Cleveland Clinic

Notable NURSING

The Stanley Shalom Zielony Institute for Nursing Excellence

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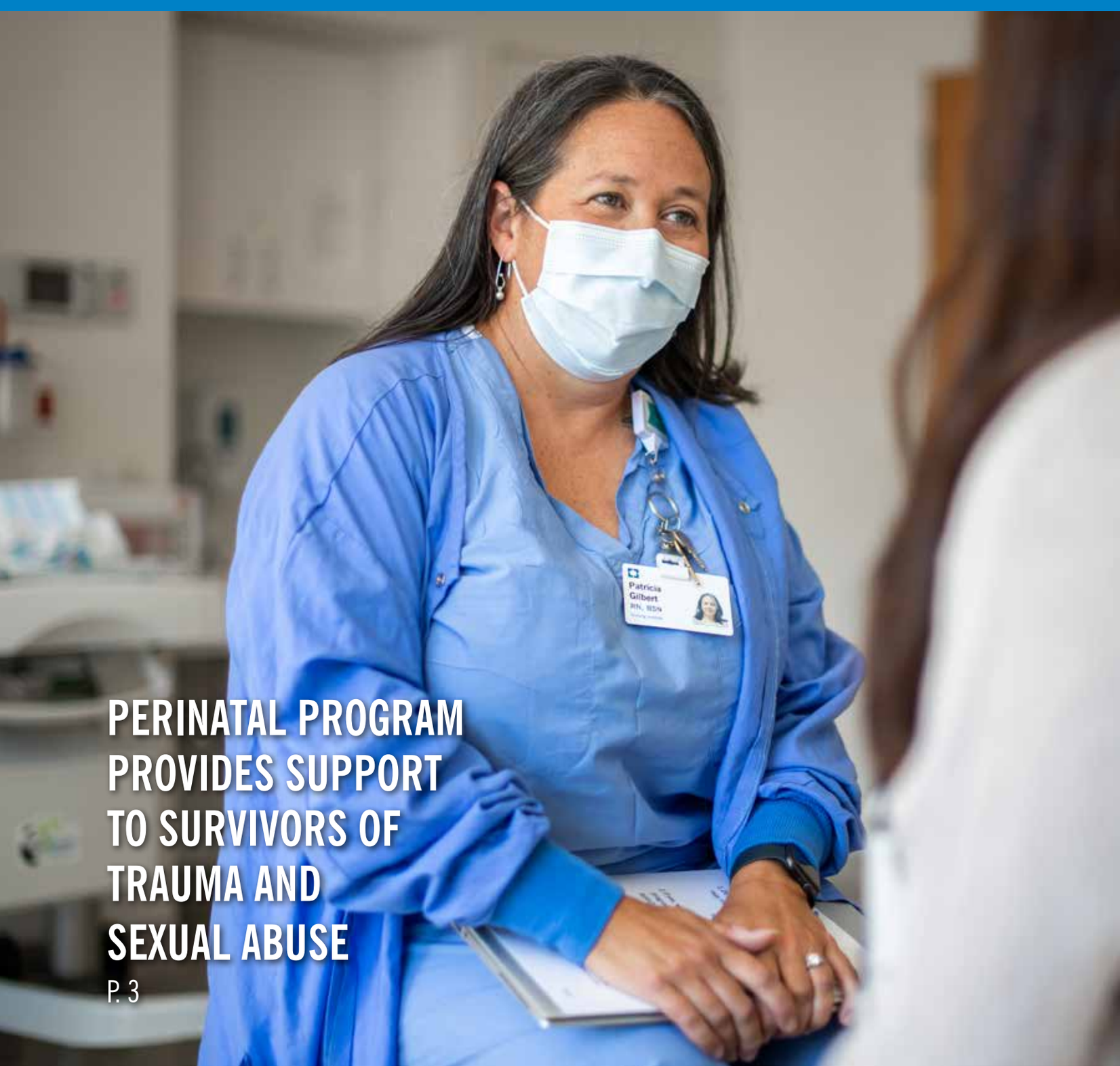

PERINATAL PROGRAM PROVIDES SUPPORT TO SURVIVORS OF TRAUMA AND SEXUAL ABUSE

P. 3

Dear Friends,

This issue of *Notable Nursing* features stories that depict the incredible variety of clinical services that nurses provide. Although the following pages describe a wide assortment of clinical cases and programs, several themes emerge. Among them are the compassion, dedication and talent with which Cleveland Clinic nurses approach their patients and fellow caregivers.

Our cover story describes how caregivers can promote healing by addressing the emotional needs of those who have survived abuse, rape, a previous miscarriage or stillbirth, or other events that may increase the risk of a traumatic birthing process.

On page 7, we explore empathetic ways to approach patients with body modifications and explain the importance of setting aside prejudice when managing individuals with tattoos and piercings. Beginning on page 15, we take a closer look at the complexities of advance directives for geriatric patients and the moral conundrums that accompany end-of-life care.

As described in the feature on pages 9-11, workplace violence is an ever-present threat to front-line caregivers, who are often called on to prevent and de-escalate potentially dangerous situations. On pages 12-13, we describe how Cleveland Clinic's new Nursing Ethics Fellowship is training caregivers to navigate morally and emotionally difficult clinical scenarios. In addition, we take a deep dive on pages 14-15 into the value of nursing research, while exploring the factors that encourage nurses to pursue basic, translational and clinical science.

We're proud to showcase just a few of the countless ways our caregivers are making a difference. I hope you'll join me in celebrating the distinctive perspectives and opportunities presented in this very special edition of *Notable Nursing*.

MEREDITH FOXX, MSN, MBA, APRN, NEA-BC, PCNS-BC, PPCNP-BC, CPON
Executive Chief Nursing Officer, Cleveland Clinic

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On the cover: Patricia Gilbert, BSN, RN, and her team work to alleviate the extreme anxiety that can be heightened in pregnant patients with a history of abuse or trauma.

These care priorities help keep our focus on caring for patients as if they are our own family, treating fellow caregivers as if they are family, maintaining our commitment to the communities we serve, and treating the organization as our home.

Patricia Gilbert, BSN, RN, and her team use a three-question screening tool to help identify at-risk patients.

Novel Perinatal Program Provides Support, Reassurance to Survivors of Trauma and Sexual Abuse

M-POWER AIMS TO MEET THE UNIQUE NEEDS OF PREGNANT PATIENTS WHO STRUGGLE WITH FEAR AND ANXIETY

For women with a history of sexual assault or abuse, childbirth can trigger strong emotions associated with previous traumatic events. Although one-quarter of patients who give birth report having endured significant personal trauma at some point in their life, little clinical guidance exists on how to best support these survivors during the birthing process.

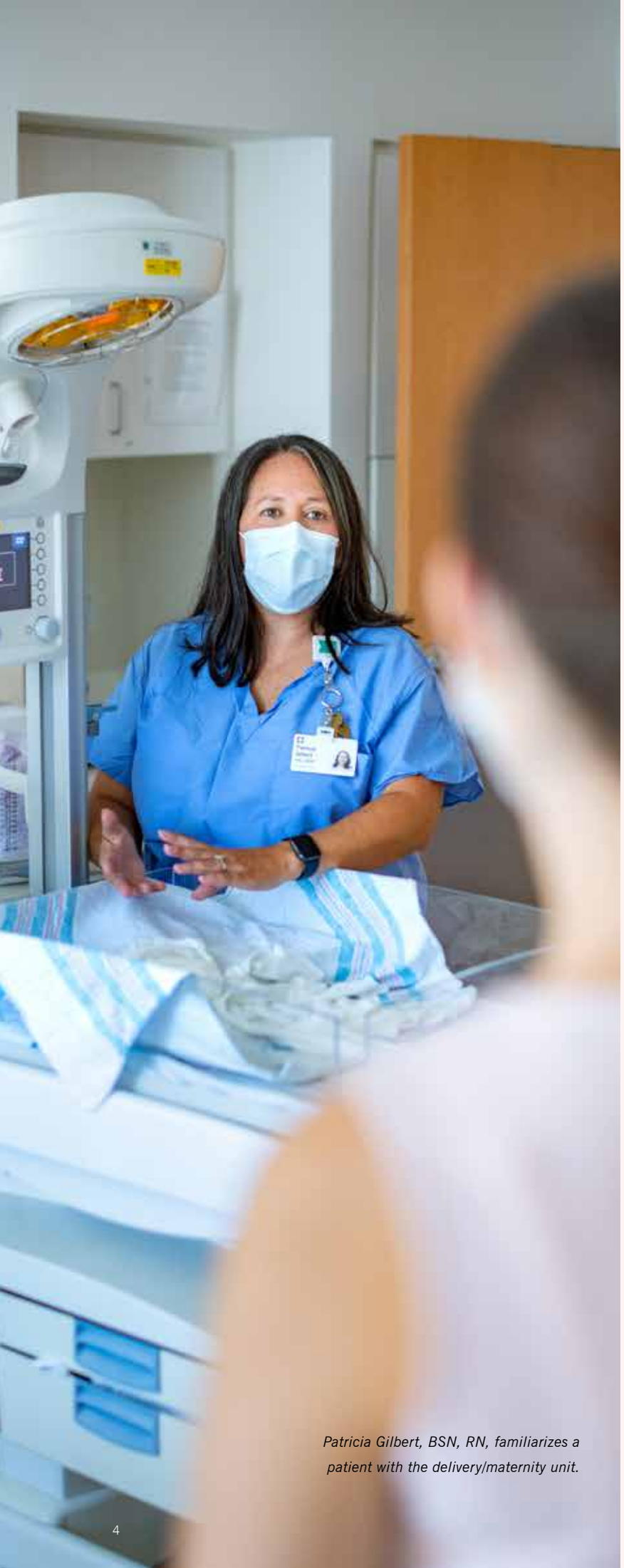
Patricia Gilbert, BSN, RN

In her 20-year career as a labor and delivery nurse, Cleveland Clinic nurse Patricia Gilbert, BSN, RN, became intrigued by patients with difficult backgrounds. Recognizing an opportunity to improve the care of survivors during the perinatal period, she approached Dusty Burke, MSN, RNC, Director of Nursing Operations, about developing a trauma-informed care program. Burke embraced the innovative idea, which involves identifying survivors prior to delivery and providing them with a supportive birth experience, and the M-Power program began to take shape.

The team began by diving into the nursing literature and was surprised by what was found. "There were plenty of statistics on how many women have been affected by childhood sexual assault and abuse, but we discovered very little information about how those experiences can affect the childbearing years of life," explains Gilbert, M-Power's nursing coordinator.

Dusty Burke, MSN, RNC

What's more, Gilbert says that although many authors mentioned the need to develop a standardized protocol for managing perinatal patients with a history of trauma, nothing had been



Patricia Gilbert, BSN, RN, familiarizes a patient with the delivery/maternity unit.

done about it. She and Burke took the news as a call to action. “We were confident that we could fill that gap,” she says.

IDENTIFYING AT-RISK PATIENTS

Gilbert notes that some trauma survivors exhibit extreme anxiety and a need for control — responses that can be heightened during pregnancy.

“The sudden focus on intimate areas of a pregnant patient’s body can elicit a powerful gut response,” she says. “In particular, the physiological changes and repeated, potentially invasive physical examinations that accompany pregnancy can cause significant stress in patients who have endured previous abuse or injury.

“M-Power is designed to identify survivors before they give birth, address their concerns and work with them to develop a holistic care plan based on safety and trust. We want to make sure these patients feel fully supported and heard by their caregivers,” Gilbert explains.

CALMING THE EMOTIONAL STORM

The M-Power process begins with a referral, which can be initiated by the patient or provider. Gilbert and Burke worked with their multidisciplinary steering committee to create a three-question screening tool to assist with the referral process.

“Patients with a significant history of abuse are often uncomfortable disclosing details about their past, so we’ve created a specialized screening protocol that takes the patient’s privacy and potential apprehension into account,” says Burke.

Women who meet the criteria for enrollment in the M-Power program are given the opportunity to tour the labor and delivery unit and work with a specially trained resource nurse to create an individualized plan of care. Each patient’s medical record includes specific care notes that outline optimal strategies for meeting their individual needs.

Although the details of past trauma need not be known to provide this level of care, Burke emphasizes the importance of documenting each patient’s needs before the patient is admitted to the labor and delivery unit. “When a patient arrives to give birth, the staff can respond appropriately because they have already been briefed on that individual’s unique concerns, triggers and personal preferences,” says Burke.

Women enrolled in the M-Power program are given the opportunity to work with a specially trained resource nurse to create an individualized plan of care.

Gilbert adds, "Many of these women arrive with potential triggers related to touch, exposure and unfamiliar procedures. Some may become uncomfortable when strangers are involved in their care. In other cases, the patient's chief concern is pain. We've learned to diffuse these fears by providing specific details about what to expect during labor and childbirth, thoroughly discussing options for managing their symptoms, and even describing the physical sensations they may feel during each step of the process."

PREPARATION IS KEY

Gilbert emphasizes that the success of M-Power is largely dependent on caregiver education. "It is essential that every clinician involved in the birthing process have the tools needed to best support these patients, many of whom arrive in 'fight or flight' mode," she says.

A recent Cleveland Clinic Caregiver Catalyst Grant has allowed M-Power leaders to further develop the novel program. After nearly a year of training development with a certified *When Survivors Give Birth* instructor, the team has created a custom-tailored education protocol for Cleveland Clinic caregivers. The training also allowed the team to provide a two-day symposium on trauma-informed care for obstetrical caregivers and M-Power resource nurses.

After a full year of planning, M-Power went live on Aug. 1 in all six Cleveland Clinic Ohio locations that provide obstetrical services. Burke says they plan to expand the program to other Cleveland Clinic hospitals next year.

In the meantime, the team is focused on further developing relationships with local community centers, rape crisis centers and other outreach programs.

> "It is essential that every clinician involved in the birthing process have the tools needed to best support these patients, many of whom arrive in 'fight or flight' mode."
>
> — *Patricia Gilbert, BSN, RN*

LOOKING AHEAD

Although it is too early to assess whether M-Power will have a measurable effect on maternal outcomes, Gilbert and Burke are confident the program has provided a more supportive birthing experience for both trauma survivors and delivery room staff.

"We are enormously grateful for the support that has allowed us to bring this program to fruition," says Burke. "We're aware that recent changes to reproductive healthcare laws may affect the demand for this specialized service, and we're prepared to do what it takes to meet the needs of our most vulnerable patients."

Email comments to notablenursing@ccf.org.

When managing patients with body modifications, including tattoos and piercings, experts emphasize the importance of offering encouragement and refraining from judgment.

Scott Sharp, RN, meets with a newly admitted patient in the emergency room.

Sensitivity and Open-Mindedness Are Key for Managing Patients with Body Modifications

GROWING POPULARITY OF TATTOOS AND PIERCINGS CHALLENGES NURSES TO SET PRECONCEPTIONS ASIDE

Preparing apprehensive patients to undergo magnetic resonance imaging was nothing new for Christina Canfield, MSN, APRN, ACNS-BC, CCRN-E, but when a woman with more than 10 piercings was brought to the imaging room, the Cleveland Clinic nurse knew she was in uncharted territory. When the patient learned the ornaments would need to be removed, she tearfully explained that they held deep personal meaning and implored Canfield to do whatever she could to preserve her piercing tracts.

Christina Canfield, MSN, APRN, ACNS-BC, CCRN-E

Dianna Copley, DNP, APRN, ACCNS-AG, CCRN

"I was struck by how important the piercings were to the patient, but I lacked the tools and knowledge needed to safely remove her jewelry and maintain her piercing tracts," she recalls. "For a long time, I was haunted by how unprepared I was to address her concerns."

Determined to learn more, Canfield began to explore how to manage patients with body modifications – a growing concern for healthcare providers around the world. She and fellow Cleveland Clinic nurse Dianna Copley, DNP, APRN, ACCNS-AG, CCRN, recently presented some of their insights at the annual conference of the American Association of Critical Care Nurses National Teaching Institute.

DON'T JUDGE A BOOK BY ITS COVER

Although body modifications can present a number of unexpected challenges for clinicians, the first – and perhaps most important – step in managing these patients is to set aside any preconceived notions, says Copley, a clinical nurse specialist in the surgical intensive care unit (ICU).

"We encourage nurses to do three things when approaching all patients, particularly those with body modifications: offer acceptance, remain open-minded and ask questions," she says.

One of the most prevalent biases is the assumption that people with tattoos or unusual piercings are more likely to engage in high-risk behaviors, notes Canfield, Program Manager in ICU Operations and eHospital ICU Telemedicine. Not only does that belief reinforce the perception that the patient may be to blame for their illness, but it is a chief reason these patients are more often held accountable for the cost of their medical care, she explains.

Despite these negative stereotypes, studies show that individuals with body modifications are actually more likely to vote, participate in volunteer work, donate to charities and maintain a healthy body mass index than their peers.

LET EMPATHY LEAD THE WAY

Many people use tattoos and piercings to commemorate a meaningful life event or celebrate their ability to heal from trauma, which is all the more reason to regard these personal expressions with respect and sensitivity, explains Copley. For others, body modifications may have important cultural or religious significance.

"Some of these patients have incredible stories to tell, but you'll miss them if you shut down conversation by making snap judgments," she says.

There are, however, certain body modifications that may demand greater scrutiny. For example, it is increasingly common for victims of human trafficking to be "branded" with tattoos to signify that they belong to their trafficker.

Although victims may have numerous tattoos on various areas of their body, locations commonly linked to human trafficking include the neck, arms and above the groin. In some cases, these tattoos may have a "homemade" appearance. Common red flags include tattoos that depict barcodes, initials coupled with a crown, and currency symbols (e.g., moneybag, coins or dollar bills).

From gauges and barbells to surface-anchor screws and implants, the growing number of available body modifications can challenge unprepared clinicians.

Any interaction with a potential trafficking victim is a rare opportunity to offer potentially lifesaving intervention, says Canfield. "That's why it is so essential to establish trust by demonstrating genuine concern and curiosity."

Tattoos used by traffickers may vary by region, adds Copley, who suggests that clinicians consult with their local law enforcement agencies about markings that may be common in their area.

RISK VS. REWARD

Nurses may also encounter patients who present with complications – infection, most commonly – after undergoing a piercing or tattoo. In such cases, it's imperative to obtain a thorough medical history, including details about how and when the body modification was made, says Canfield.

Once again, she emphasizes the importance of offering encouragement and refraining from judgment. "These infections can sometimes progress very rapidly, so it's important to make these patients feel comfortable about seeking medical care," says Copley. "By the time a patient arrives, the modification has already happened. We can't turn back the clock, but we can tell them how glad we are that they sought care."

Nurses may also find themselves counseling patients with preexisting conditions like diabetes or HIV who are interested in getting body modifications. Although safety is a justifiable concern in high-risk populations, Canfield encourages nurses to thoughtfully explore the patient's questions before reflexively telling them to avoid these body modifications altogether.

"In many cases, the patient has already decided to pursue the piercing or tattoo, so fearmongering does them a disservice," she says. "The most compassionate, practical thing we can do is help them navigate the safest way forward."

KNOWLEDGE IS POWER

If a nurse is unsure about how to handle a body modification, the first person they should talk to is the patient, says Copley. From gauges and barbells to surface-anchor screws and implants, the number of available body piercings continues to grow – which, she explains, is another reason nurses must rely on the expertise of their patients.

"The patient is the true authority on their body modification," she says. "They can often provide the best guidance on how a piercing can be removed without damaging the jewelry or the patency of the piercing pathway."

However, Copley cautions that piercing removal can cause significant stress for some patients and encourages clinicians to consider other possibilities before reaching for a hemostat. She also urges nurses to ask about the presence of piercings even if none are readily visible during the examination.

For additional guidance on the management of body modifications, Copley and Canfield suggest reviewing *The Piercing Bible* by Elayne Angel. Local body-modification artists can be another valuable source of education, they add.

Email comments to notablenursing@ccf.org.

Banners stationed at all hospital entrances remind guests of Cleveland Clinic's position on violent behavior.

Nursing Leaders Respond to New Joint Commission Standards on Workplace Violence Prevention

EXPERTS EMPHASIZE IMPORTANCE OF EDUCATION, PREPAREDNESS

Healthcare workers are five times more likely to suffer a violent injury at work than those in any other industry, according to the U.S. Bureau of Labor Statistics.[1] In an attempt to slow the steady rise of these incidents, The Joint Commission has issued new standards that outline how healthcare organizations can use policy changes, monitoring and education to address the growing problem.[2]

We sat down with two Cleveland Clinic nursing leaders – Barbara Morgan, MSN, RN, NE-BC, Associate Chief Nursing Officer of Emergency Services, and Mary R. Sauer, DNP, MBA, RN, NEA-BC, Chief Nursing Officer at Cleveland Clinic Avon Hospital – to explore how the health system is addressing the national issue of workplace violence.

Q: The Joint Commission standards outline a number of new protocols concerning data collection, workplace analytics, and educational and staff responsibilities. How would you characterize the major thrust of these updates?

Barbara Morgan, MSN, RN, NE-BC

Morgan: Most importantly, The Joint Commission's standards are collectively drawing attention to a critical issue that affects virtually every healthcare worker in the country: workplace violence. At Cleveland Clinic, we have intentionally taken a proactive approach to building a culture of safety and emphasizing that violence directed toward our staff, our patients and/or our visitors – in any form – is unacceptable. The new requirements reinforce this important message with four specific standards that apply to caregivers at every level.

Mary R. Sauer, DNP, MBA, RN, NEA-BC

Sauer: Nurses have traditionally regarded certain aspects of workplace violence – such as verbal harassment from patients – as an unavoidable part of the job. Fortunately, that is beginning to change. No one should have to work in an environment that makes them feel mentally or physically vulnerable. The new standards not only reiterate that point, but they describe effective paths to ensure both the physical and psychological safety of every member of the healthcare team.

Q: The new guidelines entail using data to identify and monitor violent incidents. Can you share how Cleveland Clinic plans to collect and use this information?

Sauer: When it comes to workplace violence, knowledge really is power. Five years ago, we developed a committee dedicated to tracking and analyzing violent events that occur. We've been able to gather and analyze data from across the enterprise, including information collected by the Cleveland Clinic Police, the U.S. Occupational Safety and Health Administration, and our health system's dedicated online Safety Event Reporting System.

Morgan: Each group has its own process for reporting violent events, so we are continuing to work with all parties to better standardize how we collect and document these data. Synthesizing the data has been a challenging process, but the information we've gathered has been instrumental in informing our priorities and guiding our strategies for identifying and mitigating potential threats.

Q: The new guidelines emphasize the importance of clinical education and training. How is Cleveland Clinic encouraging its caregivers to learn more about the prevention of workplace violence?

Sauer: We emphasize the prevention of workplace violence in every caregiver's new-hire period. Our new-employee orientation process stresses the importance of personal safety and outlines our organizational policies and procedures for managing and mitigating potentially violent incidents. We also provide periodic educational sessions hosted by leaders from our Nursing, Protective Services, Ombudsman and Caregiver offices.

In addition to having a visible police or security officer present 24/7, our emergency department entry points are all equipped with metal detectors for weapons screening. Furthermore, our caregivers are taught de-escalation strategies for handling potential threats and are trained to respond to major events, such as active-shooter situations. We also highlight our zero-tolerance policy regarding violence by placing "safe workplace" signage in high-visibility areas throughout our hospitals.

Morgan: Our collective goal is to ensure that every caregiver in our enterprise is aligned in their ability to recognize, prevent and respond to workplace violence. Our success in providing a safe, nurturing work environment is largely dependent on our ability to execute a uniform response to violent incidents. It's critical for everyone to be on the same page, and preparedness is paramount.

Q: The last standard in The Joint Commission's guidelines suggests that hospital leaders are chiefly responsible for creating and maintaining a culture of safety and quality. How are Cleveland Clinic leaders rising to this challenge?

Morgan: This is where Cleveland Clinic excels. The prevention of workplace violence is an enterprisewide priority. From our CEO to every caregiver, ensuring the safety and well-being of others is a shared mission. We have identified and trained leaders at every level to recognize risk factors for violent behaviors, diffuse them and support those affected. When faced with a potentially violent scenario, our caregivers know where to turn for guidance and support.

Sauer: We didn't waste any time in implementing a multidisciplinary approach to workplace violence. By collaborating with experts throughout our health system, we were able to execute definitive strategies and protocols for addressing threatening behavior.

Preventing workplace violence is truly a collaborative endeavor. Thanks to the leadership at every level of our organization, I'm confident that we will continue to meet – and even surpass – the new Joint Commission requirements aimed at reducing incidents of workplace violence in the healthcare setting.

Email comments to notablenursing@ccf.org.

Cleveland Clinic Police Corporal Nicole Drayton consults with Alex Thomas, PCNA, during a patient safety watch.

References

1. *"Fact Sheet: Workplace Violence in Healthcare." U.S. Bureau of Labor Statistics, 2020. April 1. https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm*
2. *"Workplace Violence Prevention Standards." The Joint Commission, 2021. June 18. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/wpvp-r3_20210618.pdf*

Systemwide Safety Protocols Provide Anti-Violence Road Map

Nurse leaders Barbara Morgan and Mary Sauer outline specific measures Cleveland Clinic has put in place to prevent workplace violence, including:

- Giving caregivers a voice through the "see something, say something, do something" initiative, which encourages reporting every incident, no matter how small.
- Enhancing security measures at points of entry (magnetometers/handheld magnetometers) to prevent weapons from entering facilities.
- Implementing a 24/7 police presence in all emergency departments through the Cleveland Clinic Police department and partnerships with local municipalities.
- Requiring Non-Abusive Psychological and Physical Intervention (now known as Welle) training for all emergency and behavioral health caregivers and other clinical providers.
- Increasing caregiver drills and training.
- Posting notices in high-traffic areas that declare, "All staff have the right to carry out their work without fearing for their safety" (per an Ohio House bill).

To report serious safety events, Cleveland Clinic caregivers use the Safety Event Reporting System (SERS), which includes filling out a safety event report, documenting the event in the patient's chart or note, telling co-workers and managers about the event, and filing a police report. For extremely severe events, a "serious safety flag" is also created that requires a "hard stop" for anyone caring for that patient — caregivers cannot access the patient's chart without first reviewing the safety concerns and recommendations on how to safely provide care for the patient.

Cleveland Clinic's Ombudsman Office tracks all SERS events across the health system utilizing a workplace violence checklist on which every aspect of the event is noted and documented. The office follows up with patients/visitors after an event to offer added assistance, ensure they understand that what they did was wrong, and take further action as needed (behavior agreement, restricted visitation, discontinue servicing the patient, etc.). When speaking with patients/visitors, the office follows a model known as **HEART**: **H**ear the story, **E**mpathize, **A**pologize, **R**espond to the problem, and **T**hank them.

New Faculty Fellowship Prepares Nurses to Navigate Moral Challenges

PROGRAM FOCUSES ON NURTURING ETHICS LEADERS IN DAILY PRACTICE

Nurses are routinely called on to deal with ethical challenges in which they must weigh competing values when deciding how to proceed. Some clinical situations raise ethical questions that challenge nurses' professional principles – or even their organization's clinical protocols. A new Cleveland Clinic fellowship aims to help nurses navigate morally complex, emotionally charged situations by providing them with education and practical experience in nursing ethics and bioethics.

Established in 2021, the Nursing Ethics Faculty Fellowship offers nurses a unique opportunity to gain real-world training in the management of ethical challenges in healthcare. The program is a collaborative effort between the Stanley Shalom Zielony Institute for Nursing Excellence and the Center for Bioethics.

Georgina Morley, PhD, MSc, RN

"Ethics is at the heart of everything we do as nurses," explains Georgina Morley, PhD, MSc, RN, who directs the program. "Even something as seemingly simple as deciding which patient's call light to respond to first can have ethical repercussions. This fellowship helps weave the study of ethics, which is often rushed or absent in nursing training, into the day-to-day development of nursing professionals."

Georgina Morley, PhD, MSc, RN, rounds with nurses as they discuss the care of their patients.

PRINCIPLES OF ETHICAL PATIENT CARE

Cristie Cole Horsburgh, JD

When caring for patients, nurses can face ethical dilemmas for a wide variety of reasons, explains Cristie Cole Horsburgh, JD, Associate Director of the fellowship program. Difficult questions frequently arise regarding the protection of patients' rights, informed consent for treatment, advance care planning, surrogate decision-making, end-of-life care and more.

"Although it's virtually impossible to avoid moral dilemmas when you're accountable for the well-being of patients, nurses can equip themselves with the knowledge necessary to address these issues with confidence," she says. "The fellowship provides a framework for supporting the emotional, physical and psychological health of each patient while complying with the responsibilities and principles that govern nursing practice."

One of the key goals of the fellowship is to help nurses acquire the skills needed to create a more ethical climate, says Horsburgh.

"Faculty fellows are able to lead ethics rounds with nurses and other caregivers who have been confronted with an ethics question and may be experiencing moral distress," she says. "These opportunities allow nurses to pinpoint potential problems and intervene before they become full-blown ethical conflicts. Fellows are also encouraged to work with unit leadership to address systems-oriented issues and help mitigate future experiences of moral distress."

EDUCATING NURSE ETHICISTS

To be eligible for the fellowship, an applicant must be a registered nurse employed by Cleveland Clinic and hold a master's or terminal degree (DNP, PhD, JD). A strong interest in bioethics scholarship and practice and good organizational, time management and communication skills are required, as is the ability to work both independently and collaboratively. Each faculty fellow is expected to design and conduct a nursing ethics project during their fellowship year that examines an area of nursing ethics and enhances the delivery of care in clinical practice, explains Morley.

Dianna Copley, DNP, APRN, ACCNS-AG, CCRN (right), counsels Kristin Cantrell, RN.

Dianna Copley, DNP, APRN, ACCNS-AG, CCRN

Ethical challenges faced by nurses during COVID-19 were the subject of the project completed by the program's inaugural fellow, Dianna Copley, DNP, APRN, ACCNS-AG, CCRN, who worked in collaboration with Morley and two other nursing colleagues. Results of that research and reflections on the faculty fellowship and Nursing Ethics Program were presented at the Nursing Institute's grand rounds and the annual conference of the American Society for Bioethics and Humanities in October.

Copley explains, "The fellowship has improved my confidence in recognizing and interpreting ethical situations and intervening when they arise. In my role as a clinical nurse specialist, the program has provided me with the tools to mentor other nurses at the unit and system levels."

In addition to completing an ethics project, fellows are required to:

- Participate in a weekly seminar and semiweekly reading group in conjunction with other Center for Bioethics fellows and faculty.
- Spend a week shadowing a staff ethicist on Cleveland Clinic's Ethics Consultation Service.
- Attend ethics rounding and nursing ethics huddles.
- Demonstrate ethics competencies based on the American Nurses Association Code of Ethics.

The fellowship demands a weekly time commitment of four hours for educational sessions, mentorship meetings and nursing ethics rounds/huddles. Fellows receive protected time to complete the program.

"My hope is to create and sustain a network of nurses who have expertise in exploring the ethical dilemmas of patient care through the lens of nursing practice," explains Morley. "Although managing competing personal and professional values can be a career-long challenge, we believe our nursing fellows will emerge from this program with the sound judgment needed to address conflicts with logic and sensitivity."

Email comments to notablenursing@ccf.org.

Study Connects Hospital Support, Strong Mentorship with the Growth of Nurse-Driven Research

FINDINGS REVEAL PERSONAL AND PROFESSIONAL FACTORS THAT INFLUENCE NURSES' INTEREST IN MEDICAL RESEARCH

Jennifer P. Colwill, DNP, APRN-CNS, CCNS, PCCN

Nurses comprise the largest group of clinical providers in the world, yet a surprising few ever become involved in healthcare research focused on medical and nursing themes. A new study by Cleveland Clinic nurses aimed to identify some of the reasons for this shortfall so healthcare leaders could adopt processes that encourage more nurse-driven investigations.

In the study, ASSESS RN – Associations Between Nurses' Characteristics and Engagement in Clinical Research, investigators found that those who displayed attributes that reflect ongoing professionalism and participated more actively in the field of nursing or their particular organization were more likely to engage in research activities. Other factors that encouraged the pursuit of research included having a robust professional support system and adequate protected time.

"It quickly became clear that nurses who worked in encouraging, collaborative settings were far more motivated to pursue research," explains Jennifer Colwill, DNP, APRN-CNS, CCNS, PCCN, who led the study. "In previous research, work environment played a role in nurses' career satisfaction and well-being. In this study, it was exciting to find that there was a direct link between research activity and the level of professional support nurses received."

Searching For Answers

The study began with a review of existing literature, which revealed some facilitators of and many obvious barriers to nursing research; however, it didn't address the full array of factors, explains Colwill, a clinical nurse specialist at Cleveland Clinic Hillcrest Hospital.

"Frankly, we were surprised by the number of opportunities that clinical nurses did not take advantage of, as there were many options available that would foster scientific inquiry," she says. "The discovery immediately prompted the question 'What is keeping nurses from conducting research?' It was evident that something was limiting them from actively pursuing scientific study."

> "It's apparent that nurses who had support, especially from nurse-scientist mentors, were more comfortable conducting research than nurses who did not have such interactions."
>
> — *Jennifer P. Colwill, DNP, APRN-CNS, CCNS, PCCN*

The team began by surveying 310 nurses to gather multiple details. Researchers evaluated participants' professional experiences, including prior research engagement, professional certifications and other forms of career development, and assessed whether participants received dedicated time or grant support for previous research projects. Finally, the questionnaire assessed a variety of individual psychosocial factors, including curiosity, locus of control, grit, social support and comfort in conducting research.

In the analysis, study investigators grouped the self-assessed research activity of participants into four categories based on related themes. Nurses who were most active in their careers – as evidenced by more than one certification, participation in professional development activities or work groups, and organizationwide quality improvement initiatives – were more likely to be active in research.

"It's apparent that nurses who had support, especially from nurse-scientist mentors, were more comfortable conducting research than nurses who did not have such interactions," says Colwill. "Although the pursuit of research requires a certain level of personal ambition, healthcare leaders play a pivotal role in the availability of research resources, including mentors who provide guidance and encourage the development of nurse-led studies."

Interestingly, nurses who reported a personal experience with the healthcare system – as either a patient or the family member of a patient – were also more likely to pursue research opportunities.

The Big Difference a Little Support Can Make

Colwill explains that new knowledge helps confirm and validate the findings of other nurse researchers who had similar conclusions. In addition, she hopes the findings will encourage hospital leaders to continue and even advance their structured support systems and processes for nurses who conduct research, including providing them dedicated time to focus on individual projects.

"By carving out time so nurses can step away from clinical work to focus on conducting, disseminating and translating research, healthcare systems benefit," she says. "Intellectual curiosity can be

fostered in all nursing caregivers, and leaders can build on their organization's research capacity."

Next, Colwill's team will look for ways to translate their findings into enterprisewide changes at Cleveland Clinic. She recommends that any nurse with an interest in research seek opportunities and support by contacting a research mentor and becoming more involved in professional development programs.

"Nurses spend nearly every working moment observing, treating and talking with their patients, so they possess a deep, very personal understanding of clinical care," she adds. "A nurse's perspective can be quite different from that of other providers, whose interactions with patients are often limited. It's imperative for research to reflect nurses' unique voice."

Email comments to notablenursing@ccf.org.

Advance Directives for Older Adults: Why Are Completion Rates Low?

NURSES AIM TO FIND ANSWERS IN LARGE GERIATRICS STUDY

Virginia Donofrio, RN, GERO-BC, AMB-BC

Previous research shows that, despite their older age, adults treated in geriatric clinics may not perceive themselves as frail or nearing the end of life. Consequently, some older patients are insufficiently motivated to complete an advance directive or designate a healthcare proxy – steps that can help families and caregivers avoid the stress of making medical decisions on their behalf. Despite the ubiquity of the problem, specific factors that influence the completion of advance directives remain poorly understood.

To better assess the factors that contribute to the phenomenon's pervasiveness, a Cleveland Clinic ambulatory nurse led the evaluation of more than 1,600 patients treated in the Geriatric Clinic of Cleveland Clinic's Weston Family Health Center in Florida. The study's primary investigator, Virginia Donofrio, RN, GERO-BC, AMB-BC, says it is the largest study of its type conducted within a U.S.-based health system.

"Our findings indicate that advance directive documentation rates are low, which is troubling because it illustrates how frequently patients are forgoing the opportunity to express their own healthcare preferences," she says. "Our research shows how important it will be to increase awareness about this universal issue and help inform specific interventions that encourage advance planning."

Assessing Prevalence and Identifying the Causal Factors

The study aimed to answer four major research questions using data available in patients' electronic health records (EHRs). Researchers analyzed the number of complete advance directives in EHRs as well as the prevalence of incomplete or blank documents. The team also assessed how often patients declined to complete an advance directives, as noted in EHRs. Patient factors thought to be associated

According to experts, the low-pressure primary care setting is ideal for exploring a patient's end-of-life wishes.

Advance Directives for Older Adults: Why Are Completion Rates Low?

(continued)

with completion of an advance directive were assessed, as were comorbidities known to have higher rates of morbidity and mortality.

For analytic purposes, patients with "complete" documentation included those who had both a living will and a healthcare proxy; patients with "partial" documentation had either a living will or a healthcare proxy; and those with "no" documentation had neither a living will nor a healthcare proxy documented in their records.

Among the sample assessed, patients with complete documentation tended to be older, had more comorbid conditions and were more likely to be white. Patients with a complete advance directive were more likely to die in the year following the assessment date. Of most importance to investigators, the majority of patients had neither a living will nor a healthcare proxy on file within the EHR.

Donofrio notes that complete documentation is typically filed in Epic as part of the patient's EHR, which makes it accessible to providers from different medical centers when needed.

Advance Directives in the Primary Care Setting

"The take-home message is that we have to increase the frequency of discussions (both those attempted and declined and those that are completed) to understand patient preferences," she says. "Care planning is a process, and some patients may not be ready to discuss these options. In addition, we need to ensure that healthcare clinicians who discuss care planning document their findings, as documentation conveys communication with patients and their family caregivers. We know that discussions about end-of-life care are best approached while patients are still healthy and capable of making their own decisions – but, too often, opportunities are missed."

Donofrio says that the primary care setting is ideal for exploring a patient's end-of-life wishes. "The process is best addressed in a reassuring, low-pressure environment, where the patient's questions and concerns can be normalized," she says. "I encourage clinicians to explain that advance directives are designed to reflect what matters most to individuals, which is a vital part of ensuring that they receive the best care possible – now and through the end of life."

Donofrio also emphasizes that the benefits of planning extend beyond the well-being of the patient. It helps families and medical professionals avoid the unnecessary strain of making healthcare decisions without the direct input of the patient. "It can be incredibly stressful to make medical decisions on behalf of someone who is too ill or incapacitated to provide guidance," she explains. "These end-of-life scenarios can introduce discord – and even legal conflict – that can be avoided by having an advance directive on file."

Email comments to notablenursing@ccf.org.

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Tina Resser, CNP, a nurse practitioner with Cleveland Clinic's endovascular and open cerebrovascular program, was named Ohio Nurse Practitioner of the Year by the American Association of Nurse Practitioners.

Shannon A. Rives, MSN, APRN, ACNS-BC, CCRN, won the 2022 *MEDSURG Nursing* Quality Improvement Writer's Award for her peer-reviewed journal article "Decreasing Central Line Infections on a Medical-Surgical Unit." She is a clinical nurse specialist in Cleveland Clinic's inpatient gastroenterology, hepatology and abdominal transplant units.

Deborah Small, DNP, RN, NE-BC, Chief Nursing Officer (CNO) for Cleveland Clinic London, has been inducted as a Fellow of the American Academy of Nursing. Known as an intuitive leader with a focus on human relations, healthcare safety and nursing advocacy, Small has held numerous administrative and academic roles. She previously served as CNO of Cleveland Clinic Fairview Hospital and Associate CNO of Quality and Practice.

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