Correct dosage?

In the case study in the article, “Managing Patients With Acute Thyrotoxicosis” (February 2002:62), the “patient was given 40 mg of propranolol intravenously and then was given 2 mg of hydrocortisone intravenously every 6 hours. Propranolol was continued on an as-needed basis for heart rate greater than 100/min.” Am I correct in assuming that the dosages of these 2 drugs are reversed? This matter came to my attention recently because this dose of propranolol was ordered postoperatively by a surgeon (not a cardiologist or medical management physician) and I questioned it because the dose of propranolol is 1 to 2 mg intravenous slowly. I am hoping this is an error in the case study, but we should also be aware of errors in physician orders.

Joan Duckworth, RN, CCRN

The author responds:

Thank you for your letter concerning the article titled, “Managing Patients With Acute Thyrotoxicosis.” You are absolutely correct in assuming that the dosages of these 2 medications were reversed. I apologize for the misprint and thank you for following up with Critical Care Nurse regarding your astute observation. The sentence in the case study should read: The patient was given 2 mg of propranolol intravenously and then was given 40 mg of hydrocortisone intravenously every 6 hours. Propranolol was continued on an as-needed basis for heart rate greater than 100/min.

Rebecca Dahlen, EdD, MSN, RN-CS, CCRN
Long Beach, Calif

Acceptance of death and dying

After reading the Guest Editorial, “Lessons for Critical Care Nurses on Caring for the Dying? (February 2002:11), something clicked inside my head. Zara Brenner said, “Deaths are interpreted as failures, and people don’t take pride in what they could not accomplish. In the hospice/palliative care unit, success is defined by the quality of the process, not by the outcome.” With all the technological advances in the critical care setting, it is unsettling when we are not able to save someone. I asked myself throughout the article if this was a cultural phenomenon. Is it so hard to accept because we, as a country, have so many treatment options and, often, a seemingly endless resource pit?

Hospice has provided an alternative to dying in the hospital hooked up to every tube possible. I believe the concept of hospice has paved the way for pain management across the spectrum. However, hospice continues to have barriers. Healthcare practitioners hesitate to refer patients to hospice for fear of losing control of the patient’s healthcare or missing a treatment that could delay the inevitable. I was attracted to the hospice concept early on in nursing school because of its leadership role in interdisciplinary care, patient- and family-centered approach to care, and acceptance of what is meant to be. Hospice continues to make impressive progress across the world.

While attending an international research conference, our group discussed cross-cultural beliefs such as the circle-of-life phenomenon, family commitments, and how third world countries can be more advanced in their acceptance of death and dying. Our society tends to be “outcome” driven when it comes to effective therapies, whereas other countries view the “process” with equal importance. Fortunately, many clinicians and researchers are identifying the need for interventions leading to “a good death.” I hope more educators will see the importance of closing the knowledge and comfort gap in individual nurses, and include death and dying as an integral part of school curriculum and job orientation.

Connie Jaenicke, RN, BSN
Minneapolis, Minn
Make a difference with mentoring

The Editorial in the December 2001 issue, “Findings From Reader Survey on RN Shortage: I Still Love Nursing, but...” (December 2001:6), provided a detailed report of comments regarding the current and projected shortages of registered nurses. The summary of these comments reflected concerns and frustrations of today’s nursing environment and brought the reader’s attention to the areas that are in need of change within nursing. This is a time of rapid change in healthcare and though solutions to issues in our work environment and nursing practice are being developed, nurses have the opportunity to use the power that already exists in the role of the bedside nurse; that role is mentoring. Through mentoring, nurses can continue to create a common bond, feelings of acceptance, and a sense of loyalty within the profession. Mentoring is critical in nursing.

As expressed in the survey, nurses are constantly faced with the daily challenge of providing care in a setting characterized by increased patient acuity, inadequate staffing, and fewer resources. These conditions leave little time for providing leadership and patience, sharing experiences with the new nurse, and building trusting relationships required for the mentoring process. Despite the current environment, nurses must make the time to mentor. Experienced critical care nurses have a knowledge base of vast clinical expertise, realize the importance of evidence-based practice, and could not manage the care of our patients without the wisdom and expertise acquired over time. Nurses who have expanded their professional involvement by serving as committee chairpersons and leaders in patient care areas should include mentoring others to expand their leadership role by offering continuing education, providing opportunity for growth, encouraging certification, and facilitating the opportunity for the new nurse to network with others in his or her specialty area.

There are those of us who “still love nursing” and have the belief that we can ultimately bring about change, not only in the environment in which we care for our patients, but by nurturing those who will follow in our footsteps. We must not become overwhelmed and completely distracted by the ongoing changes, but continue to nurture and empower each other, as well as the new faces we meet each shift.

Nurses do have the power to make a difference, not only in the lives of our patients and families but also in the environment in which we practice. With continued mentoring we make that difference, one nurse at a time.

Selected References

Catherine Simmons, RN, CCRN
Silk Hope, NC

CORRECTION
In the February issue, Medwave’s Vasotrac APM205A was featured in the New Products section (p. 81). This BP monitoring device measures a patient’s BP continually every 15 seconds, not every 15 minutes as printed. For a full review of the Vasotrac APM205A, see page 91.
Acceptance of death and dying
Connie Jaenicke

Crit Care Nurse 2002;22 18
Copyright © 2002 by the American Association of Critical-Care Nurses
Published online http://ccn.aacnjournals.org/

Personal use only. For copyright permission information:
http://ccn.aacnjournals.org/cgi/external_ref?link_type=PERMISSIONDIRECT

Subscription Information
http://ccn.aacnjournals.org/subscriptions/

Information for authors
http://ccn.aacnjournals.org/misc/ifora.xhtml

Submit a manuscript
http://www.editorialmanager.com/ccn

Email alerts
http://ccn.aacnjournals.org/subscriptions/etoc.xhtml