

What can a Nursing Portfolio do for you?

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What is a portfolio?

A professional portfolio as an "organized collection of documents that chronicles your career and demonstrates the activities you have undertaken to assess and maintain your competence to practice" (AARN 2000). A nursing professional portfolio provides documented evidence of the your achievements. The philosophy behind the portfolio is that it is congruent with the principles of adult learning, and it offers an expressive form of self-evaluation and goal setting over time (Alexander et.al. 2001). The portfolio is an ideal way to display your continuing education or CME's. The portfolio creates representative records of your professional development and is not intended to be comprehensive.

The following is a suggested guideline, intended to give you general information about portfolios, and to help you start to develop your own.

What is a portfolio used for? Why would I want to develop one?

Everyone can use a portfolio. It does however take time and effort to gather all of the information you will need for your portfolio and to work through the steps in the process. Once you have developed your portfolio, it will be simple to maintain over the years. But if you do take that time in the beginning, your portfolio can be used for:

- Continuing education records
- Competence assessments
- Career plans

- Job applications and
- Evidence in a prior learning assessment in courses

The process of developing your portfolio and of annually updating it provides you with an opportunity for reflection and self-assessment. It is a chance to reflect on your growth and development throughout your professional nursing career, and to think about plans for further learning and the next steps in you take along your career pathway.

Your portfolio can also be used as a marketing tool, showcasing your work in practice, in a job interview or for career advancement in your own place of work. It provides evidence of what you have done, the competencies you have developed, and the educational programs you have completed.

Many universities and colleges are now accepting or requiring portfolios for assessment of prior learning to determine eligibility for acceptance or advanced status in educational programs.

Who else uses a portfolio?

Artists and photographers use portfolios, a model with a portfolio of advertisements, an artist with copies of the range of pieces completed, use these portfolios to display examples of their work. It is now becoming more common for portfolios to be used in professions as well, such as teaching, engineering and architecture. In nursing, educators and researchers have used portfolios as a way to demonstrate their competencies (Oermann, 1999). Many

nursing students are now being taught to prepare a portfolio in their nursing program (Alexander et al 2001)

How can I use my portfolio for CME?

You will find that the process of developing your portfolio is an excellent opportunity for reflection; and, as you will need to review and update your portfolio at least annually, you can continue to use the portfolio development process to reflect on your practice.

The result of all of this hard work will be the satisfaction you gain from recognising what you have already accomplished, and the knowledge you will acquire about yourself. The contents of the portfolio will form part of your record of continuing education.

What do I need to get started?

The equipment you will need is:

1. *A ring binder*, it is often better to use a three or four-ringed binder and not a two-ringed one as the when you lift the folder the contents often slip to the sides. Try picking up a three and a two-ringed folder at work and examine how the contents fall.
2. *Large dividers*, you can use colour coded ones
3. *Plastic sheet protectors*
4. As well as some *pocket folders* to hold multiple documents

You will then need to gather all of the information you currently have about

your nursing career. This will take time. Some of the things you should collect are: an up-to-date resume, copies of your degrees, diplomas and certificates, feedback you have received including performance appraisals, reports you wrote, presentations you made, a list of the committees in which you have been involved, and your job description (Brooks and Mada, 1999). It is best to collect everything you think might be relevant and then, when you are putting together your portfolio, you can choose what needs to be included. The College of Nurses of Ontario (1996) describes this step as the "scavenger hunt."

Layout of your portfolio

Although each portfolio will be different, your portfolio should be organised into sections. Documents in each section should be organized chronologically starting with the most recent information.

A suggested outline and contents for each section is as follows:

Section 1: My Philosophy of Nursing

Many portfolio suggestions begin with this opening section. It really sets the scene about who you are and how you feel about your chosen career. This will take time and may be easier to write after you have assembled the other sections first. It should contain your reflections about what you believe about nursing, what you value and how these beliefs and values have shaped your career path (Alsop, 1995). It may also include information on your career goals and how they are shaped by your philosophy of nursing. This does not have to be long; a page or two is sufficient.

Section 2: Curriculum Vitae (CV)

It is always wise to have an up-to-date C.V. There are many books available which will tell you how to write a resume. There is even preset formats and help on many standard computer software programmes such as Microsoft® Word.

Section 3: Examples of Work

This section is an expansion of your C.V. (AARN2001). It will contain evidence of the things you have accomplished and the competencies you have developed (AARN1999).

Don't include everything you have ever done; instead, concentrate on the samples of your work which best exemplify the different skills and abilities you possess. Thinking about why you are including a particular item will help you to identify your strengths, beliefs and values.

Some of the things you could include are:

- Job description
- Copies of presentations you have made
- List of committees you belong to and a statement about their activities
- Research proposals and reports
- Projects you have completed
- Copies of publications or articles you have written

Section 4: Education

This section will highlight your academic achievements.

Include copies of the following:

- Registration (e.g. general nursing)
- Degrees/Diplomas (e.g. BSN)
- Certificates (e.g. BLS, ACLS)
- Transcripts (e.g. marks obtained in your diploma)
- Awards (e.g. achievement)
- Certifications (e.g. CCRN)

Section 5: Reflection

This section includes the first step in reflective practice. If you like to journal, you might also use a diary type approach format for reflective journaling, or you may use your own format to document. There are a number of excellent articles on journaling for nurses and reflective practice, see the one in this magazine as an example.

Section 6: Feedback

You might also like to include such items as:

- Letters or e-mail from clients, colleagues or others
- Thank you cards and letters of appreciation
- References
- Copies of performance appraisals

Section 7: Additional Information

This section is for your own use. You may want to keep other information in this section so that all of your work records are together in one document. Examples may include:

- Health records
- Immunization records
- Hours of practice for registration renewal

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STROKE: Test Your Knowledge of the Disease

by Petra Mandysova, B.Sc.(N), CNN (c)
Clinical Resource Nurse, SKMC

1. Mr. Al-Ameri, a 65 year old, right-handed man, wakes up with paresthesia (numbness) and hemiparesis (weakness) of the right side of his face, and arm, confusion, and difficulty speaking (expressive aphasia). His family brings him to the Emergency Department of a local hospital. Ct scan shows extensive infarction in Mr. Al-Ameri's brain. Mr. Al-Ameri is not a suitable candidate for thrombolytic therapy because:
 - a. Those patients whose presenting symptoms include confusion are excluded
 - b. It is not certain when his symptoms began
 - c. There are signs of infraction on the initial CT scan
 - d. Both b) and c) are correct

Correct answer: d

Rationale: Before starting thrombolytic therapy, the patient should be assessed to determine whether he meets clearly defined criteria for therapy. The criteria for thrombolytic therapy include the absence of any signs of infraction on the initial CT scan and a well-defined, short interval (3 hours) between the onset of symptoms and the initiation of therapy. In this case, it is prudent to exclude Mr. Al-Ameri from thrombolytic therapy out of concern that his symptoms may have been present for hours while he slept. In addition, the CT scan shows brain tissue destruction. Restoration of blood supply to such a damaged area is unlikely to restore function and creates the possibility of haemorrhage through damaged blood vessels into the infarcted brain tissue. For these two reasons, the risk of intracerebral haemorrhage would be too high, and so the thrombolytic therapy should not be initiated. Confusion is not an exclusion criterion for thrombolytic therapy.

2. Based on Mr. Al-Ameri's symptoms, you suspect that his infarction occurred in:
 - a. The left middle cerebral artery
 - b. The right anterior cerebral artery
 - c. The left posterior cerebral artery
 - d. The right middle cerebral artery

Correct answer: a

Rationale: Mr. Al-Ameri has weakness on the right side, which means his stroke occurred on the left side of the brain. This is related to the fact that the descending motor pathways between the cerebral cortex and the periphery cross over to the opposite side at lower levels (mainly the brainstem), and so

each side of the brain controls skeletal muscles on the opposite side. Since Mr. Al-Ameri is right-handed, it is his left cerebral hemisphere that is "dominant". The "dominant" hemisphere also contains the Broca's speech area, which, when impaired, leads to expressive aphasia. The fact that Mr. Al-Ameri has difficulty speaking further confirms your theory that his stroke occurred on the left side of the brain. Moreover, you know that the middle cerebral artery supplies this area. The middle cerebral artery also supplies the part of the motor and sensory cortex that is responsible for movement and sensation of the face and arm. The anterior cerebral artery, on the other hand, supplies the part of the motor and sensory cortex that controls leg movement and sensation. See Figure 1.

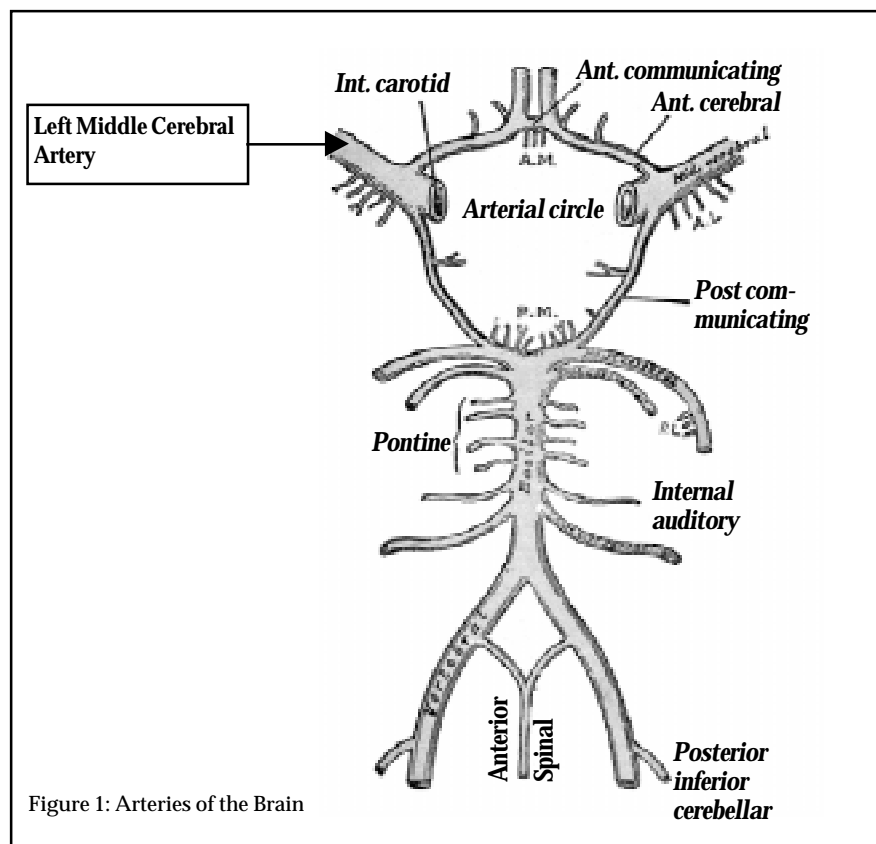


Figure 1: Arteries of the Brain

Taken From: Gray, H. & Clemente, C.D. (2000) Gray's Anatomy of the Human Body (30 edition), New York: Accessed on the World Wide Web on <http://www.bartleby.com>

3. To help Mr. Al-Ameri improve his speech, it is important to:
 - a. Be sensitive to his reactions and needs
 - b. Complete the sentence for him if he is having difficulties
 - c. Discuss practical and concrete matters
 - d. Always treat him as an adult

- Answer:1) a, b, c
 2) a, b, d
 3) a, c, d
 4) b, c, d

Correct answer: 3

Rationale: The inability to talk can cause anger, frustration, fear and hopelessness, and so it is important to be sensitive to the patient's reactions and needs, and to provide them with support. Completing a thought or sentence for the patient is a common pitfall that discourages the patient's effort to practice. It is easier for the patient to discuss practical and concrete matters, as opposed to abstract, complicated topics. The patient should always be treated as an adult.

4. To ensure correct positioning, it is important to:
 - a. Place a pillow in the axilla to keep arm away from the chest
 - b. Place the flaccid arm on a table or pillow while Mr. Al-Ameri is seated
 - c. Position Mr. Al-Ameri prone for 15-30 minutes several times a day
 - d. Use a splint to prevent plantar flexion

- Answer:1) a, b, c
 2) a, b, d
 3) a, c, d
 4) a, b, c, d

Correct answer: 2

Rationale: A pillow placed under the axilla to keep arm away from the chest will prevent shoulder adduction. The flaccid arm always needs to be supported to prevent shoulder pain (up to 70% of stroke patients suffer severe pain in the shoulder). Sometimes, a properly worn sling is useful to prevent

the weak or paralysed arm from dangling without support. While prone position several times a day helps promote hyperextension of the hip joints, which is essential for normal gait and prevention of hip contractures, Mr. Al-Ameri does not suffer from leg weakness and so in his case this intervention is not necessary. For the same reason, he does not need any splints for his feet.

5. Based on the symptoms exhibited by Mr. Al-Ameri, you suspect that he could also suffer from:
 - a. Dysarthria
 - b. Dysphagia
 - c. Both dysarthria and dysphagia
 - d. Ataxia

Correct answer: c

Rationale: Since Mr. Al-Ameri exhibits facial weakness, he is very likely to suffer from dysarthria (muscles of speech are impaired) and dysphagia (muscles of eating /swallowing are impaired). Swallowing assessment is necessary before food is offered. Ataxia (incoordination of voluntary muscle action, particularly walking) is common in strokes of the verteobasilar region (the vertebral and basilar arteries and their branches supply the brain stem and cerebellum which are responsible for coordination). You do not expect

Mr. Al-Ameri to have this symptom based on the other symptoms that he is exhibiting.

6. As you discuss Mr. Al-Ameri's care with another nurse, she mentions that Mr. Al-Ameri has right homonymous hemianopia. This means that he has a
 - a. Visual field defect that involves the right half of the visual field in both the right and left eye
 - b. Visual field defect that involves the right half of the visual field in the right eye, but not in the left eye
 - c. Visual field defect that involves the right eye
 - d. Double vision

Correct answer: a

Rationale: Visual loss in the eyes that is similar is called "homonymous" and if it involves half of each visual field, it is called "hemianopia". A lesion of the left optic tract interrupts fibers originating on the same side of both eyes: the temporal (right) visual field in the right eye, and the nasal (right) visual field in the left eye. Such lesion is then called right homonymous hemianopia. Double vision is called "diplopia" and is related to impairment of cranial nerves III, IV and VI. See Figure 2 and 3.

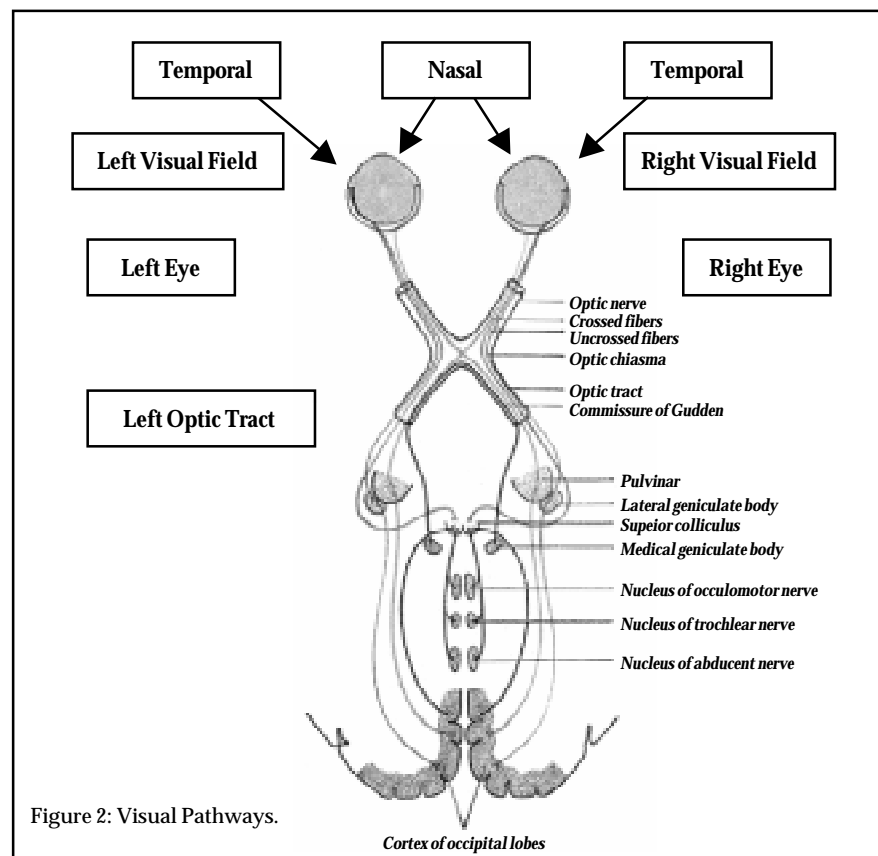


Figure 2: Visual Pathways.

Taken From: Gray, H. & Clemente, C.D. (2000) *Gray's Anatomy of the Human Body* (30 edition), New York: Accessed on the World Wide Web on <http://www.bartleby.com>

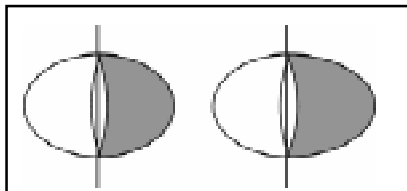


Figure 3: Right Homonymous Hemianopia: Blackened field indicates area of no vision

7. As you are aware of Mr. Al-Ameri's visual deficits, your plan of care includes:
- Approaching Mr. Al-Ameri from the left side
 - Reminding Mr. Al-Ameri to turn his head to the left side
 - Approaching Mr. Al-Ameri from the right side
 - Reminding Mr. Al-Ameri to turn his head to the right side

Answer:1) a, b
2) c, d

- a, d
- b, c

Correct answer: 3

Rationale: Mr. Al-Ameri should be approached from the side where visual perception is intact. All visual stimuli (clock, TV, calendar) should be placed on this side. Also, he should be reminded to turn his head to the affected side to compensate for the defect.

8. As you know that Mr. Al-Ameri could have another stroke in the future, you are planning to teach him and his family about stroke risk factors. These include:
- High blood pressure
 - Cigarette smoking
 - Diabetes
 - Inactivity

Answer:1) a, b, c
2) b, c, d
3) b, d
4) a, b, c, d

Correct answer: 4

Rationale: All these conditions are

stroke risk factors, and so treating them is very important. Other treatable stroke risk factors include heart disease, heavy alcohol use, and high cholesterol. Some risk factors are not treatable, such as age, family history of strokes, or history of stroke or transient ischemic attacks (Sometimes, a surgical procedure called carotid endarterectomy is performed to manage transient ischemic attacks and prevent stroke.).

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Pain - Research on nurses' response to patients

Vicky Miracle (2003), editor of *Dimensions of Critical Care Nursing* recently reviewed a study by McCaffery and Robinson (2002) on nurse's responses to pain. Over three thousand nurses in the United States were asked to complete a survey about pain management. Dr Miracle provided an overview of the findings of this critical study examining the highlights of the article. Some of the significant findings included:

- Almost 88% realised a patient could be in pain without a change in vital signs. Remember, patients with chronic pain may be in severe pain but their vital signs may be completely normal.
- The patient, not the nurse, must report the intensity of the pain.
- Approximately 90% of nurses realised that patients may sleep despite pain.
- Demerol (Pethidine) given intramuscularly (IM) was the drug of

choice. Almost 86% of the nurses in this study indicated that the choice of Demoral (Pethidine) was not a good one. There are many options for pain control today. Demerol (Pethidine) should only be used for brief periods of time in most patients.

- Medication to treat chronic pain should be routinely used around the clock and not just PRN.
- Remember, the best way to identify the pain and its intensity is to ask the patient. Pain is subjective.
- Many patients and healthcare providers felt that giving too much analgesia could lead to addiction. This rarely occurs.
- Over 86% of nurses believed that if a placebo was used, and the patient expressed pain relief, the patient could still be pain. Fortunately, this is not done much any more.
- The subjects in this study identified several trends. A few of

these were:

- the need for more education concerning pain management;
- how to assess whether or not the patient is receiving effective analgesia; and
- more information is needed to address concerns of addition.

So what does all this mean? Dr Miracle wrote that nurses and healthcare providers are making great strides in providing effective pain relief for all patients. There is still some work to do, but at least we have recognised the problem and are taking measures to treat our patients.

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The Outpatient Gastroenterology Nurse, A New Role Improves Patient Care

"The Nursing team has progressed considerably over the last two years," reports Diane Lockhart the Head Nurse of the Gastroenterology unit at Mafraq Hospital. Established in only 2001, the nine-bed day procedure unit undertakes a number of gastroenterology investigative and corrective procedures. "From routine gastroscopy and colonoscopy to E. R. C. P. (endoscopic retrograde cholangio-pancreatography) and endoscopic ultrasounds. Some more specialised procedures, including Oesophageal Stenting are also per-



formed. The majority of procedures occur during the normal working day, but out-of-hours emergencies are also provided for. We perform urea breath tests twice weekly."

The nursing team is truly multicultural and multilingual. "We come from different countries including India, Philippines, Somalia, United Kingdom and Palestine and we each speak at least two languages" Diane was proud to state. Continuous education is important to the team members having "completed several In-Service courses available here at Mafraq Hospital; including I.V. Cannulation & Therapy, Preceptorship and Clinical Teaching. We also have Medical Staff from other Units for training and accept Nurses for 1-3 months work experience."

"This is a patient focused unit and we aim to continue developing and delivering a quality service to all our

patients" testifies Diane. The results of two Quality Improvement Projects conducted in the unit led directly to the establishment of a **dedicated Gastroenterology Nurse in the Out-Patient Clinic** twice a week. "Each patient booking an appointment for procedure or urea breath test is seen by this nurse" stated Diane. They receive a full explanation of the procedure by the nurse, plus the required preparation, all of this is fully documented on Patient Education Sheet that the patient also signs. Team members rotate through the role in the clinic and this has meant for many patients the same nurse who educated them is also within the unit to greet them on their visit. Patients are now able to understand how to prepare for a procedure, such as fasting and bowel preparations and the nurse is able to check this prior to entering the procedure rooms. The gastroenterology nurses have also developed patient information in both Arabic and English and are planning to develop handouts in other languages such as Urdu. All of this has significantly improved the service offered to patients by the gastroenterology nursing team. Diane affirms that "there has been a noted improvement in both patient compliance and a drop in our 'no-show' rate since this service was initiated."



With a dedicated team and multi-disciplinary co-operation, the gastroenterology nurses are making a significant impact on improving patient care at Mafraq Hospital.

Do you have an interesting story to tell about yourself, a team or colleague? Then let us know, we might even publish it! (See information for contributions.)

Clinical Care Documentation for Nurses: Can you see the “C’s”?

Documentation by nurses has a central role in the quality of care for any patient in hospital. In addition to excellent clinical care, today's nurses must also meet a complex array of challenges (HSMN, 2002). When examining nursing outcomes, Tanenbaum(1998) stated "reviewing medical records ... we're looking for clearly stated goals and looking to see that the modalities documented on a day-to-day basis relate back to those goals." Boaston (2001) gives clear hints from those who examine patient documentation, so can you see the C's in your documentation?

Clinical Assessment

The nursing clinical assessment is the basis on which we practice. The identification of patient needs, planning care, doing it and then checking it to see if it worked is based on our skills to assess. We must document those assessments as a baseline and to justify actions that we make take with the patients, whether we use a nursing history or write directly into the patient's file.

Care Notes

Each nursing care episode require a record. Notes must include the patient's full name and details on each page, using a patient label will help you. If the documentation is missing, it's as good as if the care was not done at all.

Clarity

Notes need to be legible. If no one can read the note, it's not as bad as it not being there, but it's the next worse thing. If your colleagues have illegible writing, make them print clearly. Always clarify any unclear orders that are documented.

Content

The content of a note is the evaluation of the care you have completed with the patient. Contents are things like assessments, patient needs completed, changes in patient's condition etc... It is a nursing note, so nurses write about nursing and not about another professional group's issue.

Congruence

The message each discipline sends must be congruent with the other disciplines. If the doctor writes that patient is 'walking' and the senior nurse documents that the patient is 'bed bound', there's a problem. Patient notes need to be checked in sequential order, not by the professional discipline, especially if the professions write in different sections of a patient's file.

Challenges

The initial paperwork includes a referral, orders and assessments. Make sure that everything else that follows makes sense. Let's say you have an order to do ward blood sugar levels, but the fact that the patient is diagnosed with diabetes is completely absent! This is an obvious clinical contradiction that needs investigation.

Criticism

Criticism from the patient and how you followed up with them needs to be documented. Take important care where you document them though, complaints about their health status, such as pain, belong in the patient file, but complaints about 'Nurse N. being nasty' or 'the food being cold' belong

through the incident reporting process not in the patient file. If anything is not right, if anything does not look right, if there's a problem, it needs to be in a note or incident report. Know the difference and document on the correct tool to communicate the conflict or problem.

Closure

Each note needs to have a complete end and identify the person who is responsible. The note can be used as a legal record and a record of what happened to the patient and when it occurred. Therefore, it must include the professional's signature, legible name, date and time of entry.

References:

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A new job in meetings - Facilitator!

Are your meetings stagnant? Do you repeat the same issue without resolution? Are you confused about what the meeting was really all about? Then you might benefit from having a facilitator at your next meeting.

We all attend meetings within the nursing department, some are formal committees and some are more informal, like a gathering to solve a particular issue or the weekly unit meeting. In formal meetings, there are certain officers, like Chair and Secretary, there are Minutes to take and a Terms of Reference to adhere to, that may not be fully there in informal meetings.

Do we really need another job in a meeting? Facilitators have been used within education settings instead of trainers or educators for a number of years, indeed some educators would see themselves as facilitators and some facilitators would rather see themselves as trainers. Facilitators are now emerging within many progressive organisations as a job within departments and one that is required by teams in a variety of meetings.

Facilitation means drawing out the ideas, experience and beliefs of a group so that they arrive at conclusions and decisions that are really theirs and for which they are willing and able to take responsibility. A facilitator is therefore the person responsible for focusing a group's efforts towards its objectives.

Because the facilitator is visibly positioned in the group, this person has the ability to create bias within the team either intentionally or unintentionally. Thus, the role of facilitator is to manage the meeting structure while remaining neutral regarding the meeting content. The facilitator is part of the meeting but not part of the team.

The actual meeting content is the responsibility of the team. The facilitator's position of neutrality must be understood and practised if the team's potential is to be fully reached. Any facilitator, who becomes involved heavily in

the team's content issues, runs the risk of reducing team involvement, trust and openness. The structure and content of meetings needs to be facilitated and planned. When the team understands the structure and content of a meeting, their productivity increases.

Structure

Fulfils the "how" questions

- How the meeting's issues and subjects are dealt with?
- How the meeting proceeds in terms of agenda and team tools?
- How discussions take place?
- How decision tools are used?
- How formats, flip charts, and involvement take place?
- How the meeting's physical environment will be arranged?

Content

Answers the "what" questions.

- What are the meeting's subject, issues, problems, analysis, recommendations and supporting data?
- What issues will be dealt with in what sequence?

A team's effectiveness is heightened when members understand both structure and content issues.

So, what is the difference with other roles in a meeting? If we compare facilitation with other more traditional roles in meetings, we see that the facilitator shows the following characteristics; they avoid contributing to the content of the discussion, they focus on the process of interaction, remain neutral with no involvement in the topic of the meeting and ensure actions are agreed to.

Sometimes a facilitator is an expert in some aspect of the content of the meeting and is asked to talk as an expert. Then it is important that they need to step out of their facilitation role and

into an expert role. This is a change of role. In other words, they have to state to the group that they are moving out of one role and into another one.

One of the skills of a facilitator is to plan the meeting in advance with the leader of a team and ensure that if other roles are required such as chairing or secretarial are met by other team members. A facilitator cannot do other roles like take minutes and also to chair a meeting.

It is often tempting for a leader or a manager to say they will undertake the role of facilitating the meeting. Whilst the techniques mentioned here can help in these roles, experience shows that in really difficult meetings, the prime role of manager or leader tends to overshadow that of facilitator and this can result in an unproductive meeting.

Introducing a facilitator into your next team's meeting could enhance their ability to achieve the objectives and improve outputs. Managing the contents and structure of a meeting in an impartial and neutral way, the facilitator primary objective is the team rather than the issues, thus the team can get on with their roles and productively contribute. So next time you attend a meeting, that was the same as the last, didn't resolve anything, or was unsure about why they are even meeting, ask yourself, do we need a facilitator?

For further information on running meetings, you could try the following Internet sites:

- <http://www.uua.org/YRUU/resources/meeting.htm> easy to understand and contains a descriptions of a number of roles
- <http://www.cpcwnc.org/Toolbox/tbxmeeting.html> good site on how to run a good meeting, simple descriptions and tips

Do you want more information on nursing management? Then why don't you drop us a line, fill in the feedback form and let us know.

Instructions for Contributors

Publication policy

Publication cycle

Abu Dhabi Nurse is a quarterly publication. Contributions to sections may be made at any time

Editorial Policy

Contributions will be evaluated for congruence with Abu Dhabi Nurse editorial policies. Abu Dhabi Nurse is NOT a refereed journal. Contributions will be accepted on the following criteria:

- Main author is a nursing employee of the GAHS
- Style and information is consistent and does not contravene the MOH (2001) Code of Conduct for Nurses.
- Information contained is valid and sources referenced
- Relevancy to the profession of Nursing in Abu Dhabi

Contributions can utilise different methods and approaches, may examine methodological and/or conceptual questions, and should make a theoretical and/or empirical contribution to the profession of nursing in Abu Dhabi. Nursing in the UAE is undergoing professional growth and the GAHS continues to encourage the development of the profession, so articles dealing with clinical or professional practice, research, education and nursing theory application in Abu Dhabi are clearly welcome.

While there is no restriction on style or content, papers should contribute to building, enriching, reviewing or reiterating the body of knowledge in nursing in a coherent and cumulative manner. Research implications and/or nursing implications should be explicit and persuasive. Empirical and/or theoretical research will be clearly conceptualised, linked to actualisation

efforts and will offer new propositions.

The editorial team reserves the right to edit content of all submissions made to the magazine.

Copyright Statement

Abu Dhabi Nurse is a not-for-profit publication used as a nurse's professional training resource for Continuing Medical Education (CME) of current nursing employees of the General Authority for Health Services for the Emirate of Abu Dhabi. All contents derived externally, quotations and extracts shall state the relevant source and the name of author in published material in compliance with UAE Federal Law No (7) 2002 regarding Copyright and Neighbouring Rights.

Contributions

Contributions can be made in English or Arabic. Arabic contributions are requested to include a 100-word summary of the main points in English.

Contributions can be transmitted as an electronic file attachment to **abudhabicme_nsg@hotmail.com** (Otherwise, please send a CD or 3.5-diskette accompanied by a paper copy to Nursing Education, Mafraq Hospital, PO Box 2951, Abu Dhabi UAE)

Contributions submitted to Abu Dhabi Nurse should be presented in the following format:

A cover page should include the title, as well as the author's name, institution, and coordinates (telephone, fax, e-mail).

A title page, including a synopsis of no more than 100 words, should be included.

The number of pages is not specified, but the contributions will be evaluated, amongst other criteria, on its length-to-contribution relationship.

Software: Arabic/ English Microsoft® Word 2000 or less

Format

- Line-spacing at 1.5
- Title characters used:

TITLE:

BOLD, CAPITALS, CENTRED

SECTION HEADINGS:

CAPITALS, BOLD, LEFT-ALIGNED (English)/ RIGHT-ALIGNED (Arabic)

Sub-headings:

bold, small letters, left-aligned (English)/right-aligned (Arabic)

- Tables and figures should be titled, integrated in the text, and referred to in the text.
- Any footnotes should be at the bottom of the appropriate page.

References used should be acknowledged and include, in brackets, the authors' names and the year of publication. Reference to or citation of unpublished papers is to be avoided. References should begin on a separate page headed "REFERENCES", and should follow APA reference system:

For further information on referencing and style, please use guidelines delineated in the Publication Manual of the American Psychological Association, 5th ed., 2001. (<http://www.apa.org/books/pubman.htm>) The author must assume responsibility for the accuracy of references.

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Clinical Tips on PICC Lines

by Kathryn Allen CRN Oncology/Medicine
Shaikh Khalifa Medical Center

Peripherally Inserted Central Catheter (PICC)

Specific Hospital Policies always apply if in place

PICC lines are percutaneous central venous catheters inserted peripherally. Venous access is obtained by puncturing the cephalic or basilic vein just above or below the antecubital fossa. The tip rests in the superior vena cava at the junction of the right atrium. The catheters are approximately 40 cm long, but are individually sized upon insertion. These catheters are recommended for patients requiring IV therapy for more than six weeks.

Type of Catheter

Is it single, double or triple lumen? Is it an open ended or closed ended catheter?

All CVC are either open-ended or closed-ended. An open-ended tip opens directly into the vein. A closed-ended catheter has a valve either at the

tip or at the hub of the catheter. The valve is designed to remain closed when not in use. The pressure exerted by flushing or aspirating opens the valve. The valve eliminates backflow of air/blood in to the catheter, therefore clamping and heparinizing are not required.

Observations to make when using PICC Lines

All central catheters must be treated with a great deal of care and proper technique is one of the reasons these catheters can be used for extended periods of time. Monitor the site for any swelling or signs of infection. Watch for catheter migration out of the vein and report immediately.

Basic Maintenance and Dressing Care

Caring for the site and changing the dressings should be a sterile procedure. Sterile gloves and mask should always be used when opening the system. A

transparent dressing (i.e. 'Op-site 3000' or 'Tegaderm') should be used in order for proper observation to occur. The transparent dressings are impermeable to liquid, water and bacteria but permeable to moisture vapor and atmospheric gases. Their clear design allows visualization of the wound.

Dressing should be changed every 5-7 days or PRN

Caps on the end of catheters every 3 days if being used or every 7 days if not being used.

Flushing will depend on the use but a general guideline is minimum of 2 times per week. Also depends whether it is an open or closed-ended catheter.

Heparin Flush solution is used with a concentration of 100u of Heparin per 1 ml of Normal Saline.

What to Report?

Please report to the medical staff any obvious signs of infection, swelling, migration of the catheter and difficulty in flushing the catheter.

FEEDBACK

This magazine is for you, the nurse living and working in Abu Dhabi, so is important that we hear from you. Especially what you think and what you want to know about. Your feedback will help shape the future of your magazine.

Which facility do you work?

- Al Ain Hospital Al Jazeera Central Hospital Corniche Hospital Shaikh Khalifa Medical Centre
 Tawam Hospital Mafraq Hospital Other : _____

My favourite article in the first magazine was : _____
Because : _____

I would like to read an article on : _____

I need more information on : _____

Please feel free to attach further pages; it is important that we hear from you. Thanks, your feedback will help with forthcoming issues
Return this to your facility Nurse Educator, or send to :
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