

GPAC GAZETTE QUARTERLY

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VENT MANAGEMENT WITH
APRV-GETINGE



You are monitoring a patient with a pulmonary artery catheter. You are unable to measure the patient's pulmonary artery wedge pressure. To obtain a value that corresponds to the pulmonary artery wedge pressure, you check the:

- ☐ Pulmonary artery diastolic pressure
- ☐ Pulmonary artery mean pressure
- ☐ Right ventricular pressure
- ☐ Right atrial pressure

Answer the above
CCRN

question to win a prize.
Submit your response
to
<https://gpaacn.nursingnetwork.com/contact>

FUN EVENING SLATED FOR JANUARY 14TH 2021, 6:00PM-7:00PM SPONSORED BY HONORHEALTH: CERTIFICATION RENEWAL SPEAKER: TRACY THOMAS

[HTTPS://US02WEB.ZOOM.US/J/88275774215?](https://us02web.zoom.us/j/88275774215?pwd=UWLUAS84VG50AUPLOVFUAFPLMNPRQT09)
PWD=UWLUAS84VG50AUPLOVFUAFPLMNPRQT09

Free membership for a full year of fun GPAC events. After checkout on the GPAC website, use code "free membership renewal" this offer expires April 2021

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"COVID-19 HAS IMPACTED OUR COMMUNITIES IN SO MANY PROFOUND WAYS. PLEASE TAKE A MOMENT TO CARE FOR YOURSELF, AS WE ARE SO PERSONALLY IMPACTED BY THIS TRAGIC TIME IN OUR LIVES"

Hello! My name is Tracy Thomas and I am the President-Elect For the chapter. I have been a nurse for 15 years, all focused in critical care. I started my journey into critical care nursing as an extern in the emergency department (VA Medical Center) and then transitioned as a new graduate nurse into critical care (Medical ICU at St. Joseph's), and then gained experience in several specialties of critical care: medical, surgical, post anesthesia, trauma, and neurotrauma. I obtained my BSN in 2005 from Arizona State University, and then later obtained my MSN as a Clinical Nurse Specialist from Grand Canyon University in 2011. I have been a CCRN since 2008, a TCRN since 2016, and a board certified Adult Health Clinical Nurse Specialist since 2013. Currently, I am the Critical Care Clinical Nurse Specialist at St. Joseph's Hospital and Medical Center over all 6 of our adult critical care specialties. I am also a Course Director for the Society of Trauma Nurses' Advanced Trauma Skills for Nurses course, an ACLS instructor for the American Heart Association, and a member of the Arizona State Board of Nursing's Advanced Practice Advisory Committee. Critical care and caring for the complex patient are my passions! When I am not in the hospital, I am enjoying time with my family – my husband of 13 years, our 3 year old son and 2 canine children. Pictured below are my 3 kids being themselves– Alex (the human), Ruby (10 year old German Shorthaired Pointer) and Bullitt (4 year old Boxer). In my spare time (ha!), I love to read, cook and bake, and look at fun home & yard improvement projects (that I'll probably never finish). I enjoy being active our AACN chapter, gaining knowledge and colleagues from around the state.



TURNING TUBE FEEDING OFF WHILE REPOSITIONING PATIENTS IN BED

NORMA METHENY, RN, PHD,

ALTHOUGH RESEARCHERS HAVE NOT DIRECTLY ADDRESSED THIS TOPIC, SEVERAL STUDIES PROVIDE RELEVANT INFORMATION THAT CAN BE USED TO DETERMINE “BEST PRACTICE.” THESE STUDIES, AS WELL AS RISKS

AND BENEFITS OF INTERRUPTED FEEDINGS, ARE DISCUSSED HERE.

Risk Versus Benefit of Interrupted Feedings: As pointed out by the reader, the risk of interrupted feedings is inadequate delivery of calories (a serious problem because a poorly nourished patient is predisposed to poor outcomes). In the absence of definitive guidelines, nurses often choose to turn feedings off when the head of the patient's bed is lowered. For example, in a study of 44 critically ill patients, McClave et al¹ reported feeding interruptions of up to 1 hour for the performance of routine nursing procedures, presumably because nurses forgot to restart the feedings when the procedure was completed. If the flow of formula is interrupted frequently throughout the day to reposition patients, caloric intake could be seriously compromised. For example, stopping feedings 12 times a day for 5 to 10 minutes would result in 1 to 2 hours of missed feedings. This situation is a distinct possibility because standard care mandates frequent position changes to prevent pressure ulcers as well as pooling of respiratory secretions. When missed calories due to position changes are added to those associated with feeding interruptions for other reasons (eg, preparation for surgery or diagnostic procedures), it is clear that a critically ill patient's nutrient intake may be significantly decreased. For example, in a study of 39 critically ill patients followed for 276 tube feeding days, Elpern et al² reported that patients received a mean of 64% of the goal energy intake (largely because of feeding interruptions). The mean length of feeding interruptions in the study was 5.23 hours per patient per day; 15% of the interruptions were associated with changes in the patient's body position. To evaluate the potential benefit of reduced gastric volume after a brief feeding interruption, it is necessary to consider the rate at which the stomach empties. In a study³ of 10 healthy males, a mean of 89.5 minutes was required for 50% of a specially marked 200-mL liquid meal to empty from the subjects' stomachs when they were sitting up. Gastric emptying is even slower in many critically ill patients.⁴ For example, another group of investigators found that the mean gastric half-emptying time was 155 minutes in a group of critically ill patients (as opposed to 133 minutes in a group of healthy volunteers, $P=.008$).⁵ Findings from these studies strongly suggest that stopping feedings for a few minutes is unlikely to significantly reduce gastric volume.



Relationship Between Aspiration and Body Position: To understand the relationship between aspiration and body position, it is helpful to review findings from a widely cited study⁶ on this topic. In a randomized, 2-period crossover trial that included 19 intubated patients receiving mechanical ventilation, Torres et al⁶ compared the incidence of aspiration on 2 separate days when the patients were positioned supine versus in the semi recumbent position (45° head-of-bed elevation). To measure aspiration, the investigators instilled Tc-99m sulphur colloid into the patients' nasogastric tubes and subsequently measured the radioactivity of bronchial secretions collected at 0, 30, 60, 120, 180, 240, and 300 minutes. Radioactivity was recorded in counts per minute (cpm). As expected, radioactivity of the bronchial secretions was significantly higher when the patients were supine than when they were semi recumbent. Additional findings demonstrated that aspiration increased over time when the patients were supine, as manifested by much higher radioactivity levels of bronchial secretions at 300 minutes than at 30 minutes (2592 versus 298 cpm, respectively, $P=.01$). In summary, findings from this study demonstrate that a supine position increases risk for aspiration, and the longer a patient is supine, the greater is the risk for aspiration. Because of a variety of treatment needs, most patients cannot remain in a bed with the head elevated to a 30° to 45° angle every minute of the day. Clearly, the goal is to minimize the amount of time a patient is positioned flat in bed.

body text



Conclusion: Based on the preceding discussion, the logical conclusion is that it is unnecessary (and even counterproductive) to turn feedings off during the brief period of time the bed is lowered to reposition a patient. This conclusion is supported by recent practice recommendations for enteral nutrition published by the American Society for Parenteral and Enteral Nutrition.⁷ After the patient is repositioned, it is imperative to quickly elevate the bed to the desired angle (usually at least 30° and preferably 45°, unless contraindicated). Doing so requires a conscious effort because it is not uncommon for caregivers to become distracted and forget to return the bed to an elevated position.⁸ One final consideration: In situations where the head of a patient's bed should not be lowered even for a brief period, it may be possible to reposition the patient while the bed is in reverse Trendelenburg position (while feedings are continued).

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Huge Thank-You to everyone who was able to donate to our Toy Drive, Santa didn't disappoint for sure



Our February meeting will be packed with learning on ventilator management focusing on APRV this is not a meeting to miss...

If you have suggestions for an upcoming meeting, we would love to hear your suggestions, please email us at

<https://gpaaacn.nursingnetwork.com/contact>

