Placement of a nasogastric tube

I recently read the article “Brain Tissue Oxygen Monitoring in Severe Brain Injury, II (August 2003:29-44). I found this article very insightful, but I must disagree (clarify) one point. Table 1 calls for the placement of a nasogastric tube; however, traumatically brain-injured patients may also have basilar skull fractures (the periorbital ecchymosis or Battle’s sign may not manifest itself for a few hours) and there may be associated facial fractures. Therefore, we teach that an orogastric tube should be inserted in the face of traumatically brain-injured patients. This article was cited recently during a discussion we were having in our surgical intensive care unit. Gastric decompression is important, but the nasal route should be avoided initially until all other injuries are ruled out.

Carol Rajda, RN
Detroit, Mich

The authors respond:

The reader raises a point that needs clarification. According to ATLS and ATCN guidelines, placement of a tube to the stomach for gastric decompression in a severely brain-injured patient should be through the oropharynx. In Table 1, the wording “nasogastric” tube was an oversight and deserves clarification. At our trauma center, all traumatically brain-injured patients receive an orogastric tube for gastric decompression. The placement in the oropharynx not only is the preferred method to prevent inadvertent placement of the tube through a basilar skull fracture but it also reduces the risk of sinus infections. Thank you for this opportunity to clarify a very important issue.

Mary Kay Bader, RN, MSN, CCRN, CNRN
Mission Viejo, Calif
Linda R. Littlejohns, RN, MSN, CCRN, CNRN
Karen March, RN, MN, CCRN, CNRN
San Diego, Calif

Bedside nursing is “hard” and therefore undesirable

In the article, “New Graduates: A Precious Critical Care Resource” (October 2003:47-50), much time and effort went into describing the nursing shortage and educational paths toward emotional mentoring of new graduates. This article underlines some real issues that need to be addressed. There is a reason people over age 40, or under age 40 for that matter, don’t stay at the bedside. Who wants to work long hours, weekends, holidays, and night shifts? Who wants to tolerate an undermining pay scale, verbally abusive medical staff, and unrealistic administration? Indeed, new graduates are our precious resource; it is important to nurture them the best we can. However, sooner or later, our new graduates will come to the conclusion that bedside nursing is a hard profession. There is a reason nurses go back to school to get their master’s or doctoral degrees: for better and higher-paying jobs with less stress, better hours, and more respect. I cannot deny this fact to my new graduates if they ask. Furthermore, I would never advise my children to become nurses, unless they get a master’s or doctoral degree. Perhaps the answer to the nursing shortage must come from those who so idealize the profession. If the author of this article, and others like her, worked at the bedside 12 to 24 hours a week, perhaps the bedside nurse can be enlightened with their presence and such positive thinking. Otherwise, those who live in glass houses should not throw stones!

M. Chauvette, RN
N. Alexander, RN, CCRN, TNCC
Indianapolis, Ind

The author responds:

The American Nurses Association surveyed 7271 nurses, and found that 54.8% of those surveyed would not recommend nursing as a career to their children or others and 23% would “actively discourage” an interested person from entering the nursing profession. The authors of this letter to the editor aptly stated many reasons why so many
nurses might share this opinion. However, these nurses equate furthering education in nursing with an escape from the patient bedside. The authors also appear to believe that new graduates in critical care who leave their positions to further their educations do so for the explicit reason of escaping the problems that are described as concomitants of bedside nursing.

In reality, I believe that advanced education is the key to advancing the profession, and that ultimately, education offers the greatest hope for alleviation of the nursing shortage. Younger-generation nurses are looking for opportunities and challenges over the entire span of their careers, not stagnation. Maintaining a vision that equates successful nursing with skill acquisition, knowledge application, and knowledge generation, as described by Wieck, will allow them to continue to make an impact at the bedside rather than drive them away from direct patient care. Wieck’s model of the nurse as doer, thinker, practitioner, and researcher offers veterans, as well as the new generation of nurses the opportunity to thrive, not just survive in today’s ever-changing healthcare environment.

More than 20 years of critical care nursing practice as a staff nurse, charge nurse, staff development educator, and academic nursing instructor (who maintained practice hours at the bedside while teaching) have taught me that failure to communicate the many opportunities available to professional nurses will ultimately result in the members of the new generation bypassing careers in nursing. Are we as incumbent nurses ready to see nursing as we know it disappear altogether? I do not wish to see successive generations avoid nursing because they feel it is not a meaningful profession. What opportunities and challenges might future generations miss by foregoing the hard work, but also the untold satisfaction, that a career in nursing affords? I know that there are other nurses who share this belief about our profession, and I am grateful to them for mentoring the next generation of nurses who are so badly needed to care for critically ill patients.

References

Ainslie T. Nibert, RN, PhD
Houston, Tex

Missing opportunities to practice in ICU settings

I am writing this letter in regards to the article “New Graduates: A Precious Critical Care Resource” (October 2003:47-50). While I fully agree with the author’s analysis of the nursing shortage and how the shortage of new graduate nurses affects the work place, I believe that she has overlooked a major resource—experienced RNs. I have been practicing for 4 years and as I looked for a nursing position where I could be trained in intensive care unit (ICU) nursing, I found very little in the way of hospitals that were willing to train me. I have worked the last 18 months in an ICU step-down unit and moving up to ICU is where I had hoped to progress to next. However, I was limited to another step-down job. The title of the article gives rise to the notion that new graduates are the main resource for ICUs to recruit new staff, but I feel that as a new graduate, I had no place in the ICU and now, as a nurse with 4 years experience, I cannot find a hospital that will train me.

Michael Loyd, RN, BSN
Modesto, Calif

The author responds:

Lynn Wieck, RN, PhD, President of the Texas Nurses Association and CEO of Management Solutions for Healthcare wrote that the major challenge for today’s nurses is to be attractive to the younger generation. Nurses with 4 years of experience, such as this author of the letter to the Editor, represent the new generation of nurses. Wieck describes this group as desiring expanded opportunities and smooth transitions from one practice area to the other in order to expand their skills and receive recognition for their work. I completely agree that these nurses should be offered the positions they desire in critical care, and also recognize that many healthcare institutions should (and I believe that most do) welcome these new nurses with open arms, especially in view of the vast numbers of staff nurse vacancies in many ICUs today. However, it is important that these new recruits receive a comprehensive orientation based on an objective competency assessment, which will prepare them adequately for their new critical care positions.

References

Ainslie T. Nibert, RN, PhD
Houston, Tex
Preceptors helping with remediation

As a nurse educator working within an undergraduate program, I was very interested in the ideas presented in the article, “New Graduates: A Precious Critical Care Resource” (October 2003:47-50). Although our program uses a different comprehensive test than the Exit Exam (E2) of Health Education Systems, it does use a standardized series of testing to identify students who are at risk for NCLEX-RN and it requires these students to do remediation. Although our remediation program has been successful in NCLEX pass rate, it is certainly not the complete answer. The idea of using preceptors to help with this remediation seems exciting; however, I do see a problem. Unless the preceptors are also members of the faculty, students’ rights to privacy would prevent disclosure of scores without student consent. Because students often do not feel that a test score truly reflects their knowledge, I question that all students would wish for the preceptors to be aware of their low scores. Perhaps a better approach would be if all nurses working with students would try to take the time to share decision-making approaches and/or ask students questions about how a decision could be reached. Frequently, staff nurses/preceptors only ask factual questions or even tell the student what needs to be done. This approach does not allow the students to grow or have any insight into their own deficits; thus the student perception, “I really know the information. I am just a bad test taker.”

Students tend to believe that the preceptor is much more realistic about what a nurse really needs to know than the nursing faculty. Therefore, if the students can follow the preceptor’s directions, the student believes he or she is being successful. Of course, there are times when direction is the only safe thing to do, but if the experienced nurse truly values the student/new graduate, the time spent helping all students, not just the ones with low test scores, learn to think critically will be an investment in our profession and in our own future healthcare. I believe the author is on the correct path; I would just like to see the path widened.

Jo Ann Jenkins, RN, MSN, CCRN
Kansas City, Mo

The author responds:

I agree with this reader—student consent is essential for disclosure of exam scores. However, I believe that many students will willingly share such information if it is sought as a means of assisting them in becoming successful candidates to the NCLEX-RN, as well as successful new staff members.

Use of exam findings for a positive outcome is likely to encourage the new graduate to share such information so that the preceptor has a base upon which to build teaching-learning experiences. Additionally, because many nursing programs require a minimally acceptable score on these exams for the student to progress to graduation, new graduates from such programs will have achieved at least this minimally acceptable score. Therefore, exam findings related to the individual’s strengths and weaknesses can be addressed in a safe and helpful environment, an environment created by the preceptor and one in which the preceptor is viewed as an advocate of the new graduate.

There is no question that the “Socratic questioning” approach to teaching and learning in the clinical area is extremely valuable for all those involved. However, the use of such an approach does not negate the value of additional information, such as those data provided by standardized exams, NCLEX-RN performance, and hospital-based competency assessments. Use of this information to guide orientation to a specific clinical area, while providing an atmosphere that is nonthreatening and one that encourages use of Socratic questioning, seems to me the best use of available resources—the preceptors’ guidance and the data provided by reliable and valid measurement tools. Orientation is an expensive endeavor, and the use of objective data to help determine which new graduates are most likely to be successful within a specific work environment is, I believe, an economic use of the limited resources available for new employee orientation.

Today’s healthcare environment, and the current nursing shortage, require us to work together creatively to provide the best possible care for the critically ill. We cannot afford to lose even one new RN who wishes to pursue a career in critical care nursing. We owe it to ourselves as experienced critical care nurses, and we owe it to our patients, to find new ways of “widening the path” so that we can conserve our precious resources: the next generation of nurses, who will one day care for us!

Reference


Ainslie T. Nibert, RN, PhD
Houston, Tex
Chemical warfare issues

I read the article, “Chemical Warfare: Toxicity of Nerve Agents” in your October (2003:15-22) issue. It amazes me how many articles and how many journals are publishing “terrorism-related” material. There seems to be such a rush on the material that errors are often overlooked. I found some errors in the article as follows:

On page 15, it is written that “…differences in these properties influence an agent’s potential as a biological [hazard].” Chemicals are not alive! Chemical agents are not biological agents.

On page 15, it is also written that VX can persist on the ground for 2 to 6 days. Actually, it can persist for weeks.

On page 18, the authors state that treatment “begins with the rapid removal of the agent through a decontamination process.” This only applies to contamination (liquid on skin or clothing). For an exposure (inhalation), no decontamination is required.

On page 18, the authors state that removal of the aerosolized agent is done by removing clothing and thoroughly rinsing the skin with soap and water. However, when the nerve agent is inhaled (aerosolized), no soap and water is needed. Just remove the clothing and treat the victim.

On page 18, the authors state that patients should not enter the emergency department until “complete decontamination is verified.” There is no means to verify.

In the article (page 19), diazepam is listed as a treatment and the authors state that the intramuscular route is an alternate to intravenous administration. Actually, diazepam is poorly absorbed via the intramuscular route. Lorazepam (Ativan) is a good intramuscular alternate if intravenous access is unavailable.

Overall, the article may have been a good review, but not useful as a practical guide, as it lacks specificity.

Mark Hollinger, RN, MICN, EMT-B
Los Angeles, Calif

The authors respond:

Please keep in mind that our summary was meant as an overview. We do note that detailed emergency protocols must be developed by each agency. All the information reported is supported by the references listed; however, a few of the references vary regarding some of the details. The information presented is in agreement with the Center for Disease Control (CDC) Web site. We do use the term “biological weapon” because these agents can destroy biological and physiological systems. Even though agents may cause death by inhalation, they may persist on clothing and skin for a period of time. Therefore, decontamination is advisable. Whenever history suggests that a chemical exposure has occurred, it is also advisable to decontaminate outside the emergency department for protection of personnel and patients. Lastly, valium is the antidote recommended by the CDC.

Tina Martin, RN, MSN, FNP
Sharon Lobert, RN, PhD
Jackson, Miss

Family visitation

After reading Protocols for Practice Update 2003 in the October issue, my brain would not let go of the subject matter. The adult critical care unit I work in has very liberal visiting policies. This fact has led us to consider limiting our access, not increasing it.

Critical care nurses are increasingly looked at as the coordinator of care as well as the provider of direct patient care. When an RN is charged with the care of 2 critically ill adults, it is near impossible to meet your patients’ needs, when you are constantly bombarded with family questions, comments, chit-chat, and family psychosocial needs. Most nurses have seen that patients and families don’t always want 24-hour access. Nurses who are new to the profession need to concentrate on patient assessment and what they are doing for the patient, and these frequent interruptions lead to more errors and high frustration. I know this is one of the reasons many nurses have left the bedside. A nurse can not be all things to all involved and still meet his or her patient’s needs first.

I would hope that as we move forward with research in this area, we look seriously at not only patient and family needs, but to the bedside nurse and how we can best support their mission. Heaven knows we need to mentor and support the nurses we have left!

Marjorie A. Stock, RN, CCRN
Anchorage, Alaska

The authors respond:

Nurses do indeed have many demands on their time during their work. A proactive approach to meeting family needs will reduce the workload over the long haul. There are a few interventions that nurses can use...
proactively to prevent nurses and families stress. One approach is to meet families’ needs as a team, which can be done a number of ways. Develop a group of senior nurses to be “experts” in meeting family needs. These senior staff can be role models and troubleshoot for less experienced nurses. The group of “family experts” can develop orientation materials and a competency to build the expertise of other nurses.

Nurses can also supplement their support for families by working with their advanced practice nurses, nurse managers, social worker, chaplain, and others within their organization. Ask these services to meet with the nurses to identify how to best collaborate and plan regular “rounds” on the patient unit and in the visitor’s lounge. Consider posting a sign to advertise a weekly family support meeting facilitated by the advanced practice nurse and social worker as a team. If families have particularly extensive educational needs, consider including the advanced practice nurse in obtaining or developing supplemental educational materials on routinely used equipment and procedures. Direct families to the hospital library and thus access to written and internet resources.

Consider contracting with families. Helping the family anticipate availability up front is also an important intervention to meet their needs and respect the availability of nurses. When a patient’s family first visits and is being oriented to the unit, it may be helpful for the unit to identify times when families may be asked to leave the unit. When you explain that these requests will be limited and may not be related to their own family members illness or recovery, but help focus nursing care to best meet the patient’s needs, families will be prepared up front and will usually cooperate with these requests. Begin the first discussion of the shift with the family by introducing yourself, updating the patient’s progress, answer any immediate questions, and outline when you will or will not be available to them. Remind families that they need to take breaks and take care of themselves with plenty of sleep and rest, nutritious meals, etc, to help them “be there for the long haul” during their loved one’s recovery. Again, anticipating and communicating with families the times when nurses must concentrate on meeting patient’s needs and contracting will allow nurses and families to work together.

A proactive approach to meeting family needs will pay off in the long run. If the patient’s stay begins with family support and education, nurses build rapport that will facilitate positive and timely decision making later in the patient’s illness.

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