

MEDI-LEGAL RESOURCE NEWS

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**The Role of Unlicensed Assistive Personnel [UAP]
In Health Care Delivery by Bobbi Black RN CLNC****INSIDE THIS ISSUE:****THE ROLE OF THE UAP IN DELIVERY OF HEALTHCARE 1****TBI INTERNET RESOURCES 2****NEW CPR PROCEDURE 3****PREECLAMPSIA 4****ROLES AND RESPONSIBILITIES**

- The use of unlicensed personnel increases the nurses' responsibility for client safety
- Contextual presence, is the core of nursing. Frequent "walking rounds" creates that presence
- Safe delegation includes interpreting information or cues reported by the UAP.

Besieged with financial and political restraints, the addition or substitution of less expensive nursing personnel is quickly gaining popularity, in the health care setting. The American Nurses Association [ANA] defines unlicensed assistive personnel as any individual who is trained to function in an assistive role to the licensed nurse. The majority of these disciplines typically do not require licensure at the state or national level. These changes in the health care environment has altered the scope of nursing practice and its relationship to activities delegated to UAP. The ANA stipulates that it is responsibility of the nursing profession to establish standards and the responsibility of the individual nurse to implement those standard when working with UAPs and governing bodies at the state and national levels have established guidelines, articulating clear principles of delegation and defining those duties that may be appropriately delegated; in efforts to ensure there is adequate nursing involvement in patient care situations and that the UAP is not inappropriately performing functions that fall within the scope of nursing practice. It is further stipulated that the when working with a UAP, the licensed professional nurse retains ultimate responsibility and accountability for the delegation of duties to the UAP as well as the management and provision of all care that requires the skill and/or knowledge of the professional registered nurse.

Nursing delegation is recognized as the act of entrusting the performance of selected tasks to an individual who is qualified, competent and able to perform such tasks. The ability of the RN to assess real or potential harm to a patient is seen as integral in determining which tasks may be performed by a non-nursing caregiver. It is the professional nurse's responsibility to delegate appropriate tasks to the appropriate individual which requires the RN to first assess/evaluate the patient

in order to determine the level of care that is needed before she/he can determine if that level of care falls within the scope of assistive personnel. Tasks delegated to a UAP are considered to be those that are technical in nature, standard and/or unchanging and/or felt to have predictable results with minimal potential risk. Tasks that require nursing judgment or complex, multi-dimensional application of the nursing process should not be delegated to the UAP. According to the National Council of State Boards of Nursing; the right task, right circumstances, right person, right direction/communication and right supervision are key to appropriate delegation. The UAP can observe and report however it is the RN's responsibility to interpret the patient information as well as establish a means of effective communication or feedback from the UAP in order to determine the desired result is obtained.

Many UAPs hold certification within their area of practice. Certification is awarded by an organization to an individual who have met and/or maintained various accomplishments within a specific discipline. Nurses are licensed following completion of an accredited nursing program and passing state licensing examination. EMTs, paramedics, technicians and nurses aids may be certified through respective organizations however state licensing examination is typically not required by most states. Although these individuals may excel in performance within their specific disciplines they are not trained in regard to the skills particular to nursing. The delivery of healthcare must be designed to meet the needs of its patient population and health care facilities are responsible to maintain a working knowledge of all regulations pertaining to appropriate scope of practice for any licensed practitioner or a job description for any unlicensed worker, in their employ and provide care by staff functioning with

THE ROLE OF THE UAP [CONTINUED]

approved scopes of practice. It is the responsibility of the organization to develop appropriate job descriptions, prepare / provide time for RNs supervision and evaluation and take corrective action for substandard performance.

The professional registered nurse has both a legal and an ethical obligation to render safe, competent care.

It is the nursing profession that determines the scope of nursing practice.

It is the nursing profession that defines, supervises the education, training and utilization for any unlicensed assistant roles involved in direct nursing care areas

The professional RN is responsible and accountable for the provision of nursing practice

It is the professional RN who supervises and determine the appropriate utilization of unlicensed assistant involved in providing direct patient care, and

It is the purpose of the UAP to enable the professional nurse to more efficiently provide direct nursing care to the patient; not replace it.

Characteristics of appropriate delegated tasks are those that:

- Recur frequently in daily care of the patient

Are performed according to an established sequence of steps

- Involve little or no modification from one patient care situation to another

Lack inherent involvement of ongoing assessment, interpretation or decision-making that cannot be logically separated from the procedure itself.

The RN retains responsibility and accountability for nursing practice by:

Verifying competency of the UAP before delegating the duty and establishes a means of reporting or communicating patient observations

RN performs ongoing supervision of the care provided by UAP.

The professional nurse performs activist that involve assessment, planning, evaluation, nursing judgment and problem-solving.

The RN evaluates the patient responses to the care provided.

The history of nursing has been replete with periods of over-supply and the abundance of nurses to periods of undersupply and the need for nurse extenders a/k/a UAP unlicensed assistive personnel and most likely will continue to change in the future. Established professional guidelines are paramount in support of the nurse effectively and collaboratively working with the UAP as well as assisting other health care professionals and administrators in developing appropriate roles, defining job descriptions and responsibilities that promote favorable patient outcomes.

TRAUMATIC BRAIN INJURY [TBI] ONLINE RESOURCES

BY MARGUERITE BARBACCI , RNC, MPH, BSN, LNCC

Alabama Head Injury

<http://www.ahif.org/>

AHIF assists family and friends to help understand the results of brain injury.

American Academy of Neurology

<http://www.aan.com/>

Brain Injury Association

<http://www.biausa.org/>

Provides information on prevention, treatment,

and rehab, resources and support.

Brain Injury Association of Texas

<http://www.biatx.org/>

Helps families in their search for facilities and support for loved ones who have sustained brain injury.

Traumatic Brain Injury Resource Guide

<http://www.neuroskills.com/>

TBI resource guide, with information about brain injury and rehabilitation, illustrations and other resources



Nurse's Aides and Patient Care Technicians assist the nurse in providing basic cares like answering call lights, serving meals .

The internet serves as a great source for health related information



however it is important to verify those sources.

NEW CPR PROCEDURE, CAN IT SAVE MORE LIVES

BY PATTIE PATTERSON RN, LNCC, CLCP

A new procedure, developed by Purdue University biomedical engineer professor Leslie Geddes is said to increase blood flow by 25 % more than the current CPR (cardio-pulmonary resuscitation) procedure. The current method for CPR has a 5 to 10% success rate depending on how quickly and effectively the procedure is performed. Plus, for one minute of delay the rate of survival decreases by 10%. (This does not include victims who have been submerged in water resulting in hypothermia.) This means if CPR is delayed for 10 minutes, resuscitation efforts are absolutely futile.

Aside from the low success rate for the traditional CPR there are other problems. For instance, if the chest compressions are too hard or the hand placement is improper, the victim's ribs could be cracked, possibly damaging the lungs and/or heart. Also, if the compressions are not forceful enough, they serve no benefit to the victim. If air is blown into the stomach by the person performing CPR this can not only cause multiple problems, but makes the whole effort ineffective. Also, if too much air and/or force is used the lungs can be damaged. A final risk of mouth to mouth breathing is the possibility of transferring infections. These reasons are why lay persons are only taught chest compressions.

"In standard chest-compression CPR, which has been in practice since the 1960s, the rescuer pushes on the chest and blows into the subject's mouth twice for every 30 chest compressions. However, the risk of infection is so grave that many doctors and nurses often refuse to administer mouth-to-mouth resuscitation. In one 1993 study of 433 doctors and 152 nurses, 45% of doctors and 80% of nurses said they would refuse to administer mouth-to-mouth resuscitation on a stranger.¹"

Another problem with the standard CPR methodology is that the blood sometimes flows the wrong way, delivering deoxygenated blood back to the heart muscle which reduces the effectiveness of CPR and the likelihood of successful resuscitation. Also the rescuer administering chest compressions

needs to depress the chest 1.5 to 2 inches at a rate of 100 times per minute which takes 100 to 125 lbs of force to be accomplished. To really accomplish this properly there really needs to be 2 people, one to do compression, the other to do mouth to mouth breathing.

This brings up an interesting question, with all of the issues with the current method of CPR and the low success rate, why even bother performing CPR? Well, the alternative is if the person does not receive CPR they ARE going to die. This method, although significantly flawed, is the only method we have had up until now.

The new CPR alternative called OAC-CPR also known as "only (rhythmic) abdominal compressions" works by pushing on the abdomen as opposed to the chest. This forces the blood from blood vessels around the abdominal organs, where approximately 25% of the body's blood volume is known to be contained. Researchers found that in performing this maneuver 60% more blood was pumped to the heart than by the standard CPR method. Also, with this method there was no issues with the blood being pushed the wrong way.

These abdominal compressions also serve to push up on the diaphragm expelling air from the lungs. Decompression causes the lungs to expand and take in air, just like normal inhalation. This eliminates the need for mouth to mouth breathing and also a second rescuer is no longer required.

"Researchers have known since the 1980s that pushing on the abdomen circulates blood through the heart. The idea was originated by Purdue nursing doctoral student Sandra Ralston...She made the remarkable observation that if you pushed on the abdomen after each chest compression you could double the CPR blood flow.²"

When using OAC-CPR the rescuer doesn't have to push as hard or as fast as in the current CPR scenario. Dr. Geddes has even created a device that can be used to effectively deliver the thrusts, although the thrusts can be done quite effectively with bare hands. Now it is up to the researchers



[CPR] is an emergency medical procedure for a victim of cardiac arrest or in some circumstances respiratory arrest

Discover the facts of the medical record and gain the winning edge in your next health-related case.



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CPR [CONTINUED]

to decide whether or not to implement this new type of CPR procedure. But in my humble opinion, having taught CPR for many years, including the Heimlich maneuver, similar to the OAC-CPR, I think this certainly is a better route than the present procedure. For the record, it took 2 years from the first publication of the findings for the Heimlich maneuver until it was accepted by the AHA (American Heart Association) and the Red Cross as part of their CPR education for choking. That said, AHA has had issues from the beginning about the use of the Heimlich maneuver for drowning victims. I wonder how this study will affect their opinion. I guess time will tell.

For more information go to American Journal of Emergency Medicine, published by Elsevier, September 2007.

Bibliography:

^{1,2}Doctor's Guide News, September, 6, 2007, *New CPR Promises Better Results by Compressing Abdomen, Not Chest*, <http://www.docguide.com>

Reuters, September 21, 2007, *Change in CPR may Make it More Effective*,

PREECLAMPSIA MANY THEORIES NO DEFINITIVE CAUSE

BY DOLORES TAYLOR RN CLNC

Preeclampsia is a disease of the placenta and also a multi-system pregnancy-specific disorder with a high maternal and perinatal morbidity and mortality, but its pathogenesis remains poorly understood. This disease is second only to thromboembolic disease as a cause of maternal death in the United States, complicating up to 8% of all pregnancies (1,2), and is responsible for 12% to 18% of all pregnancy-related maternal deaths (2-4). Preeclampsia is classified as "mild" or "severe". Epidemiologic studies and biochemical research have developed several theories to explain this disorder, however no single theory can account for all the findings in preeclampsia.

Diagnosing preeclampsia is a three-part process as this is not a single disease but one with three distinct elements, those being: (1, 5)

(1) A new onset hypertension (sustained sitting blood pressure $\geq 140/90$ in a woman with previously normal readings)

(2) New onset proteinuria ($>300\text{mg}/24\text{h}$ or $\geq 2+$ on a clean catch urinalysis)

(3) New onset of significant nondependent edema.

The diagnosis of preeclampsia is only reliable after 20 weeks gestation. Once you have diagnosed a patient with preeclampsia, the first principles of management are the stabilization of the mother's conditions and assessment of well-being of the fetus. The only effective treatment for preeclampsia is the delivery of the fetus and the placenta. Delivery is recommended for women with "mild preeclampsia" once a favorable GA has been reached, however, immediate delivery, regardless of GA must be performed for all women with "severe preeclampsia to prevent maternal and fetal complications. (5)

A serious complication of preeclampsia is "HELLP syndrome" and maternal and fetal death rates soar to 24% in maternal deaths and as high as 60% in fetal deaths. Delayed diagnosis and delayed inappropriate treatment are commonly cited to explain the poor overall prognosis associated with HELLP syndrome. (6-7)

On admission to a Labor and Delivery Unit, Magnesium Sulfate is infused to prevent seizures in the patient with preeclampsia. Magnesium Sulfate needs to be carefully and accurately infused and is always given via an infusion pump. The normal course for infusion is a "Loading Dose" of 4-6 gms over 20 minutes. The infusion is then set to infuse @ 2-3 gms/h maintenance dose. Therapeutic blood levels are completed at the end of the loading dose and every 6 hours while the infusion is running. A therapeutic level of MgSO_4 is 4-8 mEq/L is desired. Corticosteroids are also given to enhance fetal lung maturity. Dexamethasone is usually the drug of choice and 6 mg, IM is given every 12 hours x 4 doses. (6-9)

Features of Severe Preeclampsia

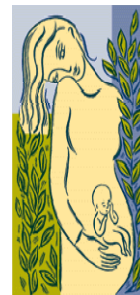
Symptoms:

There are symptoms of CNS dysfunction (Central Nervous System). These symptoms would include blurred vision, scotomata, altered mental status, and severe headache.

Symptoms of liver capsule distention or rupture (right upper quadrant or epigastric pain or both)

Signs:

Severe elevations in blood pressure, defined as $\text{BP} \geq 160/110$ on two separate occasions at least 6 hours apart.



Preeclampsia occurs during pregnancy and the postpartum period. It affects both the mother and the unborn baby.

PREECLAMPSIA [CONTINUED]

Pulmonary edema.

Eclampsia (generalized seizures and/or unexplained coma in the setting of preeclampsia and in the absence of other neurologic conditions).

Cerebrovascular accident.

Cortical blindness.

Fetal intrauterine growth restriction (IUGR).

Lab findings:

Proteinuria (>5 g per 24 h).

Renal Failure or oliguria (<500 ml per 24 h).

Hepatocellular injury (serum transaminase levels \geq 2x normal)
Thrombocytopenia (<100,000 platelets/mm³).

Coagulopathy

HELLP (Hemolysis, Elevated Liver enzymes, Low Platelets)

We know the risk factors for developing preeclampsia but unfortunately, we still cannot predict with any certainty which pregnancies will be affected. Despite intensive research we are helpless to prevent preeclampsia from developing. Obstetricians are currently focusing on identifying this disorder early on. With blood pressure readings and urinary screening at regular prenatal visits, we aim to follow early identification with aggressive and gestational age (GA) appropriate management.

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Learn more: [Preeclampsia Foundation](http://www.preeclampsiafoundation.org)

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