The Importance of Cultural Assessments for Nurses
Ann Bhat, M.S.N., ACNP-BC, ACHPN, Palliative Care Nurse Practitioner, Internal Medicine/Palliative Care, Royal Oak

We are a diverse nation and have long been considered a melting pot. Cultures and sub-cultures may mesh, assimilate or acculturate. Nurses sometimes work alongside other staff or care for patients that are members of a culture different from their own. How can nurses understand, harmonize and respect the varied beliefs and values and then incorporate those into relationships and nursing practice? The following will provide insight into the process of becoming culturally competent.

Madeleine Leininger, Ph.D., LHD, D.S., CTN, RN, FAAN, FRCNA (1997) defines culture as “…the learned, shared, and transmitted values, beliefs, norms and lifeways of a particular culture that guides thinking, decisions and actions in patterned ways and often intergenerationally.”

“Cultural competency is an ongoing process where the healthcare professional continually strives to achieve the ability to work effectively within the cultural context of the patient, family and community,” according to Josepha Campinha-Bacote, Ph.D., RN, CNS, BC, CTN, FAAN (2007).

The literature abounds with studies identifying that cultural competence is an important component of providing safe and effective care for patients and families during all phases of health and illness. The lack of clear understanding of cultural beliefs and values may cause moral disputes, raise ethical concerns and prevent healthcare providers from delivering culturally competent care.

Is culturally competent care something new?
There have been studies of diverse cultural groups for many years in an effort to determine how to improve adherence to treatment plans and improve outcomes. We are aware that globalization has affected the shift in demographics. In the United States the shift reveals increasing racial and ethnic minority populations which translates into a blending of varied cultural backgrounds. This changing face of America brings forth several concerns. The Office of Minority Health identifies that racial and ethnic minorities experience poorer health outcomes for a variety of reasons with one being misunderstanding of cultural norms and miscommunication based on language barriers. They have proposed using culturally and linguistically appropriate service standards (CLAS) at every point of healthcare delivery. These comprehensive fourteen standards, revised in 2013, guide providers and institutions to insure effective, respectful and understandable care compatible with cultural health beliefs and practices. The CLAS standards specifically speak to ongoing education and training for healthcare providers in the area of cultural and linguistic appropriate service delivery.

In addition, the Joint Commission (2010) has an element of performance related to hospitals respecting the patient’s culture and personal values, beliefs and preferred religious and spiritual services. Patients and families, being vulnerable due to illness, trust the nurse to have the skill and knowledge to provide culturally appropriate care, thereby making the nurse essential to patient safety.

Is providing culturally competent care during serious life-limiting illness different from “usual” care?
There are even more challenges inherent in the provision of palliative and end-of-life care because of the delicate nature of the subject, potential for anticipatory grief and anxiety when facing one’s own mortality. Nurses may be further challenged when cultural norms differ from their own beliefs and this may affect the delivery of care during serious illness. It is vital that nurses recognize the unique and specific influences that culture has on the behaviors, attitudes, preferences and decision-making of patients and families, throughout the health-illness continuum. The Joint Commission (2010) recommends that

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Ferndale Pride Festival
Carolyn Reimann, Registrar, Patient Registration Services, Royal Oak

“Diversity: everyone matters.” This is a motto that Beaumont Hospitals hold near and dear, yet it is something that not everyone in our community knows we support.

This past June, some of our team members staffed a diversity booth at the Ferndale Pride Festival. At this booth we provided information about our health care system, physical therapy packets, advance directives and of course, the main attraction - freebies for those who stopped by.

Although the hand sanitizers and key chains may have been what attracted some people, the majority of the event goers who approached our booth were there to give us praise for being at the event. They let us know that Beaumont was the only health care system represented at the festival.

People shared stories with us of operations they had, how generations of their family had been born at our hospitals and how they have been associated with Beaumont for years. Everything we heard was positive. Some members from the lesbian, gay, bisexual, transgender/transsexual, or LGBT community, who have worked with or are currently part of our team, mentioned that they were unaware that we had a diversity program. They indicated that they were thrilled to be associated with an organization that supports them. The simple act of being part of the Pride event spoke volumes on our character as an organization.

One of the most important things we were able to hand out at this booth were advance directives. An advance directive allows people to designate an advocate to make health care decisions should they not be able to make decisions themselves. In the LGBT community, many cannot list their partners as next of kin, as they are not a legal spouse or blood related. Completing an advance directive ensures patients have the person they want making medical decisions. The positive response was overwhelming, and by the end of the evening we had handed out around 200 advance directives to our community.

Pride is not only the name of the event. It is how we should feel for being part of a team like Beaumont Health System where everyone truly does matter.

Lorna Post-Powell, B.S.N., RN, administrative manager, 8 South Neuroscience, Royal Oak and Annette Sciberras, B.S.N., RN, administrative manager, 8 North CPCU, Royal Oak, were selected for a poster presentation at the Nursing Management Congress 2013 in Chicago, September 9-13, 2013. The title of their poster is Integration of a transformational leadership shared governance culture to positively impact patient outcomes and staff satisfaction.

Wendy Chandler, M.S.N., RN, has accepted the position of director, Quality and Patient Safety for the Beaumont Medical Group. Most recently, she was the director, External Quality Measures. Wendy has a master’s of science degree in nursing from the University of Phoenix.

Alicia DeCaria, B.S.N., RN, has been appointed to the nursing committee of the American Society for Radiation Oncology or ASTRO for 2013 – 2014. She is the administrative manager, Radiation Oncology at Royal Oak.
Beaumont and Oakland University - Camp RN Program

Cynthia Nelson, B.S.N., RN, Education Specialist, Nursing Education and Research, Royal Oak

On July 19, 2013, Beaumont, Royal Oak welcomed tomorrow’s leaders – future nurses, doctors, lawyers, teachers and all fields of dreamers for the CAMP RN program. Held annually by Oakland University, this program brought youths, aged 10 to 14, to the Royal Oak campus for one day so they could explore some of the realities involved in daily hospital operations. Thirty students were selected by Oakland University for the program and were divided into three teams for the site visit. The teams were led by Cynthia Nelson, B.S.N., RN, Jennifer Fraga, B.S.N., RN, Julie Stomp, B.S.N., RN, OCN and Gail Ranger, B.S.N., RN, all education specialists from Nursing Education and Research.

Visiting the Pediatric unit and observing the enhanced playroom was an exciting experience for everyone. One student stated, “This should be my playroom at home.” The importance of the playroom in promoting the healing of sick children was explained.

The students also toured the Telemetry Monitoring Unit. The staff took time to explain heart disease and why monitors are used on certain patients. The students were fascinated when they were shown different rhythms on the screen and how alarms notified staff of any problems with patients.

Visiting the Mother Baby unit was also a big hit since everyone loves seeing newborn babies. The administrative manager for the Mother Baby unit took time to show the eager campers the babies and explained some key issues with infants that were hours to days old.

In our classrooms, campers had opportunities to learn how to use the patient electronic lift and AED, take vital signs and learn what the normal ranges are and how to make an occupied patient bed. The education specialists gave hands-on demonstrations of how to care for choking in adults, children and infants. Infant safe sleep was discussed and demonstrated using manikins to show correct positioning of babies when placed in cribs.

To top off the tour, the Security department presented the latest additions to the Beaumont K-9 unit: Nitro and Zena. This really excited all of the young campers.

We would like to thank all of the staff at Oakland University as well as the Beaumont Health System staff for making this another great and memorable event.
The birth of a baby is both a miraculous as well as a nerve wracking experience for new parents. Imagine going into labor but not being able to speak the language. Those parents are nervous, scared and still have the same worries that any other new parent-to-be has. As a nurse, I have had many patients with limited English proficiency during my fifteen years working in labor and delivery. Until recently, I believe that I have not fully considered how little information is given to these patients about what is happening to them medically.

In previous years we used family members to assist with interpretation. It was easy to ask a family member when they were right there with the patient. Even today, when an adult accompanies a patient to the hospital, there are circumstances where having them translate are perfectly appropriate. However, in medical situations, how do you know that they are accurately translating what you are saying? How do you know that they even understand what you are asking? And who can forget the cumbersome double telephone, which was definitely not user-friendly. For the past couple of years, the staff at Beaumont have had access to MARTTI, a portable, easy to use video relay interpretation system on wheels. WiFi is required for operation of the device. All you have to do is bring MARTTI to the patient bedside and press the call button. An operator comes up on the screen, asks a few questions then connects you to an interpreter. You may get just a voice or both voice and video.

I had a chance to fully implement MARTTI during a recent delivery experience with a non-English speaking family who had no one to interpret for them. I have used MARTTI in the past but just briefly. On this particular occasion, I began using MARTTI when my patient requested an epidural. The first translator was voice only and assisted the anesthesia department in obtaining the patient history, explaining what the epidural was and risks involved. MARTTI was left on during the procedure and was helpful in explaining to the patient the correct position for the procedure and what the patient would feel. Afterwards, the patient was positioned on her side and final questions were answered before disconnecting with the interpreter.

When it was time for the patient to begin pushing we connected again with the translator. This time we were connected to a female interpreter with video. She interpreted how to push and stayed on video the entire time. This interpreter was very helpful to both the staff and the patient. The patient watched the screen and listened intently to the translator. At times she would ask questions and the interpreter would relay our answers. You could see how dependent both the patient and her husband were on the interpreter. When asked if either had any questions, they usually had one or two. I always had the impression that my patient and her husband felt well informed and assured of what was happening because by using MARTTI, we were able to explain everything to them.

MARTTI has made translation services much easier for staff and more accurate and personal for patients and family members. If you are hesitant to try MARTTI because of previous awkward and time consuming experiences, I challenge you to give it a try.

Andrea Zinke, RNC-OB, Staff Nurse, Obstetrics, Troy

**Translation made more effective with MARTTI**

**Patient Care - Corporate Policies:**
- **Interpreters for Patients with Limited English Proficiency Policy 316**
- **Obtaining Interpreters for Patients with Limited English Proficiency Policy 316.1**

**Using MARTTI:**
- **Grosse Pointe**: If your area is not assigned a MARTTI unit, call the Nursing Office at extension 1655 to borrow a MARTTI device
- **Royal Oak**: If your area is not assigned a MARTTI unit, call the Nursing Resource Office at extension 80933 to borrow a MARTTI device
- **Troy**: If your area is not assigned a MARTTI unit, call Nursing Administration at extension 45160 to borrow a MARTTI device. After hours contact the Administrative Supervisor at 248-995-9852

**Ambulatory Sites**: Each site will follow the practice of the hospital to which they report
Michelle Wallace, B.S.N., RN, OCN, has been appointed as the chair of the nursing committee of the American Society for Radiation Oncology, or ASTRO for 2013 – 2014. She is a nurse clinician, Radiation Oncology at Royal Oak.

Beaumont, Royal Oak is the recipient of the Nursing Compass Operational Excellence Award sponsored by The Advisory Board Company. The award-winning submission was Reducing indirect hours by crosstraining existing workforce. Maureen Bowman, M.A., B.S.N., RN, NEA-BC and Randy Whitney, M.S.A., B.S.N., RN, NEA-BC accepted the award on behalf of the hospital. Maureen is the Vice President and Chief Nurse Executive and Randy is a Director of Nursing at Royal Oak.

Kim Wesley, M.B.A., B.S.N., RN has accepted the position of clinical nurse specialist for 5 North Surgical at Royal Oak. Kim received her M.B.A. and B.S.N. from Oakland University. She has held previous positions as a nurse clinician for general surgery and staff nurse in the SICU.

**JUST CULTURE STAFF EDUCATION ROLL-OUT**

*Alice Speers, M.Ed., B.Sc.N., RN-BC, Nurse Manager, Surgical Services Education, Royal Oak*

**What is Just Culture?**
Beaumont Health System is striving to create an open, fair and just culture by:
- Proactively managing risks and behavioral choices
- Designing safe systems
- Responding in a fair and consistent manner to adverse events
- Learning through transparent dialogue about risks and safety expectations

**Why is it important?**
- A safe environment encourages reporting of mistakes and hazards. Knowing that we will be managed fairly when we make a mistake or are involved in an adverse event is essential to creating this safe culture.

**What will success look like?**
- Leaders will identify and correct safety hazards.
- Expectations for safe performance will be clear and well-defined.
- Staff will feel safe reporting their mistakes and workplace hazards, knowing that safety issues will be addressed and they will be treated in a just, fair and consistent manner.
- Leaders will investigate events by using a standard approach/algorithm and teach staff the importance of making safe behavioral choices.

**What must staff do?**
- Recognize risk and hazards in your environment
- Recognize the behavioral choices you make
- Report safety issues to your department leaders and work with your department leaders to design safe work systems
- Cross-monitor other healthcare team members

Over the coming year your manager will be expected to review the vignettes with the staff. The vignettes are each about 10 minutes long and include all the points that need to be discussed. Vignettes to be reviewed include:
- by October 31, 2013 – Staff to view “Just Culture: Safe Choices - No Small Consequences” (CUL13003) on Halogen or in groups
- by March 31, 2014 – Manager and staff to view and discuss vignettes 1 and 2
- by June 30, 2014 - Manager and staff to view and discuss vignettes 3 and 4
- by September 30, 2014 - Manager and staff to view and discuss vignettes 5 and 6

Your manager will facilitate discussions with each unit/team centered on the vignettes and the concepts of Just Culture.

Watch for revised policies and a new Just Culture Advisory Committee.
It all starts with the **blessing**... Reverend Rik comes to deliver a blessing to the community garden and those who care for it.

The Unit Practice Council at Troy has had a community garden near the west entrance of the hospital for a few years. We are always happy to celebrate the rewards it brings. This year, when the new Rehab unit opened, I was approached by the manager, Fran Borg, B.S.N., RN, and the recreational therapist, Linda Edwards, M.A., CBIS, CTRS, about their interest in the garden for the patients on the Rehab unit. We met and decided to combine our efforts and have an area designated for a raised garden so wheelchair/walker patients who could not bend to help could still achieve benefit from walks outside, some weeding and harvesting. It has been a wonderful success! The patients enjoy the “outing” and it has shown wonderful accomplishments with what they can do in spite of deficits.

Then comes the **harvest**...

One gentleman suffered a stroke which left him initially unable to move and use his left hand, arm and much of his leg. Two weeks of strengthening and exercise and he was picking vegetables from the garden!

He harvested one of the very first tomatoes from the garden and I received a call to his room where he presented me with the “Trophy Tomato.”

The harvest is picked by volunteers from the PNC and then is delivered to our very own veggie transport, Monica Taubitz, B.S.N., RNC-OB, C-EFM. Monica is a Nursing Manager at Troy who donates her time and efforts to deliver our prize vegetables to her church, St Anastasia, where it is offered to those in need in our community. The rest is the **thanks** we feel for **giving**.
On August 14th, after many months of planning, developing and testing, the Human Investigation Committee implemented an electronic submission system, called iMedRIS. Implementation of the new system provides many advantages for researchers. They are no longer required to print and submit multiple copies of applications and forms because all transactions are done electronically, including signoffs by the clinical research nurse managers and department chairs, correspondence with the HIC, responses to required modifications and the submission of other study forms. Principal investigators and chairs are prompted by an email when they need to log into the system and provide review or approval. By simply logging into iMedRIS, researchers have ready access to the status of their submissions and actions which need to be addressed. Most importantly, iMedRIS is web-based and accessible from any computer – inside or outside the Beaumont system.

Training began in July with series of live seminars and hands-on workshops. Training modules and a link to the system are available on the iMedRIS website, which links from the HIC main page on Inside Beaumont. Researchers log in using the Beaumont Health System username used for other Beaumont systems.

For existing studies (those reviewed prior to iMedRIS implementation), researchers must enter an abbreviated iMedRIS application comprised of a limited amount of information taken from the original HIC application. We expect this activity to take about 30 minutes per study. Once the HIC has confirmed the information to be correct and consistent with the original HIC approval, which may take up to two weeks, you may submit amendments, protocol deviations, unanticipated problems and progress reports. To avoid a lapse in HIC study approval, we recommend researchers enter abbreviated applications as early as possible.

**Key dates:**

**August 14:** iMedRIS opened and researchers began entering studies, follow-up forms and reports. Researchers with studies approved on the paper system (prior to October 4, 2013) began entering abbreviated applications.

**October 5:** All initial HIC Application submissions, Amendments, Progress Reports, Unanticipated Problems, Protocol Deviations and Final Reports must be submitted in iMedRIS. No paper forms/documents will be accepted after October 4, 2013.

**November 1:** The first HIC meeting using iMedRIS will be held. All submissions to be reviewed at this meeting must be entered into iMedRIS (e.g., Initial Applications, Amendments, Progress Reports, Protocol Deviations, Unanticipated Problems, Final Reports).

For more information about the iMedRIS implementation, see our website: http://employee.beaumont.edu/portal/pls/portal/ip30dev.page_pkg.page?xid=iMedRIS or contact the Beaumont Human Investigation Committee at 248-551-0662.

The Research Institute is confident that this system will streamline our HIC application process and the correspondences/responses that accompany applications.

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**VISIBLE IN PRACTICE**

The Audrey N. Kottenstette Nursing Scholarship endowment was established in 1994 by Dr. and Mrs. Thaddeus Joos, daughter of Audrey Kottenstette. This is a specialized nursing scholarship endowment for Beaumont, Grosse Pointe nurses seeking a graduate degree.

There are three awardees for the 2013 scholarships. **Benjamin Borton**, B.S.N., RN, is a staff nurse, in the CCSU. He is attending the University of Michigan, Flint doctor of nursing practice program. **Molly Czoykowski**, B.S.N., RN, is attending Oakland University. Her goal is to become an advanced practice nurse. **Marisa Engel**, B.S.N., RNC-OB, is attending the University of Detroit Mercy, in the Health Systems Management-M.S.N. program. She is staff nurse in the Family Birth Center.
Domestic violence: what to do when the answer is “yes”

Linda Caurdy-Bess, LMSW, Manager, Social Work, Royal Oak, Debra Brike, M.S.N.-Ed, RN, CEN, Clinical Nurse Specialist, Nursing Education, Grosse Pointe and Sallie Amalfitano, LMSW, Manager, Social Work, Troy

Domestic violence and abuse are used for one purpose and one purpose only: to gain and maintain total control over you. An abuser doesn’t play fair. Abusers use fear, guilt, shame and intimidation to wear you down and keep you under his or her thumb. Your abuser may also threaten you, hurt you or hurt those around you.

In early 2000, The Joint Commission instituted a standard that requires all patients to be assessed for abuse. While many health care providers have always been aware that many of the patients they were seeing might be victims of domestic violence or other abuse and that some of their physical complaints were the result of trauma and stress, this standard required a hospital wide response to develop an assessment tool and necessary interventions. This article will focus on the issue of Domestic Violence as October is Domestic Violence Awareness Month.

Domestic Violence is a learned pattern of behaviors used by one person in a relationship to control the other person. Partners may be married, separated, divorced or dating. Violence affects women, children and men of all ages, in all cultural, ethnic, religious, educational and socioeconomic groups. Relationships may be between different sex or same sex partners. According to Michigan Incident Crime Reporting statistics for 2011, there were 95,024 offenses of domestic violence reported to law enforcement. 101 of these incidents resulted in a victim fatality.

When you complete an assessment of your patient and they respond with a “yes” to the question “Have you ever been verbally, emotionally, physically or sexually harmed or threatened by your partner or anyone else?” Now what? First take a deep breath. Provide empathy to your patient. “Everyone deserves to feel safe. We have information about how to get help and how to protect yourself and your family. Would you like this information?” Then ask some follow up questions about potential immediate risk and the patient’s intent at this time.

Leaving a domestic violence situation is not an easy decision. Research shows that it takes a victim multiple attempts before leaving. Don’t judge the success of the intervention by the patient’s action. A woman is most at risk of serious injury or even homicide when she attempts to leave an abusive partner and it may take her a long time before she can finally do so. We must support our patients in their decision making ability, they know the situation best. Also remember so often they have been stripped of this power to make choices. We would not want to further victimize them in this situation. Making a statement such as “Regardless of your decision, I am here to support you” or “You have choices about what to do next, I am here to support you” can be very helpful.

Except for a few specific situations, you can assure your patient confidentiality. But when someone is being treated for a gunshot, stab wound or injury by other means of violence, a report to local law enforcement is required. In cases of suspected child abuse or elder abuse, Child Protective Services or Adult Protective Services must be called. Most situations do not meet this definition and we can assure the patient that their story will not be shared.

Know your hospital and community resources. Ask you patient whether they would like to talk with someone about their situation. If yes, contact social work or if the patient is agreeable, a victim advocate from the local domestic violence shelter (in Oakland County - Haven, Macomb County - Turning Point and in Wayne County - Looking for my Sister). Offer the patient resources such as the purple abuse help cards available in our public restrooms. Refer to the Corporate Abuse Policy 320.2.

Document any/all injuries and include the patient’s statements in your documentation.

The role of healthcare providers:
• you cannot stop violence
• you cannot make choices for competent adults
• you can make a difference, one person at a time

Watch for Domestic Violence events taking place throughout Beaumont Health System in October.

“If the numbers we see in domestic violence were applied to terrorism or gang violence, the entire country would be up in arms, and it would be the lead story on the news every night”

– Mark Green
The DAISY Award for extraordinary nurses at Beaumont is presented monthly. Co-workers, families, physicians or volunteers may nominate nurses, using a form created by the Professional Nurse Council. The most recent recipients are:

**GROSSE POINTE RECIPIENTS**
- Leslie Caplat, RN
  3 SE/Ortho
- Linda LaHood, RN
  2 E

**ROYAL OAK RECIPIENTS**
- Jean Moroski, RN
  2 NT PACU
- Betsy Monette, RN
  2 NT Pre-op

**TROY RECIPIENTS**
- Leanne McMinn, RN
  Mother Baby
- Kevin Burke, RN
  4 West
- Susan Mason, RN
  3 North PCU

**Still have questions? Here are some resources:**
- Student Center problems: Esvin Alpirez Mateo, 248-27-36306 or Beaumont University, 248-27-36300
- Corporate mandates/online course development: Lynn Farr, 248-27-36304
- Log in issues: Help Desk, 248-59-72727

**2013 CORPORATE MANDATORIES**

Remember that the absolute deadline for employees and physicians to complete corporate mandatories is December 31, 2013. In some areas, managers may determine an earlier deadline.

Instructions for how to use the Student Center can be found on the Beaumont University home page.

**Holly Lechner**, B.S.N., RN, has been promoted to associate nurse manager for 9 North Medical, Royal Oak. Holly received her bachelor of science degree from Loyola University. She previously worked as a staff nurse on 9 North.

**Donna Polom**, M.S.N., RN, CMSRN, ACNS-BC has passed the certification exam as an adult clinical nurse specialist. Donna completed her post-graduate certificate as a clinical nurse specialist at the University of Detroit Mercy. She works as a staff nurse on 3 West at Grosse Pointe in addition to teaching at Macomb Community College and Oakland University.

**Patrina Johnson**, B.S.N., RN has accepted the position of associate nurse manager for 9S/Orthopedics at Royal Oak. Patrina received her B.S.N. from University of Detroit Mercy. Her previous position was as a staff nurse on 9 South.

**Nadine Greening**, B.S.N., RN, has been has been promoted to associate nurse manager for 6 South Medical/ GYN, Royal Oak. Nadine received her bachelor’s degree from Madonna University. She previously worked as staff nurse in Women’s Health as well as orthopaedics, endoscopy, and medical surgical at Henry Ford Macomb Hospital. She was also a house manager at Henry Ford Macomb.
The following nurses have attained/maintained Professional Level III:

- **Tiffani Abrams**, RN  
  9N/Medical Royal Oak
- **Carmen Bartley**, RN  
  3E/SICU, Royal Oak
- **Cathlene Beebe**, RO, RN  
  2E/SICU, Royal Oak
- **Nicole Beneteau**, RN  
  Oncology, Royal Oak
- **Rodella Celis-Bugayong**, RN  
  SICU, Troy
- **Erika D’Aoust**, RN  
  EC, Troy
- **Lisa Davis**, RN  
  5C Nephrology/Transplantation, Royal Oak
- **Kristin Dickens**, RN  
  PICU, Royal Oak
- **Heidi Dover**, RN  
  4S, Troy
- **Cindy Engle**, RN  
  SICU, Troy
- **Jolly Jaimon**, RN  
  MICU, Troy
- **Renee Jenkinson**, RN  
  4W, Troy
- **Jennifer Jones**, RN  
  PICU, Royal Oak
- **Timothy Joseph**, RN  
  5E/SICU, Royal Oak
- **Fran Kemp**, RN  
  4S, Troy
- **Andrea Kline**, RN  
  MICU, Royal Oak
- **Kristen Maki**, RN  
  FBC, Royal Oak
- **Desiree Marentette**, RN  
  3E/PCU, Troy
- **Shari Mullaly**, RN  
  MCH, Troy
- **Monica Schweiger**, RN  
  6S GYN/Medical, Royal Oak
- **Danielle Stinchcombe**, RN  
  4E/MICU, Royal Oak
- **Kelly Tenaglia**, RN  
  6S/GYN-Med, Royal Oak
- **Theresa Ulicny**, RN  
  4S/PCU, Troy
- **Irene Uy**, RN  
  5C Nephrology & Transplantation, Royal Oak

The following nurses have attained/maintained Professional Level IV:

- **Cindy Check**, R.N.  
  8N/CPCU, Royal Oak
- **Jai Georgy**, R.N.  
  CPCU, Troy
- **Marisa Engel**, R.N.  
  FBC, Grosse Pointe
- **Frances Makarski**, R.N.  
  5E/SICU, Royal Oak
- **Debra McLaughlin**, R.N.  
  FBC, Royal Oak
- **Jill Pendergraft**, R.N.  
  6C/Hospice-Palliative Care, Royal Oak
- **Marianne Snopkowski**, R.N.  
  PICU, Royal Oak

**CONGRATULATIONS!**

The following nurses have achieved Gerontological Nursing Certification:

- **Cheryl Caruss**, RN-BC, 6 Center/Hospice & Palliative Care
- **Crystal Alcala**, RN-BC, 6 Center/Hospice & Palliative Care
- **Tracy Rebkowec**, RN-BC, 6 Center/Hospice & Palliative Care

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Volunteering at the Gathering Ministries Health Fair

On Saturday, August 3rd, Beaumont Royal Oak nurses, **Diane Dinkha**, B.S.N., B.S.P., RN, Staff Nurse, 5N/Surgical; **Deanna Freeman**, B.S.N., RN, Associate Nurse Manager, 9S/Orthopedics; **Gina Layog**, B.S.N., RN, Staff Nurse, 4C/MPCU; **April McCain**, RN, Staff Nurse, 9S/Orthopedics and **Annette Seiberras**, B.S.N., RN, Administrative Manager, 8N/CPCU, volunteered by manning a table at the 2nd Annual Health Fair at Gathering Ministries Church of God in Christ Church, Detroit. Their focus was teaching diabetes prevention and management, the effects of undiagnosed and unmanaged hypertension and the signs and symptoms of stroke, including the need to call 911. They also provided blood pressure checks and distributed materials on healthy food choices, healthy lifestyle and prevention of coronary artery disease.

Gina commented “Representing Beaumont Healthcare System, I felt that we made a very good impression that Beaumont is always there for the community.”
The Professional Development Committee at Troy, as part of the PNC, recently developed the ROSE (Recognition for Outstanding Service Encounter) Award to recognize and celebrate our nursing assistants and nurse technicians as an integral part of our patient care team. The ROSE Award is given out monthly as a way to recognize a nurse assistant or nurse technician for exemplifying outstanding service going above and beyond their normal duties. Grosse Pointe ROSE Award winners are Natalie Serafano, N.A., 3W and Fran Soyka, N.T., EC.

Troy ROSE Award winners are Kevin Kirby, N.A., CPCU, Rachel Rotar, N.A., Inpatient Rehab Services and Angela Stern, N.A., Mother Baby.

The following are a sample of the variety of topics available. A list of all online courses can be found in the “2013 Online Course Catalog,” on the BU home page.

**Genetics and Genomics (NSG13063)**
This module discusses the impact of genetics/genomics on the future of health care, and is part of the study, “Expanding RN scope of practice: A method for introducing a new competency into nursing practice.” It provides an overview of the basic elements of genetics, patterns of inheritance and how genetic mutations occur.

**Hill-Rom TotalCare Bed (NSG13070)**
An interactive module (30 minutes in length) that shows you how to use the TotalCare bed.

**Neonatal Shock (NSG13054)**
An overview of shock, including the types, causes, assessment, management and treatment, with a focus on the neonate.

**Pediatric Emergency Management (NSG13056)**
The focus of this introductory module is the management of pediatric emergencies in the EC, including the unique challenges in caring for ill and injured children.

**Periop Nursing Skin Assessment & Bundle (SS13013)**
Although the target audience is perioperative staff, much of the information will apply to other areas of nursing. Topics include skin assessment, prevention of skin tears/pressure ulcers and the Surgical Services skin bundle.

**BIP Pharmacy Math Quiz (BIP13001)**
This quiz-only module will test your knowledge about calculating drug dosages.
CULTURAL ASSESSMENTS continued from page 1

all hospitals identify and integrate the patient’s cultural, religious and spiritual beliefs and practices into care at end-of-life. Professional organizations, such as the American Association of Colleges of Nursing, have specific competencies for end-of-life care that stress the importance of preparing nurses to provide high quality care during the transition to end of life. Importantly, the competencies include recognizing diversity of the population as well as recognizing one’s own attitudes and beliefs.

Studies indicate that many cultural differences exist between groups in relation to advanced directives, life support, communication and decision making. Planning for end-of-life, for instance, is predominantly a North American concept. Some groups feel it is bad luck to talk about death and that saying certain words make the event come to fruition. Others feel that autonomy is disrespectful to the family and therefore defer decision-making to others. Still others may feel that the physician’s role is paternalistic and therefore the patient is to follow whatever the doctor recommends. Several groups feel that quantity of life is more important than quality.

How can nurses find out about the patient’s and family’s cultural preferences?
The first step is to understand oneself. What is your cultural background, your beliefs and values? How do you feel about diverse groups? Do you stereotype or have prejudices? Do they impact delivery of your nursing care? Edward Morrow (1955) said, “Everyone is a prisoner of his own experiences. No one can eliminate prejudices; just recognize them.”

The second step is to recognize that there are different ways to achieve the same goal. Patients and families may not always understand the western method of healthcare and unless we ask questions, we may be talking in parallel dimensions. In 1990, the government enacted the Patient Self Determination Act which speaks of fundamental rights such as informed consent, truth telling and open communication with providers. This may be in direct conflict with cultures that do not believe bad news should ever be given to the patient, but only shared with family. They may consider this western practice disrespectful, causing a cultural conflict, dissatisfaction and distrust. A simple question that can be asked would be: “Is there anything in your cultural background that is important for the healthcare team to know so we can provide the best possible care”? Another question may be: “Are you a person that wants to know the details of your medical condition and if not, who makes those decisions for you?”

When do nurses ask these questions and are the answers documented in the chart?
Registered nurses are key providers in a prime position to perform a cultural assessment during any interaction with the patient and family. There are three areas in the nursing admission assessment related to cultural, spiritual and a combined area of Cultural/End-of-Life/Spiritual needs. The drop down menu allows several selections and there is also a section for comments. Reviewing the listed options can trigger questions such as: “Are there any religious or spiritual practices that are important during illness? And, if so, how can we assist in supporting those practices? Perhaps there are cultural beliefs that require a same gender caregiver or chaperone in the room during delivery of care. If so, how can we accommodate and negotiate to provide safe and respectable care? These are only a couple examples of how nursing can be involved in cultural assessments, document the findings in the electronic medical record and thereby provide access for all health care providers and allow for integration of cultural beliefs and values into the plan of care.

How can I learn more about promoting cultural competence in nursing?
There are three online modules on the Beaumont Student Center which promote the lifelong process of cultural competency. The modules focus on self-assessment and definitions, learning about diverse cultures and finally on how to incorporate cultural assessment into usual nursing practice.

You can self-register for these courses:
• NSG13065 Promoting Cultural Competence 1
• NSG13066 Promoting Cultural Competence 2
• NSG13067 Promoting Cultural Competence 3