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NOTICE!

State agencies will be closed on the following dates:
Thursday, December 25, 2014
Friday, December 26, 2014
Thursday, January 1, 2015

The Alabama Board of Nursing is a state agency and will be closed on these days as well. Registered Nurses who have not renewed should carefully note the dates. Following the Christmas holiday, the last day the board office will be open is Wednesday, December 31, 2014.

The law states that any RNs license not renewed as of December 31, 2014 (at midnight) shall automatically lapse. Online renewal is available 24 hours per day, 7 days per week at www.abn.alabama.gov. There is no payment for articles published in The Alabama Nurse.

Guidelines for Article Development

The ASNA welcomes articles for publication. There is no payment for articles published in The Alabama Nurse.

1. Articles should be Microsoft Word using a 12 point font.
2. Article length should not exceed five (5) pages 8 x 11.
3. All reference should be cited at the end of the article – not in body.
4. Articles should be submitted electronically.

Submissions should be sent to: edasna@alabamanurses.org or Editor, The Alabama Nurse
Alabama State Nurses Association
360 North Hull Street
Montgomery, AL 36104

ASNA reserves the right to not publish submissions.


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NURSES DAY AT THE CAPITOL
March 11, 2015 Montgomery, Alabama

The Alabama Legislature has many new faces after the November election. This first year of their term, we want to send a message that nurses are engaged and participating in advocacy for the profession and for the highest standards in patient care. This year’s event will have a selection of several educational forums about healthcare and public policy followed by a rally in front of the Alabama State House. Mark your calendar for the morning of the 11th. Let your voice be heard.

THE ASNA OFFICE WILL BE CLOSED FOR BUSINESS DECEMBER 24, 2014 THROUGH JANUARY 1, 2015

Our normal office hours are
Monday – Friday 8 a.m. until 4 p.m.

ASNA would like to extend our sympathy to the family of Genesia Rucker

ASNA is committed to promoting excellence in nursing.

Our Values

- Modeling professional nursing practices to other nurses
- Adhering to the Code of Ethics for Nurses
- Becoming more recognizably influential as an association
- Unifying nurses
- Advocating for nurses
- Promoting cultural diversity
- Promoting health parity
- Advancing professional competence
- Promoting the ethical care and the human dignity of every person
- Maintaining integrity in all nursing careers

Our Mission

ASNA is committed to promoting excellence in nursing.

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The Alabama Nurse is published quarterly every March, June, September and December for the Alabama State Nurses Association, 360 North Hull Street, Montgomery, AL 36104

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Ebola and Beyond - The Need for Unity

Brian Buchmann, BSN, RN, MBA

Hello Alabama nurses! As I start my term as ASNA President, I want you to know it is my privilege to serve you and work with you in continuing our mission to promote excellence in nursing. Your ASNA Executive Board will be meeting soon to create the 2015 Strategic Plan based on input from many of you. Our strategic plan will guide our action in meeting our mission for excellence. There are many health care challenges facing nurses today and there will be more in the future. Nursing and our health care system are ever changing. This is a perfect time for Alabama nurses to stand out as health care leaders in our state and nation. We have the knowledge, skills, expertise and passion to lead the way in improving our health care system, our nursing profession, the care we provide to our patients, and the communities we serve. We can only accomplish these goals by working together and aligning our voices and abilities. If Alabama nurses join ASNA and work together we can continue our journey to excellence.

Recently, health care associations and leaders from across our state and nation have united to address issues such as Ebola and other health care concerns. During difficult times people tend to join forces because there is strength in numbers and consistency. For months now, the ASNA has been monitoring CDC bulletins, the American Nurses Association’s alerts, the Alabama Department of Public Health advisories, and has communicated with other associations such as the Alabama Hospital Association and the Alabama Board of Nursing. The ASNA goal is to remain informed regarding any health care challenges impacting Alabama nurses and to communicate these findings to Alabama nurses. Regarding Ebola, the ASNA encourages all Alabama Nurses to keep updated on the latest infection control information and guidelines, work with health care agencies to develop proper isolation plans, and to be advocates for appropriate preparation and training for all health care workers.

Unity is a necessary ingredient to improve our health care system. Unity with other health care associations is necessary but, to meet the goals mentioned above for our state it will require the unity of all Alabama nurses. This unity is created by joining our professional state organization; the ASNA. Strength does come from numbers and consistency. Nursing is not only recognized as the most trusted profession, we are the largest profession in the health care system. We have a responsibility to stand up as leaders and use our expertise to help determine health care policy, new innovations, and best-practice interventions that will meet the ever changing needs of those we serve.

As your ASNA President, I am calling out to all Alabama nurses asking you to join ASNA so we can unite our voices and work together as the largest health care profession to lead the way for excellence in our health care system and for our state.

ASNA’s thoughts and prayers go out to all patients, families, communities, nurses, and health care workers who professionally and passionately face the challenges presented by various infectious diseases and other health care challenges on a daily basis. We are Alabama nurses, let’s stand together united!

The Alabama Board of Nursing has two nursing positions available, Full or Part-Time:

NURSE WORKFORCE RESEARCHER – 40654
Salary: $59,317.60 - $90,724.80
- Earned Doctorate degree from an accredited college or university in Nursing or a closely related field.
- Six years of experience within an agency providing or supervising the provision of health services.

Position conducts research related to nursing workforce and regulation of nursing. Previous research can be reviewed on the Board’s website, www.asnaboard.org.

NURSING CONSULTANT, Full Time – 40652—
GENERAL PRACTICE OPTION – 341
Salary: $52,663.20 - $90,724.80
- Master’s degree or higher from an accredited four-year college or university in Nursing
- Six years of current professional nursing practice experience including one year as a clinical instructor or nurse educator and one year as a nursing service manager or supervisor.

Position includes reviewing legal case files to determine if disciplinary action should occur, and writing reports for the Board relating to disciplinary actions. Also involves testifying at administrative hearings as an expert witness.

Both positions are permanent, located in Montgomery, require travel.

Apply through the State Personnel Department and use the State Application.
www.personnel.state.al.us
Nursing Consultant can apply online.
Nurse Workforce Researcher should apply via paper application.

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April, Betty, Charlene, Don and John
From the ASNA Staff
Just Tell the Truth When Called to Testify

Don Eddins, BS, MS, JD

What do you do when you’re subpoenaed to testify in court of law or at a deposition? As ASNA attorney, I’m often quizzed on what approach to take for under-oath testimony. First, stay calm – both when you receive the notice and when you testify. Court trials and depositions happen. The attorney who summons you is just doing his/her job in seeking creditable evidence.

With regard to any sworn testimony, I always advise my clients to tell the truth. If you lie under oath to cover up a mistake, then you have two problems – the original mistake and the false testimony. Tailor explanations in the best light for yourself without telling a falsehood. You absolutely want to convey the information in a way that is best for you, but you do not want to make a statement that could come back to haunt you. And remember, if you lie under oath to help a friend or relative, you have placed yourself at risk for a perjury charge.

Also, be cognizant of the fact that when you tell the truth during a deposition, you don’t have to try to recollect what you stated later at trial. If you make an untrue statement, you might have difficulty remembering details of the lie you made up. Our American system of justice essentially is an honor system. It’s predicated upon the availability of accurate information and testimony. In absence of reliable evidence, the system fails.

But I should add that you never are compelled to testify against yourself or your spouse. If you fear that you have done something that is against the law, you do not have to implicate yourself. You can “take the fifth,” as they say, since the 5th Amendment to the United States Constitution shields you against self-incrimination.

I caution my clients to only answer the questions that they are asked. When a witness starts volunteering a lot of information that is when things can go awry. And don’t get angry because you don’t like the question. Remember, when a person becomes angry, he loses his/her ability to think clearly. An angry witness often says things under oath that he/she regrets later. Another thing is that if you don’t know the answer to a question answer that you don’t know. Don’t give an opinion. If you can’t remember something, state that you can’t remember – don’t give an answer that may or may not be accurate.

When summoned to testify, it is wise to consult with an attorney – both for a criminal and civil matter. The lawyer most likely will help you go over details and organize matters on which you can and cannot testify.

Of course, if you are a member of the Alabama State Nurses Association you are entitled to a legal consultation on any matter – whether it’s connected to your job or not. In such case, I will help prepare you for your testimony and, perhaps, put your worried mind at rest.

Hospital Nurse Leader is New ASNA President

Dr. John C. Ziegler, MA, D, MIN.

Thankfully, ASNA has been blessed for the past two years with a nurse educator as our president, Dr. Arlene Morris. Dr. Morris had many years of clinical experience as well. Our new president is a hospital nurse leader. ASNA President, Brian Buchmann is the Manager of the Clinical Nursing Practice Department at Huntsville Hospital. In this capacity at HHS, Brian has responsibility for managing global nurse orientation, continuing education, scope of practice, competencies, policy and procedures, quality improvement, research and trials, the simulation lab, liaison to the ABN, liaison to all affiliated nursing schools and the facilitation of clinical and preceptor programs.

Brian is the first male president of ASNA in its 101-year history! WOW! Let that sink in for a moment … Most of the 86,000 nurses in the state work in clinical settings and Brian is a nurse leader who understands their daily challenges and dedication. For the past two years he has served as President-elect of ASNA. I have seen him at the Alabama Legislature, the Governor’s Office and in Washington, DC lobbying for your profession. Whether conversing with a United States Senator, the Governor or an Alabama Legislator, he represented ASNA well. His passion is to advocate for YOUR needs as you strive to deliver quality patient care.

ASNA has a diverse membership with nurses from all specialties and settings of care. Most nurse specialty groups, especially at the state level, are not large enough to rally support for or against legislation. For 101 years, ASNA has served as the hub organization to give nurses of all specialties a unified and powerful voice. Sadly, Alabama has fallen behind states like Mississippi, Tennessee and Georgia in maintaining a unified nursing advocacy front. Although Mississippi has fewer nurses, the MNA has almost twice the membership of Alabama (ASNA)! This is mainly due to their ability to keep members from isolating by JUST joining their specialty group and DROPPING their ASNA membership. Mississippi Nursing Association remains strong because CRNAs, CNPs and other specialized nurses have maintained dual memberships.

The good news is ASNA is growing again! More and more specialty nurses are realizing the necessity of keeping a strong hub organization while they also participate in their specialty organization. People are seeing that ASNA benefits exceed the cost of dues anyway … so why not join? Since, most nurses in the state are hospital / clinical nurses they have a hospital nurse leader (man) as the new ASNA President. Brian Buchmann has a vision to enhance the careers of ASNA members, maintain a unified voice for nursing and by the way … he knows how badly your feet hurt after a twelve-hour shift.

Donate by December 31st – Tax Deductible!

The Alabama Nurses Foundation

How many qualified, dedicated and talented people have turned aside from their goal to become a nurse because of finances? You can help.

The Alabama Nurses Foundation is a tax-exempt foundation set up to support nursing scholarships, workforce development and educational endeavors.

The Foundation accepts general donations, endowments or gifts designated to the memory of a family member or friend. Gifts may also be given in honor of an event such as a birthday, anniversary, or graduation. You may donate online at http://form Ice/form.us/forms/4097510390147. If you wish to send your donation by mail, use the following address:

Make check out to – The Alabama Nurses Foundation
360 North Hull Street
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Looking for the perfect career?

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Find the perfect nursing job for you!
There is an old adage that “nothing stays the same” and “the only thing that’s for certain, is change.” Such is the plight of the L.P.N. Practice.

As healthcare evolves and the cost of health care increases, the skill mix has changed. Whether for a short period of time, or permanently. Such is the case with L.P.N. Practice in the hospital setting. Most of the hospitals across the country are seeking Magnet Status or just going to all RN staffing for patient care, with the assistance of unlicensed personnel.

Employers of healthcare workers may soon discover this mix may not be as cost effective as they think. Although there are other opportunities for L.P.N.’s, it is still relevant to keep up all of the skills we have learned and certifications we have earned. NLN has gone on record with “A Vision for Recognition of the Role of L.P.N.’s and L.V.N.’s in Advancing the Nation’s Health.” The National League for Nursing supports the critical role of L.P.N. / L.V.N. in providing quality patient centered care and evidenced-based care to vulnerable groups across the health care continuum. The L.P.N. / L.V.N. work force has not been strategically addressed for the 21st Century transformed health care system. This lack of focus not only affects the quality and safety of patient outcome, it may lead to an unintended consequence: A significant void in the health care provider continuum, particularly among older adults and other population clusters that need “long term, community-based chronic care.”

Google NLN’s Vision Series for their vision for L.P.N. / L.V.N.’s. Remember “Greatness is not defined by the title you hold, but by the need you fill.”

Donald E. Williamson, M.D.

Ebola is an infectious disease that is transmitted through direct contact with blood or body fluids. Infection occurs when the organism has a route to enter another host through mucous membranes or a break in the skin. Symptoms of Ebola Virus Disease include fever, malaise, headache, nausea, vomiting, diarrhea, and bleeding.

Although highly contagious, risk can be minimized while caring for a patient with Ebola by adhering to standard infection control measures and utilizing proper Personal Protective Equipment (PPE). Working in teams is recommended as a strategy to minimize potential breaks in protocol when using PPE. The team approach can identify errors in donning and doffing PPE and reduce the risk of self-contamination. It is imperative that nurses and other members of the healthcare team work together to educate and mentor each other to ensure that safe procedures are in place and followed.

The Alabama Department of Public Health encourages nurses throughout the state to stay informed. The Centers for Disease Control and Prevention (www.cdc.gov/chie/ebola) and the Alabama Department of Public Health (www.adph.org/ebola) are two resources for gaining knowledge about Ebola. Information found on these sites is updated routinely. It is important to note that not all media information is reliable.

With modern modes of travel, the world has become a smaller place. Caring for individuals with emerging infectious diseases is occurring more frequently. As nurses and other health care providers continue to strive for excellence in care, we will be well prepared for the future.

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Greg Howard, LPN

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Over 90% of our members are joint members of ASNA and ANA. Joint membership greatly expands what you receive in benefits and your influence as a nurse advocate. Some members prefer state only membership and that is available as an option as well.

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Read and sign the authorization below. Enclose a check made payable to ASNA for the first month’s dues (see rates listed above). This amount will be deducted from your checking/credit card account each month.

By signing the form below, I am authorizing ASNA/ANA to withdraw annual/monthly dues from the financial institution I have designated. If paying by automatic bank draft, I have enclosed a check for the first month’s payment. Bank drafts will occur on or after the 15th day of the month, Credit Cards will be charged on or after the 1st of the month.

Authorized Signature: ______________________________________ Date: _____________ CVV Code: ____________

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Payments to ASNA/ANA are not deductible as charitable contributions; however 70% of your dues are tax deductible as a professional organization for Federal Income Tax Purposes.

Please return this completed application with your payment to ASNA, 360 North Hull St., Montgomery, AL 36104 or Fax to 334-262-8578

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Dr. Suzanne Fogger | Specialty Track Coordinator (205) 996-6052 sfogger@uab.edu uab.edu/nursing
Lack of State Nurses Association Membership is a Practice Issue

Sarah Pierce Wilkinson, MSN, BA, RN
ASNA District 1 President

As an emerging leader in the Alabama State Nurses Association (ASNA) and newly inducted District 1 President, I have learned of several reasons why nurses do not choose membership in the one professional association that represents all nurses and speaks for the entire profession regardless of practice specialty. Many nurses claim time restraints as their reason for non-participation, while others believe they have nothing to gain from membership. Others do nothing but complain about the current state of affairs in nursing and in healthcare across the spectrum. One nurse claimed her retirement in six years as a reason for not rejoining the ASNA. In Alabama there are 90,000 nurses, but only 1263 are actually members of the ASNA. Regardless of the practice setting, nurses who choose not to join the ASNA compromise their own professional development, patient care, and the future of the discipline in a rapidly changing environment.

The key stakeholders in this dilemma are Alabama nurses and their patients. The ASNA does not represent a single specialization, but rather all nurses regardless of their level of education or expertise. Membership in the ASNA provides nurses with opportunities to network with other nurses, participate in evidence-based continuing education activities, and a voice in decision making at the administrative and legislative levels. In an edition of the Pennsylvania Nurse, Brancato stated that nursing’s influence on healthcare begins at the district level of state nursing associations and transcends to the state and national levels where policy is formed. If nurses everywhere want to improve the outcomes that result from others dictating to the profession, then they must begin to act as partners in the decision-making processes of policy and practice. For healthcare to realize reform and quality improvement, Batalden and Davidoff suggested in Quality and Safe Health Care that all nurses, who collectively represent the greatest number of care providers, must be tireless in their efforts to bring about change in the system.

Rather than offer reasons of limited time and money to participate, question what they have to gain from membership in the ASNA, or challenge the current state of affairs in the profession, Alabama’s nurses must instead (a) allocate a fraction of time to their professional development and to the advancement of their practice specialty, (b) realize what they and the association have to gain from supporting one another, and (c) focus their voices on an area of interest in which they desire support or improvement. Every nurse can use his or her talents as instruments of change, and all have voices that can influence change if they are willing to give back to the profession just a fraction of what has been afforded to them. Our profession should be a priority for all Alabama nurses. Members of ASNA can and will improve the nursing profession, healthcare systems, and local communities through active participation in district and state activities. We must take the knowledge and collaboration generated in the workplace beyond those boundaries and work as teams in ASNA’s local districts if we are to make a positive difference in our communities and worldwide.

The ASNA promotes the well-being of the individual and the discipline and influences the policies that affect nursing, thus bringing about quality improvement in patient care. Membership in the ASNA provides nurses with opportunities for professional collaboration and development of their careers and the discipline. Without these opportunities, nurses are in danger of passively remaining in the shadows of shapeless care providers, instead of actively engaging in the shaping of their futures as nursing professionals. If nurses are not involved in the health of our profession, then advances in healthcare reform will also suffer from the lack of their participation.

References

District One: Sarah Wilkinson, MSN, BA, RN swilkinsonrn@yahoo.com
District Two: Julie Savage Jones, MSN, RN-BC jsavagejones@yahoo.com
District Three: Wanda Spillers, DNP, RN, CCM wspillers@va.com
District Four: Erica Elkins Little, BSN, RN ericaelkinslittle@gmail.com
District Five: Tammy Smith, MSN, RN tsmith@asna.org

Contact your district officer to find out about activities in your area.

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Synonyms: Champion, campaigner, supporter

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The Alabama Nurse • Page 7
December 2014, January, February 2015

Membership News

District Officer’s Contact Information:

District One: Sarah Wilkinson, MSN, BA, RN swilkinsonrn@yahoo.com
District Two: Julie Savage Jones, MSN, RN-BC jsavagejones@yahoo.com
District Three: Wanda Spillers, DNP, RN, CCM wspillers@va.com
District Four: Erica Elkins Little, BSN, RN ericaelkinslittle@gmail.com
District Five: Tammy Smith, MSN, RN tsmith@asna.org

Contact your district officer to find out about activities in your area.
This page contains a document discussing resolutions passed by the Alabama State Nurses Association (ASNA). The resolutions cover various topics including domestic violence awareness, health literacy, and health promotion initiatives. The document also mentions the Alabama State Nurses Association (ASNA) will encourage each district to provide education on domestic violence and refer individuals who are in need of services and be further encourages the ASNA website to help individuals and families become more informed and educated concerning domestic violence awareness. Additionally, the ASNA will foster the development of a strong nursing community and support the growth and development of nurses as they transition in professional practice. The resolutions encourage the ASNA website to help individuals and families become more informed and educated concerning domestic violence awareness. The resolutions also encourage the ASNA to publish an article in The Alabama Nurse related to Domestic Violence Awareness and be further encourages the ASNA website to encourage each district to provide education on domestic violence and refer individuals who are in need of services and be further encourages the ASNA website to help individuals and families become more informed and educated concerning domestic violence awareness.
2014 Annual Convention

2014 Alabama State Nurses Association Annual Convention

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UT Health Science Center College of Nursing
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2014 Scholarship Winners

ASNA Scholarships Winners:
Michael Nichols
Susan G. Williams

District 3 Scholarship Winners:
Olivia Brown
Andrea Gregory
Nanci Swan

2014 Election Results

President-Elect ........ Rebecca Huie, DNP, ACNP
Treasurer ............ Debra Litton, MSN, RN, AOCNS

Commission on Professional Issues
Abby Grammer Horton, MSN, RN
Dr. Wanda Spillers
Dr. Marilyn Sullivan
Sarah Wilkinson, MSN, BA, RN
Dr. Susan Hayden
Lindsey Harris, MSN, FNP, BC

Nominating Committee .......... Patricia Green, MSN, RN, NE
Gayle Stinnett, MSN, RN

2014 Award Winners

Outstanding Legislative Advocate of the Year Award – Senator Gerald Dial

Outstanding Health Care Organization Award – Southeast Alabama Medical Center

Outstanding New Member Award – Abby Grammer Horton, MSN, RN

Cindajo Overton Outstanding Educator Award – Ann Spradley, MSN, RN, GNP, OCNS-C

Cindajo Overton Outstanding Educator Award – Susan W. Gaskins, PhD, RN, ACRN, FAAN

Outstanding Nursing Administrator Award – Academe – Suzanne S. Prevost, PhD, RN, COI

Lillian B. Smith Award – Kim Inman Smith, MSN, RN

Outstanding Retired Nurse Award – Lynne Richardson, RN

Lillian Holland Harvey Award – Norma Cuellar, DSN, RN, FAAN

Lillian Holland Harvey Award – Teresa McLester, MSN, RN

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Pre-Conversation ASNA Board of Director’s meeting

Vendors

Decoration Winner – Delegates table

Incoming and outgoing presidents have some fun

ANA’s Janet Haebler

AANS Board of Directors

CE Student Nurses Session

Awards Banquet

Diners enjoy the Awards Banquet
Sports Related Concussions Poster: The purpose of this poster is to help educate advanced practice nurses on the importance of sport related concussions. It is also designed to help explain what to look for in this patient population and when to return them to play.

Assessment Signs/Symptoms:
- Headache
- Nausea or vomiting
- Dizziness
- Loss of balance or coordination
- Confusion
- Fantasy
- Amnesia
- Slurred speech
- Fainting
- Convulsions

Physical Assessment Skills or Initial Clinic Visit:
- Orientation to time, place, and person
- Fundamentals of physical examination
- Complete neurologic examination
- Complete history and physical examination

Management REST, REST, REST
- No return to school or sports
- Degree of severity determines rest time
- No participation in sports or school any longer
- No physical or mental stress

Return To Play
- Recommendation that an athlete return to play after a concussion is made only if medically cleared by a qualified health care provider
- Return to play decision must be individualized

Communication in Critical Situations Poster: This poster shows the importance of communication in a critical situation for patient safety in the hospital environment. We believe that by using the tool of communication called debriefing after each emergency situation we would improve nurse knowledge, improve future care, and reduce cost by reducing errors.

Epidemiology
- Definition
- Incidence
- Risk Factors

Assessment
- Signs/Symptoms
- Physical Assessment Skills or Initial Clinic Visit
- Management
- Return To Play

References
Raising the Bar! Advancing Nursing Practice by Establishing a Burn Curriculum for Trauma Services

Courtney Edwards, MSN, RN, CNL; Kristen Noles, MSN, RN, CNL; Cynthia Williams, RN

University of Alabama at Birmingham Hospital

Introduction

The Clinical Nurse Leader (CNL):
- Created to address the growing concern over patient safety, quality, and health care outcome
- Engages in ongoing professional development
- Motivates others in lifelong learning opportunities
- Enables nurses to continue as leaders of the health care team maintaining the highest standards in providing patient care.

CNL Core Competencies in Action:
- Communication
- Designer/Coordination of Care
- Assessment
- Provider/Manager of Care
- Risk Reduction/Health Promotion/Disease Prevention
- Resource Management

Purpose

The purpose of this presentation is to describe how the CNL skill set was utilized in the evaluation, design, and implementation of a cross-training curriculum for nursing staff at a Level 1 Regional Trauma Center.

Methods

- Identified an opportunity to raise the level of clinical expertise of the nursing staff on an Acute Trauma Care Unit
- Performed a gap analysis of the education deficits of the nurse on the unit
- Collaborated with another CNL to create a strategic process focused on the staff’s knowledge deficit
- Created a burn care management and treatment curriculum including: competencies, procedures, and experiences to be
- Designed a survey to assess nurse knowledge and confidence in providing burn care before and after implementation of the new curriculum

Outcome data

There has been great improvement in staff confidence in providing burn care across the 68-bed service. In addition, the clinical experts serve as resources for all disciplines that care for burn patients at UAB Hospital.

Conclusion

As the healthcare environment changes, it is critical that nurse leaders build upon the foundation of clinical expertise utilizing the CNL skill set in a variety of roles. The influence of the CNL on an acute care floor has created a framework for continued professional growth of the entire nursing staff.
Sepsis Poster:
The Stop Sepsis initiative at Huntsville Hospital is a multidisciplinary effort with the primary objective of implementing a systematic method for the early identification and treatment of septic patients in an effort to decrease the sepsis-related mortality rate. During the pilot, the General Medicine and Respiratory Care Units identified potentially septic patients with a manual paper screening tool and handheld media device. With positive screens, a Sepsis bundle was implemented. In analyzing the results, post-intervention data from January to June 2014 was compared to the same period in 2013. All cause mortality on the two units decreased 48.8% and thirty-day readmission rates decreased 46.2%. Through the formation of an interdisciplinary taskforce, the hospital observed successes in patient care, increasing awareness of sepsis, and improving sepsis management strategies.

Pediatric Simulation Poster:
Pediatric simulation allows for development of specific pediatric skills without the restraints associated with caring for real pediatric patients. This project focused on comparing actively participating students with students that observe the same simulation. Is it possible to substitute clinical with simulation and do observing provide the same experience as actively participating?

A Pediatric Simulation Experience: Development, Implementation and Lessons Learned
Tedra S. Smith, DNP, MSN, CRNP, PNP-PC
University of Alabama School of Nursing, University of Alabama at Birmingham

Background/Purpose
- Two primary obstacles impede nursing students from experiencing a meaningful pediatric clinical rotation. First, there are a limited number of pediatric clinical sites.
- There is only forty-three free standing pediatric hospitals in the United States.
- Nursing enrollment has increased by 5.7%.
- Second, the student’s role in the health care setting has been limited because of rigorous patient safety regulations.
- The purpose of this study was to evaluate the effectiveness of the simulation as a clinical experience as compared to real-life.
- The overall goal was to provide a guide for the development and implementation of a pediatric simulation

Method
- Students (n=73) enrolled in a baccalaureate of science nursing program entering the fourth semester. Divided into Active and Observation Groups.
- The setting was a university based simulation center.
- The simulation was developed and implemented by Course Faculty.
- IRB Exempt

Results
73 students were enrolled in the course and all completed the evaluation:
-68 (80%) reported feeling as though the simulation better prepared them to care for real patients.
-71 (89%) reported feeling more confident in determining what to tell the healthcare provider.
-61 (84.7%) reported that they were challenged in their thinking and decision-making skills.
-13 (17.9%) disagreed that the simulation helped them better understand classroom content.
-9 (12.3%) disagreed that the simulation helped them feel more confident in their decision-making skills.

Future Plans
- Determine if observing a simulation provides an experience similar to actively participating.
- Incorporate simulation into didactic courses.
- Further research the effectiveness of simulation prior to a clinical experience as opposed to after
Continued Collaboration Poster:

This poster describes the University of Alabama’s Capstone College of Nursing’s Dr. Mary Ann Kelley’s follow-up of a grant with rural women in local churches of Alabama, a longitudinal grant.

Newborn Falls Poster:

This poster describes the first two years of an innovative and comprehensive program to prevent in-hospital newborn falls at Huntsville Hospital for Women & Children.
Understanding Non-Pharmacological PTSD Treatments

Randy Moore, DNP, RN, Laura Steedman, EdD, CRNP, MSN, RN, Kimberly Frolkisch, PhD, RN, NE-BC, VHA – CM, Nanci A. Swan, RN, MSN, & Lauren Hudson, UAB SON & VANAP student.

Birmingham VA Medical Center, Birmingham, Ala., University of Alabama School of Nursing, University of Alabama at Birmingham

Purpose

• Increase community awareness and knowledge of non-pharmacological PTSD treatment in the veteran population.
• Describe adjunctive treatment and evidence that support their use.
• Promote an inter-disciplinary approach to veterans diagnosed with PTSD

Significance

• Veteran returning from Iraq Freedom. New Dawn Operations Enduring Freedom indicates high levels of combat related PTSD (8 to 20%) and other psychiatric conditions.
• Combat PTSD is associated with a significant reduction in quality of life secondary to symptomology of re-experiencing traumas, nightmares/flashbacks, & hyper arousal.

Evidence Based Treatments

Psychotherapy
Cognitive Behavioral Therapy
Cognitive Processing Therapy
• Prolonged Exposure Therapy
• Pharmacotherapy
• Hypnotherapy
• Group Therapy
• Stress-Inoculation Therapy

Implications

• Clinicians and educators need to be aware of current guidelines and emerging trends.
• Veterans with PTSD need to be reassured that their responses to abnormal circumstances are normal.

Adjunctive Treatments

• Eye Movement Desensitization and Reprocessing (EMDR)¹
• Logotherapy²
• Yoga³
• Breathing-based meditation⁴

Research Corner Posters

2014 Annual Convention

Understanding Non-Pharmacological PTSD Treatments

Purpose

• Increase community awareness and knowledge of America’s homeless veteran population and resources available.

Significance

• While veterans only comprise approximately 10% of the U.S. population (as of 2013), it has been estimated that they constitute as much as 32% of the homeless population (Elbogen, Sullivan, Wolfe, Wagner, & Beckman, 2013). These statistics are alarming and of major concern to those who deal with veteran affairs.
• It is imperative that resources be made available to veterans who are currently homeless as well as those who are at risk so that the percentage of homeless veterans can be reduced, treated, and avoided.

Strategy and Implementation

Organization staff and the National Coalition for the Homeless Council on Veterans (NCHV), National Health Care for the Homeless Council (NHCHC), & Corporation for Supportive Housing (CSH) are dedicated to reducing homelessness in the U.S. & providing resources to help those who are currently homeless or at risk for becoming homeless.

• NATIONAL CALL CENTER
• NATIONAL CALL CENTER staff at risk have 24/7 access to a hotline where they can speak with a trained counselor to identify PREVENT homelessness.
• HOUSING ABSENCE

The U.S. Department of Housing and VA allocated more than 55,000 Housing Choice vouchers for market-rate rental housing within VA provides case management services COMPENSATED WORK THERAPY

Assists homeless veterans returning to competitive employment paying at least minimum wage

Implications for Educators

Healthcare workers are trained to recognize Veterans without a permanent address. Collaborate with established programs available to our veterans and find alternative ways to reinforce the benefits of existing programs.

References


America’s Homeless Veterans

Laura Steedman, EdD, CRNP, MSN, RN, Kimberly Frolkisch, PhD, RN, NE-BC, VHA – CM, Randy Moore, DNP, RN, Nanci A. Swan, RN, MSN, MSN

Birmingham VA Medical Center, Birmingham, Ala., University of Alabama School of Nursing, University of Alabama at Birmingham

December 2014, January, February 2015

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Women Veterans: Physical and Psychological Issues

Huntsville Hospital serves as the regional referral and trauma center for more than a million people in north Alabama and southern Tennessee. In recent years, the hospital has expanded its services throughout the region with the development of Huntsville Hospital Health System. Huntsville Hospital is the second largest hospital in Alabama and the fifth largest publicly-owned hospital system in the nation.

We are looking for energetic employees to join our team.

• Oncology Registered Nurse, full time
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• Labor/Delivery Clinical Education Specialist, full time
• Neonatal ICU Registered Nurse, part time days & nights
• Labor/Delivery Registered Nurse, full time nights

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Huntsville Hospital serves as the regional referral and trauma center for more than a million people in north Alabama and southern Tennessee. In recent years, the hospital has expanded its services throughout the region with the development of Huntsville Hospital Health System. Huntsville Hospital is the second largest hospital in Alabama and the fifth largest publicly-owned hospital system in the nation.

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• Neonatal ICU Registered Nurse, part time days & nights
• Labor/Delivery Registered Nurse, full time nights

Relocation opportunities available. Please apply online at huntsvillehospital.org/careers.

Women Veterans: Physical and Psychological Issues

Purpose
• Increase health care and community awareness of physical and psychological issues facing our women veteran population.

Significance
• There are more than 1.5 million female veterans and this number is expected to grow (Kelly, Skelton, Patel & Bradley, 2011).
• Women in the military combat related trauma both physical and psychological.
• The rate of sexual assault on women during service is 21-25%, and 24-60% for sexual harassment. (Kelly, Skelton, Patel, & Bradley, 2011).
• It has been reported that military sexual abuse numbers are equal if not greater than the number of incidents in the civilian world. Sexual trauma is one of the reasons that put women at a higher risk for marital based issues post deployment. (Carlson et al, 2013).

Evaluation
• Public awareness of the issues affecting Female Veteran.
• Educating current and future health care providers on issues for women veterans in the military.
• Providing education on prevention programs and interventions available.

Strategy and Implementation
• Center for Women Veterans (CWV) created to meet specific needs for women.
• The VA has a national initiative to treat veterans who experienced Military Sexual Trauma (MST).
• Each VA medical center has a national MST Support Team and MST Coordinators.
• Disability benefits are available and can be applied for at www.ebenefits.va.gov

Implications for Educators
• Educate and raise awareness.
• Reassure the Female Veteran.
• Educate on the benefits offered within the VA for Women’s Health services.

References

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HUNTSVILLE HOSPITAL
Auburn University’s Dr. Stuart Pope named President of the board of the American Psychiatric Nurses Association, Alabama Chapter

Dr. Stuart Pope, Assistant Professor at Auburn University’s School of Nursing was recently elected president of the board of the American Psychiatric Nurses Association, Alabama Chapter. Dr. Pope is a former pastor and has been part of Auburn’s nursing faculty since 2009. He specializes in psychiatric-mental health nursing and is the head of Auburn’s animal-assisted therapy program. Dr. Pope is also an adviser to the Auburn Student Nurses Association.

Partnership Between USA Medical Center Nurses, USA College of Nursing Wins Prestigious Award

Lisa Mestas (left), USA Medical Center Chief Nursing Officer and Assistant Administrator and Dr. Valerie Dearmon (right), Chair of the USA College of Nursing’s adult health department, pose for a photo with the 2014 American Association of Colleges of Nursing Exemplary Academic-Practice Partnership Award. The award was given, in part, in recognition of a series of initiatives and studies that engage frontline nursing staff in programs to improve patient care. These initiatives have garnered national honors for the partnership between the two institutions.

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ASNA Nurses in the News

December 2014, January, February 2015
Cultural Assessment of Korean Patients

Author: Charlene M. Roberson, MEd, RN-BC, Director of Leadership Services, Alabama State Nurses Association

Disclosures: Neither the author or planning committee have any conflict of interest.

Target Audience: All health care workers.

Goal: Improve care to Korean patients.

Objectives: By the conclusion of this activity the learner should be able to:

1. Rephrase essential elements of a general cultural assessment.
2. Describe the cultural profile of a Korean.
3. Relate how nursing care must be modified to meet the cultural needs of Koreans.

Directions: Read the article carefully. Complete the written material as directed (answer sheet and evaluation) and handling fee of $10. Make checks payable to ASNA.

Cultural Assessment continued on page 19

CE Corner

December 2014, January, February 2015

Looking for a New Career Opportunity?

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Bilingual candidates encouraged to apply. DCH Health System is an EOE.

Cultural Assessment continued on page 19
During the process of delivering nursing care, be prepared for them to ask you personal questions. Examples would include, “How old are you?” or “Are you married?” These are not impolite questions to a Korean. Especially the age question, because if you are an older nurse you will be afforded more respect, much as an elder in their community. Their tone of voice implies many qualities with wide varieties of pitches and tones. A nurse may interpret a normal conversation as arguing because the speaker will talk louder on an aspect deemed important. They will also speak louder and more authoritatively toward younger individuals or younger nurses. Elders and gray haired nurses are always spoken to in quieter, more respectable tones. Nurses and doctors are viewed as authority figures and will be treated with great respect. When you respect someone you do not disagree with them; therefore, sometimes they will answer “yes” even when the word “no” is more appropriate. Koreans rarely use the word “no.” Instead they will provide non-verbal clues implying a negative response. A common clue is hesitation before responding. Be alert to this as many Westerners often miss this clue.

Assessments: Although Koreans will hug, touch, and even push each other when they are comfortable, it is not acceptable for you, the nurse, to touch them or enter their close personal space except for an examination. The initial nursing assessment will be difficult, as Koreans will not be forthcoming with personal data even regarding their health. Always bear in mind, they are taught from childhood not to share inner feelings with a stranger. Remember that data the nurse might consider essential and not private might be very personal to someone brought up in the Korean culture. An example would be questions about breast self exams, sleep patterns, elimination, etc. Therefore, your assessment will probably remain incomplete until a trusting relationship has been established. If you perceive an increasing discomfort level, delay asking questions not directly related to presenting symptoms. Be alert to the patient’s and their significant other’s body language and facial expressions. Nurses will notice little direct eye contact until the patient (and significant others) are comfortable with you. They may frequently glance or look at you if they suspect you are not looking at them. It is proper for the nurse to look at the patient even thought they may avoid your gaze during this initial assessment. Some nurses incorrectly interpret their facial expressions as flat or dull. However, as rapport is established, more facial expressions will be directed toward you and other members of the health care team. Once you sense the establishment of rapport or a comfort level, finish the assessments. Determine if the patient wants a family member present when completing the assessment. As they do not openly share feelings with strangers, they probably will not say “thank you,” “I’m sorry,” or excuse me” as you are providing nursing care.

Activities of Daily Living: They are very modest and women are more so than men. Provide for their privacy. In addition they are often cold natured and like the room warm by US standards. Koreans are very clean. They may need extra towels and cloths. At times they rub their skin to help exfoliate the dead cells. Older women tend to wash their hair once or twice a week. They frequently trim their nails and prefer to do their own care. If an elder needs care the younger family member will provide care without being

Cultural Assessment continued from page 18

Cultural Assessment continued on page 20

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asked. Again let them do this. Let them perform this care even if the patient is able to care for self.

Food Practices: Koreans eat 2-3 meals a day. In addition to this, they eat snacks. The family eats together. Meals are eaten with a large spoon or chop sticks. They do not like cold fluids as this is equated with causing imbalance of illness. The diet is usually high in fiber and spicy. Special favorites are Kim-chee (spicy cabbage), soups, and noodles. Rice is usually eaten with every meal. The diet consists of many vegetables and little meat. Barley water is a particular favorite beverage. Family members sometimes use food as a prescription, i.e. Ginseng for colds, black tea with honey and slices of lemon, etc. In addition they believe that a sick person may be helped with eating spicy soups with onions and garlic. In the health care setting food or drink may be refused when first offered out of politeness – even if desired. Korean culture dictates an immediate refusal. Nurses should repeat the offer at least two (2) more times to make sure the patient does not want the food or beverage.

Symptom Management: Men are especially stoic in regard to pain. A typical comment might be, “I could die.” There is not much crying, careful observation, and especially like fruit, non-verbal clues for pain. If family members are present the patient may thrust around and be dramatic. Koreans fear pain medication – they fear addiction. The preference is for oral or intravenous administration in lieu of fear pain medication – they fear addiction. The preference is for oral or intravenous administration in lieu of

Asians in general react differently to medications as compared to other ethnic groups. The most noticeable is a reduced tolerance to psychotropic medications, especially Lithium, antidepressants, and neuroleptics – thus they require lower dosages as compared to the usual standards. In addition Asians in general, including Koreans are more sensitive to the adverse effects of alcohol. Most noticeable will be increased flushing, palpitations and tachycardia.

Mating and Sexuality: Koreans: A Korean woman will seek prenatal care and carefully follow recommendations of the health care provider. She will prefer a female doctor. Expect women to take a few home remedies such as Seaweed soup to cleanse the blood and help with milk production. In addition some women may avoid eating chicken, crab, eggs, duck, and rabbit as it may harm the infant’s character or appearance. Rest is encouraged for pregnant women.

Labor practices are not remarkable. They may or may not have natural childbirth. Women, especially younger women, may be vocal during labor. Breast feeding may or may not be used. A breastfeeding Mother will wear her child before returning to work. Korean women usually do not pump their breast or store milk. Post Partum rest is considered important and encouraged. If something is wrong with the baby tell the father first and let him tell the mother. She will probably view this as something that she did wrong. The mother will need much support.

Serious or Terminal Illness: Tell the family the patient is not going to live. Tell both the patient and family. It must be emphasized that nurses and doctors do not share news of a serious or terminal illness with the patient instantly. In all probability the patient will not ask about details. In the case of a bad prognosis the family unit will gather together as a whole and support the patient. The family and the ill individual will accept their fate, as everything is pre-determined. The rationale for this is that the past is the life view as learned lessons, the present is about living and carrying on with life, and the future is not focused on. The nurse’s role at this time is to be supportive, anticipate patient and family needs, and simply be available when or if needed.

Death Rituals: When death is imminent tell the family separately. It will tell both the patient and family. Nurses and doctors do not tell the patient directly. Family members usually prefer for the patient to remain in the hospital. At the time of death, family members may mean, chant, burn incense, or pray. Provide for their privacy. To an outsider these actions may even seem over-dramatized. They will not leave the room quickly, choosing instead to remain with the body. It is common for the family members to cleanse the body after death. At death and under certain circumstances state and national laws mandate autopsies and a request for organ donations. Neither of these practices is looked on with favor as it tampers with the spirit. This presents an ethical dilemma for the nursing staff. It is advisable to have administrative and pastoral care if available support available when the family spokesman is consulted about organ donations or an autopsy. The family will probably not agree. You can speak with the body is treated with dignity and respect, and all organs are replaced in the original spot after the autopsy is over. However, even with this explanation this will be a difficult call. This is not a time for nurses to act alone. It is imperative to consult with administration.

Selected American Behaviors That Koreans Find Especially Offensive. Behaviors include:

- Not standing up when an elder or important person comes into the room.
- Showing the sole of your shoe.
- Crossing legs in front of an important person.
- Receiving or giving an item with one hand.
- Pointing the index finger.
- Smoking in front of an elder or important person.
- Shaking hands too firmly.
- Loud music.
- Wearing shoes in the home. (Home Health nurses should leave shoes at the door.)
- Licking your fingers.
- Drinking from a bottle – even water.
- Placing a pencil or pen in your mouth.
- Using a toothpick in public.
- Sitting on a table when communicating.
- Using red ink (red ink is used only in death books).
- Touching the head of another person.
- Not offering an item (juice) three (3) times.

Selected Korean Behaviors That Americans Find Puzzling: Behaviors include

- Not holding a door open for you.
- Limp handshake.
- Always giving or receiving any item with two hands.
- Giving you better gifts than you gave them.
- Asking for payment for a meal.
- Wearing white socks with suits.
- Stare and talk about Americans (non-Korean) in front of them.
- Women laughing with hands in front of mouth.
- Children being untrained until kindergarten.
- Sucking air with teeth.
- Little eye contact.
- Slap people when talking to you.
- Bump you in public and do not say, “I’m sorry.”
- Drinking from a cup and handing you the cup for you to drink from the same cup.
- A wife walking three (3) paces behind the husband.
- Men going out with men and women going out with women. (Families rarely go out together.)
- Prefer that you touch only the edges of a form or a piece of paper.
- A wife holding the family money.
- Offering you the item that you have complimented.
- Refusing – even though wanted three times for courtesy.
- Husband who never praises wife’s accomplishments – will only downplay her achievements.
- Eating rice with every meal.
- Motion for someone to come by placing palm of your hand near the person.
- Having difficulty in saying no.

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Selected bibliography

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1. Cultural Assessments should include which of the following variables:
   A. Communication style & vital signs.
   B. Length of time in the US & length of time for presenting symptoms.
   C. Use of folk remedies & English comprehension.
   D. All of the above.

2. During routine care a family member asks you, “How old are you?” Your best response is to:
   A. Tell them the truth.
   B. Create a humorous, obviously false age.
   C. Respond, “Old enough to know better.”
   D. All of the above.

3. You offer a supper tray to a new admission that has not eaten. The patient refuses the tray. Your next action should be:
   A. Start the admission process.
   B. Indicate that you will be glad to bring a snack later if wanted.
   C. Offer the tray at least two (2) more times.
   D. Ask the family to talk to the patient about the need to eat.

4. During evaluation of the room environment you notice only one used towel and wash cloth. You should:
   A. Do nothing.
   B. Offer to replace the used linen.
   C. Ask, “Do you need additional towels and wash cloths?”
   D. Provide several additional towels and wash cloths without asking.

5. A nurse knows to provide which of the following to a Korean patient?
   A. Extra blanket.
   B. Fresh water and ice.
   C. Mouth wash.
   D. Reading material.

6. A Korean man is having pain and all of the following options are ordered, which would be the patient’s preferred route?
   A. PO or IV.
   B. PO or IM.
   C. IV or IM.
   D. Any of the above.

7. Koreans women prefer which of the following?
   A. A female gynecologist.
   B. A male gynecologist.
   C. Either male or female examiner.
   D. A Nurse Practitioner.

8. When death is imminent the nurse should:
   A. Consult the doctor about contacting hospice.
   B. Tell the family spokesman.
   C. Either male or female examiner.
   D. A Nurse Practitioner.

9. At the time of death family members will probably do which of the following?
   A. Leave the bedside and remain in the waiting area.
   B. Burn incense and show little emotion.
   C. Cleanse the body and meditate.
   D. Burn incense and cleanse the body.

10. Many Koreans practice spirit worship in conjunction with other religious practices. They believe that the ancestral spirits are responsive only to:
    A. The family spokesman.
    B. The Shaman.
    C. Both A & B.
    D. Neither A nor B.

### Cultural Assessment of Koreans

1.5 contact hour Activity #: 4-0.971

**ANSWER SHEET**

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**ACTIVITY EVALUATION**

**GOAL:** Improve care to Korean patients

Circle your response using this scale: 3 – Yes 2 – Somewhat 1 – No

Rate the relationship of the objectives to the goal of the activity

Rate your achievement of the objectives for the activity

**Objectives:**

1. Rephrase essential elements of a general cultural assessment.
   3 2 1

2. Describe the cultural profile of a Korean.
   3 2 1

3. Relate how nursing care must be modified to meet the cultural needs of Koreans.
   3 2 1

**Program free of commercial bias**

3 2 1

On a scale of 1 (low) – 5 (high) knowledge of topic before home-study

5 4 3 2 1

On a scale of 1 (low) – 5 (high) knowledge of topic after home-study

5 4 3 2 1

How many hours did it take you to complete the activity?

___ hours ___ minutes.

**ADDITIONAL COMMENTS:**

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

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It may come as a surprise, but health care workers suffer a higher rate of musculoskeletal disorders (MSDs) than those who construct, maintain, or manufacturing workers. In 2011, the United States Bureau of Labor Statistics reported that the rate of health care workers suffering from MSDs was exceedingly higher than that of workers in some of the most hazardous non-healthcare jobs. Nurses and other health care workers are five to 10 times more likely to experience musculoskeletal injuries. Alarming, nursing aides and attendants ranked as the second most dangerous occupation in the United States (U.S.) regarding incidence of musculoskeletal injuries.

Safe patient handling and mobility (SPHM) programs, if properly implemented, can drastically reduce healthcare worker injuries and worker’s compensation claims. Many healthcare organizations have SPHM policies but have encountered challenges implementing and sustaining them. Unfortunately, only ten states have enacted laws related to the implementation of SPHM programs and the SPHM program components mandated within those laws are not consistent.

Background

Over the past decade, a lot of attention has been given to the health and safety of health care workers. The American Nurses Association surveyed nurses in 2011 to discover their concerns about health and safety in their work environments; 4,612 nurses responded. In the survey, 62 percent of nurses indicated that suffering a disabling musculoskeletal injury was one of their top three safety concerns, and 80 percent reported working despite experiencing frequent musculoskeletal pain. The extent of musculoskeletal disorders among the U.S. nursing workforce is particularly distressing when considered in the context of the current nursing shortage. Injuries caused by patient handling tasks intensify factors causing the shortage such as aging of the nursing workforce, declining retention and recruitment rates, and lowering social value of nursing. The current 6% nursing shortage is predicted to reach 20% by 2015 and 30% by 2020. That percentage could be even higher if nurses continue to leave the profession at a rate of 12% a year. In addition, the number of nursing shortages is increasing in states that have not had the profession for alternative careers with fewer physical demands, which contribute to the growing nursing shortage. The nation can no longer afford to lose the nurses who leave the profession.

The American Nurses Association (ANA) has led the fight to eliminate conventional practices of manual lifting, repositioning and transferring that contribute to work-related injuries and MSDs in nurses and other healthcare workers. In September 2003, ANA developed the American Nurses Association “Handle with Care” Campaign to mount a profession-wide effort to prevent back and other musculoskeletal injuries in health care facilities. The campaign addressed issues that included better education and training, the use of equipment when moving and transferring patients and a need for SPHM education in nursing school curriculum. ANA also called for a collaboration of nursing organizations, the Occupational Safety and Health Administration (OSHA), and the National Institute for Occupational Safety and Health (NIOSH) to work together to develop a plan to provide the tools to nurses and other health care professionals. Furthermore, ANA advocated for NIOSH, the Center for Disease Control and Prevention, the Joint Commission and other national working groups to research the issue and develop standards and monographs to help hospitals and other health care employers develop safe and effective programs.

Current State of Affairs

In 2011, ANA spearheaded an effort to develop national, interdisciplinary SPHM standards to be applicable across the care continuum. In June 2012, a cross-sectional team of national SPHM experts was established to define the basic content of the standards. The team developed a safe Patient Handling and Mobility: Interprofessional National Standards. The final standards contain definitions of the words used within these standards. The SPHM standards are divided into two parts. One addresses the responsibilities of the employer or health care organization; the other addresses the responsibilities of the health care workers and ancillary/support staff. The standards are derived from an analysis of existing state laws and reducing workers’ musculoskeletal injuries, and include eight principles as follows: 1) establishing a culture of safety; 2) creating a sustainable program; 3) incorporating ergonomic design principles; 4) developing a technology plan; 5) educating and training health care workers; 6) establishing a nurses’ education program for their individual needs; 7) setting reasonable accommodations for employees’ return to work post-injury; and 8) implementing a comprehensive evaluation system. The expectation is that the language in the standards will be adopted in its entirety and not modified.

Organizations that have adopted and implemented the SPHM standards have reduced their workers’ compensation claims, therefore decreasing direct and indirect costs related to employee musculoskeletal injuries. According to a 2004 OSHA study on average a provider’s compensation claim related to patient handling cost $15,600, with wage replacement of $12,000 accounting for the largest share of this cost. In addition to the direct costs, indirect costs can increase the total cost of patient handling injuries by two to four times. Since the start of the ANA’s “Handle with Care” campaign in 2003, 14 states have implemented “safe handling” laws or approved regulations. The states are California, Illinois, Maryland, Minnesota, Missouri, New Jersey, New York, Ohio, Rhode Island, Texas, and Washington. Ohio’s which required registries of employers in the health care sector and the other healthcare systems in the U.S. that implemented a Safe Patient Handling Program have shown that the initial capital investment in safe patient handling programs, and equipment can be recovered in fewer than five years. According to a 2003 study of the H.R. 2480 Safe Patient Handling and Mobility Worker Protection Act of 2013 (H.R. 2480), designed to decrease the potential for injury to health care personnel and patients, while reducing work-related health care costs and improving the safety of patient care delivery, was introduced to the 113th Congress. The Act will require employers to develop a safe patient handling and mobility program within six months of endorsement of the final standard and to obtain input from direct-care registered nurses and health care workers during the process of developing and implementing a SPHM program. The employer will also be expected to purchase and implement use of equipment no later than two years after establishment of the standard and to provide training for the health care workers annually. The H.R. 2480 Bill was introduced and endorsed by Congressmen John Conyers (D-MI) and currently has 14 cosponsors from the states of California, Ohio, Oregon, Florida, Illinois, Iowa, Arizona, New Jersey, and Nevada. The Bill has presently been referred to the Subcommittee on Health and House Ways and Means (H.R. 2480, 2013).

Traditionally, the health care industry has relied on people to perform tasks such as lifting, repositioning, and transferring patients, whereas other industries use equipment to lift and move patients. Nurses and other health care workers have often blamed for their own injuries, because he/she has “failed to do the lifting properly.” There is a paradigm shift revolving within nursing, based on a large body of research demonstrating that “lifting properly”—that is, using good body mechanics—cannot protect nurses or other health care workers from musculoskeletal injuries. Healthcare workers are in almost every situation. ANA has stated that that safe patient handling and mobility technology and methods must be used to lift, reposition, and laterally transfer dependent healthcare recipients.

Conclusion

A growing body of evidence has revealed that a comprehensive safe patient handling program significantly reduces the risk of musculoskeletal injuries in the health care setting. Common elements of a successful SPHM program includes mechanical equipment to assist healthcare workers with lifting and moving tasks, training in the use of the equipment, and a strong organizational policy. The role of the Chief Nursing Officer and other managers in continual surveillance and evaluation of the programs, as well as constant reinforcement of the proper use of the lift equipment, is also important to maintain and sustain the staff’s compliance with the program. Any organization operates more efficiently when workers are not injured and patients are not injured. The goal of SPHM is to provide quality and safety are improved by timely patient care and safer patient movement, which in turn provides improved patient satisfaction. Job satisfaction improves when patient handling is safer and more efficient. Healthcare workers are more likely to remain in the profession if their job is more satisfying and they are not in fear of becoming injured on the job. Safe patient handling is an essential component of future healthcare success.

References


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