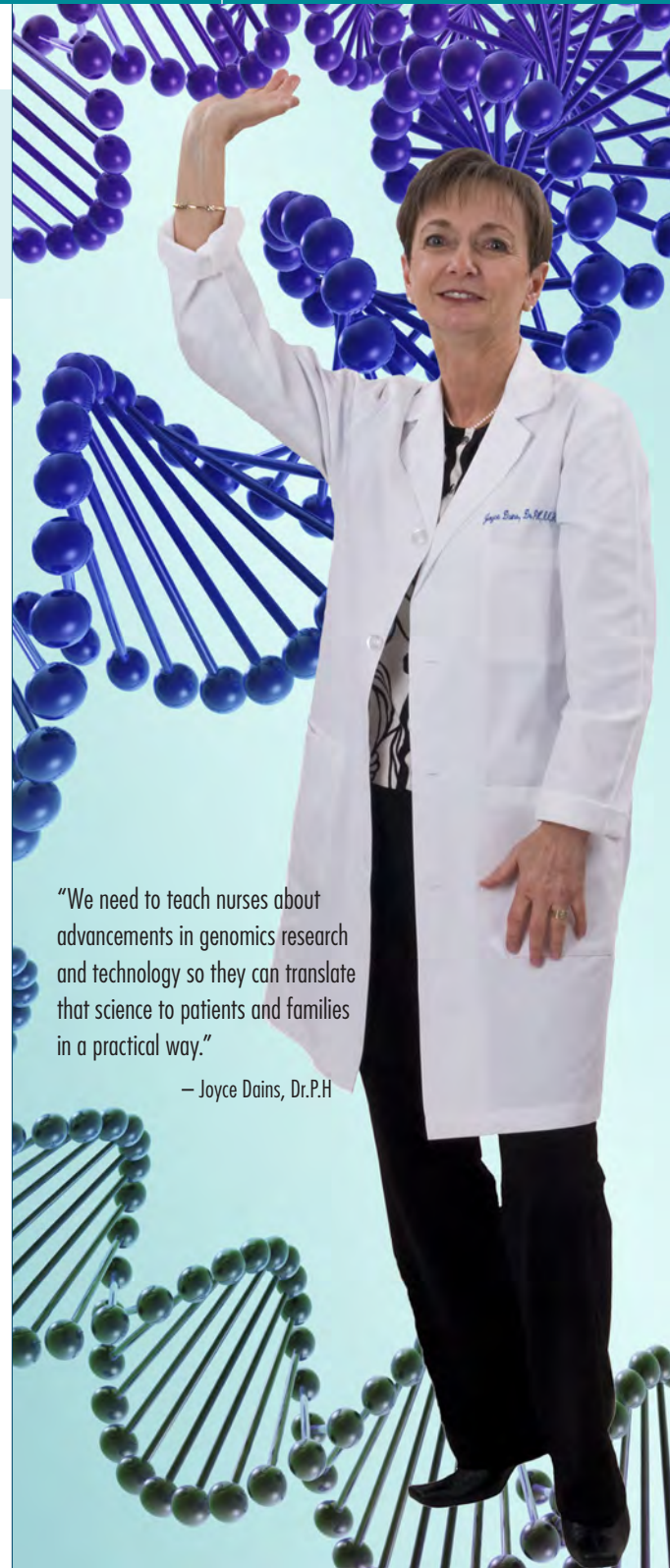
Information and discoveries stemming from data collected during the course of the U.S. Human Genome Project (1990-2003) have been the catalyst for changes in medicine and nursing practice at all levels. And with these changes, the need for nurses to become more educated about genomics has increased. Dains notes that many of today’s nurses had no genomics instruction when they were in school.

A whole new curriculum

Dains would like to see genomics education programs for all nurses in the future. “Right now, it’s informal, on-the-job education. We need to teach nurses about advancements in genomics research and technology so they can translate that science to patients and families in a practical way.”

“At no time in the history of cancer nursing have the discoveries moved so rapidly or held such promise.”

Calzone, K. and Masny, A. “Genetics and oncology nursing.”
Seminars in Oncology Nursing (2004) Volume 20, Issue 3:178-185.



“We need to teach nurses about advancements in genomics research and technology so they can translate that science to patients and families in a practical way.”

— Joyce Dains, Dr.P.H

Dear nurse colleagues,

As you know, I like to take the opportunity to tell anyone who will listen about all of the outstanding nurse-led initiatives now in effect at our institution. You all are simply doing an outstanding job. This issue highlights four excellent examples of your hard work — programs that have truly transformed patient care at M. D. Anderson.

Let's start with the nurses on **G10 East**. Through their work with interdisciplinary colleagues, they were able to successfully move discharge planning rounds out of the conference room and to the bedside. As a result, patients, loved ones and nurses - together - are more actively involved in the discharge process.

On **P7**, nurses have revolutionized the way M. D. Anderson cares for post-operative esophagectomy patients through the new "fast tracking to discharge" program. Through collaboration between nurses, thoracic surgeons and mid-level providers, these patients are bypassing the Intensive Care Unit and going to P7 directly from Recovery. Patient outcomes have been positively affected; average length of stay has been significantly reduced; and patients, family members and staff have all reported higher levels of satisfaction.

The new Post Anesthesia Care Transition Unit on **P3** has improved the ever-important issue of patient throughput. The new unit provides a place for patients, who would normally stay in the PACU until an inpatient bed became available, to stay with their loved ones and still receive expert care from PACU nurses.

And finally, nurses on **P8** worked closely with the neurosurgeons to create the NeuroProgressive Care Unit, an alternative to the intensive care unit for some patients. The post-operative environment promotes quick recoveries for simpler procedures, and reduces the ICU's patient load.

M. D. Anderson nurses are transforming care at the bedside every day, and I am honored to be a part of this exciting and vital nursing community.

Warm regards,

Barbara L. Summers, Ph.D.
Vice President and Chief Nursing Officer
Head, Division of Nursing

Genomics continued from page 1

“Genomics programs for nurses nationally have tended to be more bench-oriented and at the fellowship level,” notes Dains. “But there are a few master’s-level opportunities out there.”

Graduate-level genetics programs are available through nursing schools at:

- Columbia University
- University of Iowa
- University of California, San Francisco
- University of Pittsburgh
- University of Washington

– International Society of Nurses in Genetics

The Oncology Nursing Society recognizes three levels of oncology nursing practice in cancer genomics:

General oncology nurses

- Baccalaureate-level preparation
- Certification: Oncology Certified Nurse

Advanced practice oncology nurses

- Master’s-level preparation
- May have post-graduate preparation as clinical nurse specialists or nurse practitioners
- Certification: Advanced Oncology Certified Nurse

Advanced practice oncology nurses with subspecialties in genetics

- Master’s-level preparation
- May have post-graduate preparation as clinical nurse specialists or nurse practitioners
- Completed additional training in genetics, through continuing education and/or academic preparation
- Certification: Advanced Practice Nurse in Genetics

Genetics:

The branch of biology that deals with heredity and variation in similar or related animals and plants. The genetic features or constitution of an individual, group or kind.

Genomics:

The science that deals with genomes and their functions.

Genome:

The total genetic information present in a somatic cell and unique to any specific organism.

– Webster’s Dictionary

Fast tracking to discharge on P7:

— by Carla Baker, Katie Lewis and Wendy Lynn

Postoperative nursing care of esophagectomy patients is critical

“The Fast Track program for esophagectomy patients was started because we saw the wonderful care our patients received by the nursing staff on P7 and the dedication they showed,” explains Carla Baker, advanced practice nurse, Thoracic and Cardiovascular Surgery. “They have been superb at picking up problems early so they can be addressed rapidly.”

With their highly specialized skills, attention to the subtlest clinical changes, quick reactions and unwavering dedication to their patients, P7 nurses are revolutionizing the way M. D. Anderson cares for postoperative esophagectomy patients.

Because they are at high risk for complications following surgery (e.g., respiratory insufficiency/pneumonia, cardiac arrhythmias, poor pain control, delay of bowel function, chylothorax and anastomotic leaks), these patients used to spend two to three days in the Intensive Care Unit before transferring to the floor.

Thoracic surgeons, mid-level providers and P7 nurses wondered if patient outcomes might be improved if they could circumvent the intensive care unit and bring these patients straight to the floor where they could begin ambulating much earlier.

Getting patients on their feet

Since the fast-track program launched in March 2008, patients have been able to begin ambulating within four hours of arrival to the floor. This allows P7 nurses to identify early on those patients who are orthostatic and need additional fluids, those with poor pain control, and those who need additional assistance. In addition, the early ambulation has helped improve pulmonary hygiene, and hastened return of bowel function.

Decreasing length of stay

Nurses can now begin the discharge planning process almost immediately. Support staff, such as case managers, can get involved early to facilitate a smooth discharge process. Since the program's inception, patient length of stay has decreased by an average of five days.

Increasing satisfaction for patients and staff alike

“Nurses were a bit fearful at first,” remembers Katie Lewis, associate director of clinical nursing, P7. “But they rose to the challenge.” She reports that her staff receives a great sense of fulfillment when patients are discharged early, and complications are minimized.

Patient satisfaction has improved with the consistency and continuity of care the fast track program provides. Once the patient arrives in their room on P7, they will stay there until discharge. “Patients develop a bond with ‘their’ nurse,” reports Lewis.

What's next?

The multidisciplinary care team plans to investigate using the fast track program for other thoracic surgery procedures. And, according to Baker and Lewis, they expect outcomes will be just as positive.

“Participation and excitement for this program have penetrated the entire surgical and perioperative team.

I feel that our ‘home ward,’ P7, is the safest and most efficient area in which to care for this group of high-intensity, high-acuity patients.”

— Wayne Hofstetter, M.D.,
Associate Professor, Thoracic and Cardiovascular Surgery



P7 night-shift nurses like Jaya Mathew, left, and Okey Obioma handle critical, hourly monitoring for the first 12 hours their fast-track patients are on the unit.

- Esophageal cancer will affect approximately 16,470 new persons this year in the United States, and carries a poor 5-year survival rate, according to the National Cancer Institute.
- M. D. Anderson surgeons perform approximately 90–100 esophagectomies each year.

Transforming nurses' ideas into practice

Taking discharge rounds out of the conference room

Nurses on **G10 East** thought there had to be a better way to manage discharge planning rounds. When the planning team came to the unit, they would meet in the conference room and nurses had to keep ducking in and out of the meeting, trying to time it so they could be involved in discussion of their patients. The inefficient and time consuming process not only took them away from the bedside, it also made it difficult for patients and family members to be involved.

Nurses propose a bold new idea

G10 East nurses wanted to know if the discharge planning process would work better if the team came to the patient instead of meeting in a separate room. That way, they theorized, the nurse could stay at the bedside, patients and families could be more involved in the discussion, and the team could ask questions about concerns and obstacles to discharge.

Testing the theory

Inpatient nurses now have a framework in which they can propose ideas for improving their work environment: each unit has its own Transforming Care at the Bedside team. Nurses can bring their ideas to the TCAB team, and those ideas can be put through rapid-cycle tests of change based on the Plan, Do, Check and Act model.

TCAB, a project of the Institute for Healthcare Improvement and Robert Wood Johnson Foundation, is designed to study and develop models of care at the bedside on medical and surgical units, although it is applicable to all areas. The goals are to improve the quality of patient care and service, increase the effectiveness of care teams, improve staff satisfaction and retention, and increase efficiency.

Nurses on G10 East worked with their unit's TCAB team and other involved disciplines to test their idea, making adjustments when necessary, as the practice spread incrementally on the unit.

A transformation occurs

As a result, time needed for discharge rounds decreased by 30 to 45 minutes when people started meeting "on their feet." The new model allows nurses to remain at the patient's bedside until the team arrives, and patients and families are now more directly involved in the process.

Good ideas travel fast

By all accounts, feedback from G10 East patients and staff has been positive thus far, and the process has spread to P9 where staff have been testing and using their own version of bedside discharge rounds. Just another example of how M. D. Anderson nurses are transforming care at the bedside.



Here are some of the many other TCAB ideas that have been put into practice at M. D. Anderson:

Now in use on multiple inpatient units

- Nurse tranquility rooms
- Peace and quiet time
- Laughter yoga
- Noise reduction strategies, such as Yakker Trakkers
- "Dear Doctor" notes
- Patient discharge tickets
- Use of colored magnets to denote patient needs or characteristics
- Laminated "Don't Forget" signs that remind patients to take all their belongings
- Spanish phrases on laminated signs to assist staff with communicating about basic care until language assistance can be obtained

Now in use on all inpatient units

- Discharge nurse role
- Daily goals boards
- Standardized, online reporting tools such as the electronic change-of-shift report and the nurse-to-nurse patient care hand-off report, both constructed around the Situation, Background, Assessment and Recommendation communication model
- Easy-to-read, color-coded badge cards identifying six types of staff (e.g., RN, MD, CNA)

— by Beverly Nelson, Ph.D.

Increasing knowledge of a “new” patient population

When an inpatient unit starts running short of beds, back-up units often are designated to handle their patient overflow. In the case of G9 East’s lymphoma/myeloma patients, units P9 and P10 have assumed that role.

A TCAB project on G9 East resulted in chemotherapy training classes for staff on their overflow units. According to Yvette Ong, associate director of clinical nursing on P10, the training has helped new nurses learn how to care for the lymphoma/myeloma patient population from G9 East. P10 has an average of four to six such patients per day, accounting for 15-20 percent of the unit’s patients per month.



Max Modlin, clinical nurse, Nursing Resource Pool, left, and Nkechi Onyedum, clinical nurse, P10



Emma Morales, clinical nurse, PACU

PTU: Transitioning to a comfort zone

—by Debbie Sharp

Overnight post-operative patients at M. D. Anderson have Marian Thomas, associate director of clinical nursing, to thank for their comfortable surroundings in the Post Anesthesia Care Transition Unit (PTU).

A tight squeeze

According to Thomas, a few years back, the institution was seeing a steady increase in overnight recoveries in the PACU, as patients had to wait for available beds. Patients and family members began voicing their concerns with the high noise levels, lack of privacy, uncomfortable stretchers and limited visitation hours.

“We also were getting feedback from the physicians that surgery cases might have to be postponed because there was no room for new patients,” states Patricia Hannon, director of clinical nursing. “We decided it would be nice if there was a transition area to move the patients to overnight so they could stay under the care of the PACU while waiting on a bed – kind of like a holding area.”

A collaborative effort

In 2007, the team worked closely with multiple disciplines across the institution to set up transition rooms, first in an empty space on P6 and later moving to P3. “We met with Facilities to supply rooms with post-surgical monitoring equipment, with Pharmacy to set up a nearby Pyxis machine for faster drug access, and with physicians to make sure they knew we would be providing the same level of care by staffing the transition unit with PACU nurses,” says Thomas.

Successful move

The 16-bed unit, which officially opened in May 2007, has continued to see a steady flow of patients. “We are now fully staffed with 55 nurses between the two units,” says Thomas. “And the nurses are trained to go back and forth to keep up their skills.”

Thomas adds that patients love it because of the increased privacy, and families love it because they can stay with their loved ones in the room. Physicians also are pleased with the improvement in patient flow. There’s an empty PACU each morning ready for new pre-operative patients and cases don’t have to be canceled or postponed because of lack of postoperative recovery space.

“What I love about the transition unit is that we focused on the patients and what they were telling us,” says Hannon. “We took it seriously and looked at ways to resolve the problem. That makes me very proud to be a part of this nursing team.”

NeuroProgressive Care Unit offers alternative to ICU

—by Erika Hargrove

Not all postoperative neurosurgery patients need to go to the ICU. And in some cases, it's best if they don't.



Rose Moore,
clinical resource nurse, P8

M. D. Anderson now has a NeuroProgressive Care Unit that caters to the recovery of patients who undergo straightforward, uncomplicated brain surgeries. The new unit allows patients to go from surgery to a post anesthesia care unit and then to a private room where they are monitored by specially-trained nurses, bypassing the ICU altogether.

For years the neurosurgeons have wanted such a unit. It was their answer to the need for a postoperative environment that was conducive to quick recoveries for simpler procedures - not to mention, a way to reduce the ICU's patient load.

“And finally the stars aligned,” says Franco DeMonte, M.D., professor and vice chairman of Neurosurgery. DeMonte says one of the biggest and brightest stars was the Division of Nursing and the role its leadership played in the development of the unit.

“It's a well known fact that you can't get most things done clinically unless you have nursing behind you,” DeMonte says. “When it comes to any patient effort, you need nursing's support, and we definitely had it in this endeavor.”

“In the case of other recoveries, nurses can rely more on the monitors to determine what is happening with the patient. But there is not a monitor for the brain. So the nurses' ability to recognize specific changes in the patient is critical. By the time changes in other vital signs begin to show on monitors, the patient is dying.”

— Franco DeMonte, M.D., professor and vice chairman, Neurosurgery



NeuroProgressive Care Unit clinical nurses Yolanda Straughter (left) and Mayla Garcia

Knowledge is power

Along with the support of the division, the neurosurgeons also had Nicole Harrison, who at the time was serving as associate director of clinical nursing on the neurosurgery unit. She had significant experience in neurosurgical ICU care, and was in the right place at the right time to champion the program.

The unit opened in January 2008 and the results have been encouraging. Not only has the ICU been relieved, but NPCU patients are recovering quicker, with shorter hospital stays — up to a day and a half faster. “This is partly because they are in an area that allows them to become mobile sooner,” says Bob Massey, Ph.D., director of clinical nursing. “It’s the interdisciplinary practice between nursing and neurosurgery that has made the NPCU a success.” According to Massey, without the support of Raymond Sawaya, M.D., chairman of Neurosurgery, DeMonte, and the neurosurgeons who entrust them to send their patients to NPCU, the program would not be possible.

Massey added that not only the environment, but also the training and education of the NPCU nurses, is a huge benefit to the patients’ recovery. Once trained, these nurses have the knowledge and skills necessary to care for this patient population like no other nurses can.

And according to DeMonte, knowledge and skill can never be underestimated when it comes to these patients.

“In the case of other recoveries, nurses can rely more on the monitors to determine what is happening with the patient. But there is not a monitor for the brain,” he says. “So the nurses’ ability to recognize specific changes in the patient is critical. By the time changes in other vital signs begin to show on monitors, the patient is dying.”

In addition to specialized care, Harrison added that the cost of staying on a floor unit, such as the NPCU, is much less for patients compared to the cost of staying in the ICU. “And for every bed that is not taken up by one of these patients, it opens up a bed for someone who truly needs the acute care that the ICU provides,” she adds.

The NPCU currently has four beds. The hope is that two additional beds will be added by next spring. Approximately 270 patients have been seen at a rate of about 30 per month, according to Jason Wall, associate director of clinical nursing on P8. “The unit has done so well that only one patient has had to return to the ICU, which was due to a medical related issue,” Wall says.

To further study the success of the unit, Wall is developing ways to measure, track and compare NPCU data as the unit grows in size and scope.

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