In Defense of the DNP

Contrary to the notion that the doctor of nursing practice (DNP) degree would confuse patients and the public, I believe that such a degree could and should provide much-needed clarity around independent practice issues such as prescribing, ordering tests, and completing forms (“Doctor of Nursing Practice—MRI or Total Body Scan?” July 2005: 278-281).

I have been in clinical practice as a family nurse practitioner (NP) for 8 years following 12 years as an RN in the hospital. I have developed a vigorous and challenging practice that involves independent management of many complex patients. I manage chronic pain conditions and have my Drug Enforcement Administration number and Schedule II authority. In addition, I have a Medicare unique physician identification number and can bill for services under my license. I am the hepatitis C clinician champion and receive referrals from NPs, physician assistants, and doctors to evaluate and treat hepatitis C. I have directed a diabetes collaborative effort at our health center and manage many diabetic patients. I am also the information technology clinician champion and have led our clinicians toward better use of technology for improved clinical practice.

My practice has become so noticeably like that of a doctor that patients often call me “doctor” (despite the fact that I always introduce myself as a “nurse practitioner”); even those in the healthcare community around me cannot get my title right. Certainly my name and professional designation are known throughout the places where I make referrals, order tests and procedures, and prescribe medications, yet roughly 60% of consults (“Chris Stewart, MD” or “Dr Stewart” inscribed on them). Occasionally, too, I encounter “holdout” agencies that insist on a “doctor’s signature,” causing confusion and delay for those patients who have seen only me.

Clearly there are 2 issues here: independent practice rights and professional title. But having the professional title of “doctor” would, first of all, clarify for my patients and colleagues that I do have independent “doctoral” practice rights. Secondly, the availability of the DNP degree might push the issue for truly independent practice rights, removing the invisible walls that presently exist. I support the idea of maintaining the master of science degree for initial practice (for the NP) and adding to the curriculum for those of us who choose to seek the DNP degree. As a result, those who choose to maintain a less independent or focused role will be able to do so without having to go beyond the master of science degree, and those who wish to broaden their practice and independence can always seek the DNP.

I intend to earn this degree for precisely the reasons I’ve described, and I hope other NPs who have worked so hard to advance the NP role in their institutions will do the same.

Chris Stewart, NP, MSN
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Questioning Guidelines in the ECG Puzzler

A recent ECG Puzzler article (“Nonsustained Ventricular Tachycardia in the Elderly,” September 2006: 519-520) contained several discrepancies with the current literature. They are as follows: (1) tachycardia was defined as a rate greater than 90/min, with normal defined as 60 to 90/min; (2) short PR interval was identified as less than 0.08 seconds; (3) wide QRS was identified as greater than 0.12 seconds; (4) nonsustained ventricular tachycardia (NSVT) was defined as 3 or more complexes at a rate greater than 120/min; and (5) I was simply unsure what point was being made about QRS complex direction.

I have been teaching this content for 25 years and would define the above measurements as follows: (1) tachycardia was greater than 100/min; (2) normal PR interval is equal to or less than 0.11 seconds; (3) wide QRS complex duration is equal to or greater than 0.12 seconds; (4) NSVT rate is 3 or more complexes at a rate greater than 100/min (all tachycardia rhythms minimally fall under this definition); (5) as for ventricular tachycardia with positive QRS, in V1 the width greater than 0.14 seconds is a ventricular tachycardia characteristic; with a negative QRS in V1, the width equal to or greater than 0.16 is a characteristic of ventricular tachycardia.

There are so many more points to be made related to ECG characteristics of ventricular tachycardia that do not appear in this article, including but not limited to axis, capture and fusion complexes, previous ECG characteristics, and the 4 signs of ventricular tachycardia, which apply if QRS is greater than 0.14 seconds in V1 and/or V2. These 4 signs are (1) wide R (>0.04 seconds)
in \( V_1 \) and/or \( V_2 \), (2) slurred S (notched) downstroke in \( V_1 \) and/or \( V_2 \), (3) delayed S nadir (>0.06 seconds) in \( V_1 \) and/or \( V_2 \), and (4) q wave in \( V_6 \) when the complex is mainly negative in \( V_1 \). Opposite polarity doesn’t always diagnose the rhythm as ventricular tachycardia.

Also, it is troubling that the authors close the article with “it is important to rule out cardiac disease in this patient before he is discharged, by means of resting 12-lead ECG, serum biomarkers, echocardiography, and so on.” I find the phrase “and so on” a little disconcerting. This patient probably should receive serial ECGs (not just one), serial cardiac markers, risk assessment, and, at the very least, noninvasive testing including a stress test and perhaps a percutaneous coronary intervention.

Sandra Walden, MS, BSN, RN
Columbus, Ohio

REFERENCE

My colleague and I use AACN’s “9 features” (those that appear in the ECG Puzzler column) in a basic ECG course we teach to nurses working in the intensive care and telehealth units in our hospital. However, we’ve been wondering about some discrepancies in the column. The first deals with heart rate. Although the ECG Puzzler states that “normal” heart rate is “60-90 beats per minute,” the literature (including AACN’s literature) states that a normal rate is 60 to 100/min.

The second problem is with PR interval. According to the ECG Puzzler, a short PR interval is one that is less than 0.08 seconds. However, the literature seems to disagree on this measurement, instead suggesting that a short PR interval is less than 0.12 seconds.

The next point is about QTc and T waves. We would suggest that both of these features could include a check box that reads “cannot determine” for cases in which neither is discernible because of distortion.

Similarly, ST segments could include a check box that reads “flat,” because this has been identified as an abnormality of concern in the literature.

Michele Kilbourne, RN, CCRN
Chris Sorenson, RN, MSN, CCRN
Denver, Colo

Mary G. Carey and Michele M. Pelter reply:

Our thanks to these authors for their letters. First let’s deal with points the letters have in common.

Yes, it’s true that sinus rhythm historically has been defined as 60 to 100/min. However, physiologically and clinically speaking, sinus rhythm in the resting adult is specifically 44 to 84/min for men and 50 to 90/min for women.1,2

As for the PR interval, it is normally between 0.12 and 0.20 seconds; therefore, we’ve made a correction to the column beginning with this issue. A QRS duration greater than 0.12 seconds does suggest an intraventricular conduction delay. However, given that it is often difficult to determine exactly where the QRS begins and ends, precise measurements are difficult to ensure. And so, to improve the specificity of identifying a wide QRS in the ECG Puzzler column, the criterion of “greater than 0.12 seconds” (3 small boxes) has been applied.

We concur with Ms Walden that tachycardia is greater than 100/min rather than 120/min. We also agree that there are numerous characteristics of ventricular tachycardia easily applied to a resting 12-lead ECG (eg, QRS axis). Ms Walden is not incorrect in her assessment, but the 4 signs of ventricular tachycardia she outlines are correct only with a particular ECG waveform; for the ECG waveform in our example, Ms Walden’s criteria are not helpful. Also, our overall interpretation was not incorrect; that is, we called it ventricular tachycardia. Because our column only provided a short dual-lead ECG strip typically found in clinical practice, many additional ECG criteria cannot be applied. It is for this reason that we focus on criteria that can be applied, such as QRS width and morphology.

We agree that it is important for the patient to have a cardiac evaluation—that is why we introduced the final paragraph with the word however in italics to emphasize the point. A comprehensive list of possible cardiac procedures (eg, resting ECG, serial ECG, Holter ECG, serum biomarkers, C-reactive protein level, echocardiography, stress test, angiogram, computed tomography scan, magnetic resonance images) is beyond the scope of the ECG Puzzler column. For the sake of brevity, then, we simply used “and so on.”

The letter from Kilbourne and Sorenson raises 2 other points. Yes, “cannot determine” is not a fixed option for measures of QTc and T wave, but depending on the scenario presented in the ECG Puzzler we have added it as an option. Although notable, “flat” ST segments are nondiagnostic; in other words, they do not definitively identify a diagnosis. Given that the focus of our column is clinical, however, we prioritized true ST-segment deviation that meets diagnostic criteria.

REFERENCES
Confirmation of Nasogastric Tube Placement

I have read the AACN Practice Alert titled “Verification of Feeding Tube Placement”1 as well as the recent article by Metheny about preventing aspiration in patients with feeding tubes (“Preventing Respiratory Complications of Tube Feedings: Evidence-Based Practice,” July 2006: 360-369). My interpretation of these sources is that we should have an initial x-ray to confirm placement of any nasogastric tube prior to administering medication, feedings, and fluids.

Some of my colleagues look at these sources and infer a distinction between a small-bore “feeding” tube and a large-bore nasogastric tube (eg, Salem Sump). In making this distinction, they feel that x-ray confirmation is not necessary for large-bore nasogastric tubes; I don’t see that, however. I also notice that the AACN Procedure Manual for Critical Care does not clearly recommend x-ray confirmation for placement of these large-bore tubes.2 To me, the danger in such an approach is that large-bore tubes are sometimes used for feeding and administration of medications as well as for drainage. This fact leaves several questions unanswered. Should we trust nonradiologic confirmation techniques? Also, what exceptions should we make for Salem Sump tubes when confirming placement?

Kathleen Kunis, RN, MS, CCRN
Petaluma, Calif

REFERENCES

Norma Metheny replies:

You have raised an important question. The Practice Alert issued by AACN in 2005 recommends radiographic confirmation of correct tube placement prior to initial use in all critically ill patients receiving feedings or medications via blindly inserted tubes.1 Although it is not explicitly stated, this recommendation refers to all blindly inserted tubes regardless of size or type. The common assumption that bedside assessments work better for large-bore tubes than for small-bore tubes is largely false. A gurgling sound can be heard over the epigastrium when air is injected through a tube, regardless of its size and port configuration (of course, this “auscultatory method” is not reliable). It is easier to obtain an aspirate from a large-bore tube to test its pH and observe its appearance; however, these methods (though far better than the auscultatory method) are not as accurate as radiography.

Whereas clinicians rightly worry about inadvertent respiratory placement of a blindly inserted tube, they also should consider whether the tube is properly positioned in the patient’s gastrointestinal tract. Many institutions now require x-ray confirmation that the ports of a nasogastric tube are in the stomach (rather than the esophagus) before the infusion of bowel preparation solutions, medications, or feedings to avoid inadvertent aspiration.2 As reported in the July 2006 issue of the American Journal of Critical Care, a patient suffered a massive aspiration following the rapid administration of several liters of a bowel preparation solution via an 18 French sump tube that ended in the distal esophagus; the tube was assumed to be properly positioned based on the auscultatory method.1 There are multiple other reports3-7 of patients being harmed by substances administered through erroneously positioned large-bore tubes. In all of these situations, nonradiologic assessments indicated “correct” placement.

In my view, the cost of an x-ray to confirm correct placement of a blindly inserted tube of any size prior to its initial use to administer formula or medications to critically ill patients is money well spent.

REFERENCES

Reader Offers Solution to Blood Pressure Cuff Problem

In response to the letter from David Sherman in which he describes the difficulty of measuring blood pressure in patients whose upper arms are too large for conventional blood pressure cuffs (“Manufacturers Can Solve Our Blood Pressure Cuff Problem,” November 2006: 540), I would like to comment. The Critikon company does indeed make long cuffs that are not wide but normal length. The reference number for the cuff is 2140. It is 23 to 33 cm in length. We use them all the time at our facility and they have been great for solving the problem Mr Sherman describes.

Melinda Schell, RN, MS, MSN, CCRN
Bradenton, Fla

1. American Journal of Critical Care, January 2007, Volume 16, No. 1
Confirmation of Nasogastric Tube Placement
Kathleen Kunis

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