



Meet the Expert



Blurb:

Jessica Rainbow is an Assistant Professor at the University of Arizona College of Nursing and recently conducted a study of presenteeism with nurses across the country, including here at Stanford Health Care. Learn more about Dr. Rainbow and her work here.

Web Article:

Let's start with a brief definition of presenteeism. Presenteeism is when someone is physically present at work, but not fully engaged or performing. There can be multiple factors causing someone to experience presenteeism such as sickness, and both work and personal stressors, including workplace violence. Nursing has been found to have the highest rates of presenteeism when compared to other professions. Presenteeism in a healthcare setting can lead to negative outcomes for patients, nurses, and healthcare organizations. My interest in presenteeism stemmed from my own experiences with burned out and sick coworkers as an ICU nurse and after interviewing nurses about their fatigue while a nursing Ph.D. student. However, understanding how the different outcomes and factors leading to presenteeism are related, or the best way to measure presenteeism, was unknown. I was interested in answering these questions with my dissertation, so I designed and carried out a survey of nurses that

compared different existing presenteeism measures and assessed what leads to presenteeism, and what were the consequences of presenteeism. I recruited nurses who provide direct patient care in hospitals from around the country through social media, nursing organizations, and hospitals, including Stanford Health Care.

All in all, 447 nurses from 40 different states participated in the survey. On average, these nurses had 11.3 years of experience, worked 34 hours per week, and on average were 39 years old. Presenteeism rates on our survey were higher across different presenteeism measures than previously published studies, including measures that looked at presenteeism due to sickness, job-stress, and workplace violence. Higher presenteeism was linked to negative work environment, lower professional value (as described in the [American Nurses Association's Code of Ethics](#)), higher perceived stress, and work-life imbalance. Presenteeism was also linked to lower nurse professional quality of life, higher turnover intention, and more missed patient care.

In summary, our findings indicate that presenteeism is a prevalent problem that can have multiple contributing factors, and can lead to negative consequences for nurses, healthcare organizations, and patients. We still need to learn more about the nurses' awareness of their own potential presenteeism, their decision-making process about presenteeism, and their perceived consequences of attending work when not at their best. As a researcher, I am working to learn more about how to measure presenteeism and how to intervene to address the issues leading to presenteeism, like work stress, and presenteeism itself.

Thank you to all those who participated in my survey – your responses provide a baseline from which we can build going forward, and future direction for my research. If you are interested in learning more about nurse presenteeism and my research, you can contact me via email at jrainbow@email.arizona.edu, or follow me on Twitter

ABOUT THE AUTHOR: Hello my name is Jessica Rainbow and I have practiced as a nurse in both critical care and infusion clinic settings in Nevada and Wisconsin. I received my BSN from the Orvis School of Nursing at the University of Nevada, Reno, and my Ph.D. in Nursing from the University of Wisconsin – Madison. I am currently an Assistant Professor at the University of Arizona College of Nursing. I am very passionate about improving the nurse work environment to improve nurse and patient well-being. My passion was part of why I conducted the study on presenteeism.

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Article By: Jessica Rainbow

Research



Blurb:

It can be challenging to discuss Advanced Directives, or elicit a loved ones' final wishes for when they can no longer make medical decisions. The lack of advanced care planning can leave family members in a place of uncertainty when medical decisions must be made. A study on E1 looked to ensure that family members truly understood the wishes of their loved ones. Read more about their work here.

Web Article:

Planning and Advanced Directives

Although highly recommend, many of our patients do not have Advanced Directives or have not done any Advance Care planning for health care. This is especially true in Bone Marrow Transplant and Stem Cell Transplant patient populations that can sometimes require intensive care. When critically ill patients are unable to make health care decisions, the responsibility falls on the medical Power of Attorney if one is appointed in an advanced directive, or to the next of kin. We often find advanced care planning discussions between patients and family members has not occurred. Because of this missing communication, family members are often unable to make difficult decisions and are often unsure what a patient would want when asked to be a proxy for the patient.

Because of the lack of advanced care planning, a study was conducted on E1 BMT unit at Stanford Health Care to assess ways to bridge the gap and ensure a consensus was reached regarding what the patient wanted. The study utilized a [letter advanced directive \(LAD\)](#) with a dyad of patients and their family/proxy, where the patient and family/proxy would document their wishes or what they thought were the wishes of the patient using the LAD. A comparison of responses was performed and places of

non-agreement were reconciled to ensure a an understanding of what the patient wanted. In total the study had 80 pairs of patients and their proxies from E1.

Our approach revealed a concordance in medical wishes (73 %) across the 12 questions asked. Wanting to be pain free at the end of life held the highest agreement. The biggest disagreement were over specific treatments, such as ventilator support, which more proxies refused than patients (59% vs 46% respectively). More proxies thought the patient wanted dialysis and hospice care than patients, and more proxies refused CPR and sedation to palliate refractory symptoms, like pain and shortness of breath, than the patients wanted themselves.

When discussing the findings and differences in the LAD, most were resolved in favor of the patient wishes. This process allowed an open discussion about patient's treatment preferences between them and their proxy/family members. It helped reconcile differences and allowed family member to know what the patient wishes were and the ability to advocate for them when important decision needed to be make.

This work will be published in the Journal of Palliative Medicine and can be viewed [here](#).

Article By: Trisha Jenkins

Education



Blurb:

Members of Stanford's Shared Leadership Research and Innovation Counsel attended the world's largest gathering of nurses, Magnet 2018. Read two firsthand accounts of this experience and what made the biggest impact on them here.

Web Article:**Nick Lynch**

My first Magnet conference in Denver, Colorado themed "Educate. Innovate. Celebrate", was an eye opening and inspiring experience. This year's conference was attended by over 11,000 nurses, motivated to share and learn from their peers. The extraordinary number of nurses in attendance represented the largest Magnet conference in history. I was extremely impressed with the wide variety of Magnet and non-Magnet hospitals represented at the event, along with the high quality and pertinent information sessions and presentations.

The speakers, including [Patch Adams](#) and [Aron Rolston](#), brought diverse experiences and unique perspectives to their presentations. Though they all had very different stories to tell, a common theme was that as nurses, we have an incredible opportunity and obligation to constantly challenge the status quo and strive for ways to improve our quality of patient care. This message resonated with my role in the Research and Innovation Council because nursing led research and evidence based practice is such a critical component of any effective healthcare system.

The conference also offered many information sessions, ranging from disaster protocols to creation of evidence based practice resources for nurses. I attended several information sessions with a research theme. The focus of these sessions ranged from online pathways for nurse led evidence based practice, to incorporation of research in nurse residency programs. I left the sessions feeling enlightening with new ideas and concepts to bring back to Stanford Health Care, but also proud that SHC already seems well ahead of the curve in terms of creating resources and pathways for nursing led research.

I strongly encourage anyone who is interested in being inspired by their peers and wants to broaden their understanding of the future of patient care, to attend the [2019 Magnet Conference in Orlando](#).

Diana Zhen

My experience at the 2018 Magnet conference was incredible and humbling. I was excited as it was my first time attending. At Stanford Health Care, we often focus on our own clinical areas and topics of interest specific to our facility. Magnet gave me the opportunity to share thoughts and experiences, and see what works at other organizations.

The opening remarks was exhilarating. Seeing 10,000 nurses sharing the same passion for Magnet and the pursuit of nursing excellence was truly inspiring. It also made you feel incredibly proud to be part of the Stanford Health Care family.

At Magnet, my focus was to attend the research related lectures and see what worked at other organizations. To my surprise, we are already working on many of those initiatives as part of our strategic plan and I was incredibly proud to say that our Stanford nurses have a direct role in shaping these programs.

My favorite keynote speaker was definitely [Cy Wakeman](#) and her approach to drama and conflict management. Her reality based approach to conflict is to empower the nurse and come up with unique solutions that would work in their clinic setting given the existing challenges. This is to say what can you do now, given the reality of the situation, to help improve both the provider and patients experience. It replaced the negative feelings of venting with active brainstorming. This talk has relevant implications when dealing with challenges in the workplace as it helps redirect negative feelings with active solutions.

It was an inspiring conference and I hope every nurse gets to experience Magnet at least once.

Article By: Nick Lynch & Diana Zhen

Spotlight



Blurb:

Chart reviews are critical to answering many clinical research questions. At Stanford, there is a robust system that aids researchers in conducting chart reviews called the Stanford Medicine Research Data Repository or STARR. This article highlights ways to utilize STARR to conduct a chart review.

Web Article:

How to conduct a Research Chart Review

AVOIDING TEMPTATION

During patient care, we are often faced with difficult situations and challenges that spur us into thinking about larger questions.

I wonder how many patients have this side-effect? What are the likely outcomes of patients like mine?

The best approach when attempting to answer these types of questions is to review the available literature for related data. If insufficient data exists, you may want to add to the body of knowledge that exists around this condition by undertaking a chart review of Stanford patients. The temptation may be to acquire a list of patients and dive into EPIC to find the answer to your query, however accessing EPIC for this purpose requires additional permissions from the Institutional Review Board (IRB).

PERMISSION

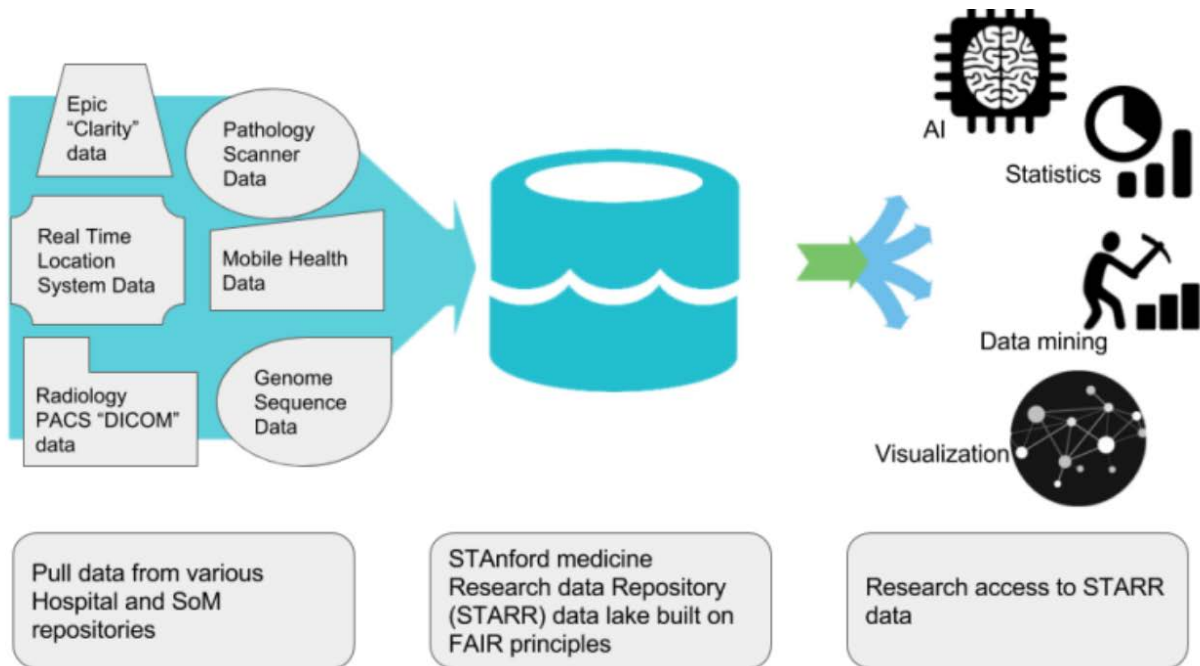
If you are sure the answer to the question can be found in the medical record (EPIC), the first step is to obtain permission for Chart Review. This involves creating a short application to the Stanford Institutional Review Board (IRB) <https://eprotocol.stanford.edu/>.

OBTAINING DATA

Information about the source of the data is required. If the information comes from EPIC, the preferred search mechanism is the Stanford Medicine Research Data Repository (STARR). This is a clinical database that includes adult (SHC) and children (LPCH) electronic data as far back as 1998. STARR covers the multiple electronic health record systems that both hospitals have used over the years.

More information about STARR can be found at:

<https://med.stanford.edu/researchit/infrastructure/clinical-data-warehouse.html>



From: <https://med.stanford.edu/researchit/infrastructure/clinical-data-warehouse.html>

The Research Information Center (RIC) approves access to STARR and requires all users to complete a Data Privacy Attestation that is linked to the specific IRB application. There are different attestations depending on whether the data has personal health information (PHI) or is deidentified. As the capabilities of data acquisition from STARR are rapidly evolving, please check the link to RIC. <http://med.stanford.edu/ric/resources/som-compliance-processes.html>

SEARCHING STARR

The STARR database does not list the information in the same format as EPIC as there are no flowsheets. The information that was entered into each EPIC cell is available for searching, however, the data is listed in a format more similar to an excel spreadsheet.

For example: once a patient record is selected, the researcher might want to know the urine output. To find out if the patient had a urinary catheter is a separate query. The color of the urine is a separate query. Or a broad category of "urine" might be used. This is the reason it is so important to have the test question and the search criteria identified before starting the study. It may be helpful to make a worksheet to guide the search. For help with a chart review study, contact the Office of Research Patient Care Services (ORPCS) at: research@stanfordhealthcare.org

Article By: Mary E. Lough