Nevada Action Coalition
Read the second article in a new column from the Nevada Action Coalition, which is advancing the Initiative on the Future of Nursing goals in Nevada. Page 11

Rural and Frontier Nurses
New committee formed to focus on the needs of rural and frontier nurses. Page 8

FDA MedWatch Program
Learn how to report a medical product or medication side effect. Page 10

Creating Serendipity
Follow these 7 easy steps. Page 13

For more information, visit www.nvnurses.org

"But however secure and well-regulated civilized life may become, bacteria, Protozoa, viruses, infected fleas, ticks, mosquitoes, and bedbugs will always lurk in the shadows ready to pounce when neglect, poverty, famine, or war lets down the defenses."

Hans Zinsser; *Rats, Lice, and History* (1934)
Bakeless Bake Sale Fundraiser

You are invited to NOT bake a cake, pie, cookies, or brownies. You do NOT have to find the recipe. You do NOT have to shop for the ingredients. You do NOT have to mix. You do NOT have to cook. You do NOT have to cut. You do NOT have to wrap. You do NOT have to wash dishes. You do NOT have to clean up your kitchen. You do NOT have to deliver the baked product. You do NOT have to stand in the heat/cold/rain to sell the baked product. You can write a check to Nevada Nurses Foundation and stay home and enjoy doing something yourself or with your family!

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Thank you for your support!
In this issue

focus
6 Antibiotics
5 Measles
8 New Antimicrobial Resistant Pathogens

articles
12 Bullying in Nursing
13 Creating Serendipity in 7 Easy Steps
10 FDA MedWatch Program
13 Fifty Years in Nursing
11 Implementing Nurse Residency Programs in Nevada
14 The Ethics of Caring
9 Vaccinations

regular features
12 Check it Out!
15 Membership Application
4 Message from President Scott Lamprecht

“Perhaps when cultural assessment is combined with genetic assessment, this could be the beginning of culturally holistic care.”

~ NNA President, Dr. Scott Lamprecht
Local Staffing with Advantages!

**Nevada Information May, June, July 2015**

Discussed "The Power of One" and active communication between NNA are aware of this and what values are important to nurses in Nevada? We communicate needs to be open, honest, and reciprocal. Being or becoming a member of NNA has great value in so many ways, but how many nurses are aware of this and what values are important to nurses in Nevada? We discussed "The Power of One" and active communication between NNA to all nurses, professional groups, facilities, and individuals in Nevada is the key. Please contact myself or a NNA Board Member to get involved in the process to better life and healthcare for all individuals in Nevada.

Best regards and thank you for your active participation!

If you would like to contact NNA or President Lamprecht, please call 775-747-2333 or email nvnursesassn@mvqn.net.
Measles is a highly contagious virus that lives in the nose and throat mucus of an infected person and is transmitted by direct contact with infectious droplets or by airborne spread when an infected person breathes, coughs, or sneezes. The virus can live for up to two hours on a surface or in an airspace where the infected person coughed or sneezed. Approximately 90% of unprotected individuals exposed will become ill. The incubation period usually is 10 – 14 days. The infectious period is 4 days before and 4 days after the rash appears. Measles typically starts with a fever, runny nose (coryza), cough, and red and watery eyes (conjunctivitis) – (aka "the 3 Cs"), and a sore throat which lasts 2-3 days. Two or three days after symptom onset, tiny white Koplik spots may appear inside the mouth. A maculopapular rash usually appears 14-17 days after exposure and lasts 5 – 7 days. Sometimes, immunocompromised patients do not develop the rash. The rash usually starts on the face or scalp, then spreads to the neck/trunk, then arms and legs, then disappears in the order of appearance. About three out of 10 people who get measles will develop one or more complications including pneumonia, ear infections, diarrhea, brain swelling and death. Individuals at high risk for complications include infants and children under the age of 5 years, adults over the age of 20 years, pregnant women, and individuals with a compromised immune system.

Measles Diagnosis
Most US healthcare professionals have not seen a case of measles. Measles should be a differential diagnosis of febrile rash illnesses. Testing for measles includes serology for IgM with the first few days of rash onset, viral swab of nasopharyngeal, oropharyngeal, or nasal membranes for PCR. At this point, if positive, the local health department should be notified. If the patient has measles, a contract investigation will need to be conducted. For more information, the CDC conducted a conference call titled - Measles 2015: Situational Update, Clinical Guidance, and Vaccination Recommendations. The slides, transcript, audio and webcast can be accessed at http://emergency.cdc.gov/coca/calls/2015/callinfo_021915.asp.

Measles Vaccination
Measles can be prevented with the MMR (measles, mumps, and rubella) vaccine and was considered eliminated in the United States in 2000. One dose of MMR vaccine is about 93% effective at preventing measles if exposed to the virus, and two doses are about 97% effective. The Centers for Disease Control and Prevention (CDC) recommends all children get two doses of MMR vaccine, starting with the first dose at 12 through 15 months of age, and the second dose at 4 through 6 years of age. Children can receive the second dose earlier as long as it is at least 28 days after the first dose. Students at post-high school educational institutions, travelers, and healthcare personnel who do not have evidence of immunity against the measles need two doses of MMR vaccine, separated by at least 28 days. The CDC assumes that all individuals born before 1957 have been exposed to the measles and do not need to be vaccinated. Adults born after 1957 who do not have evidence of immunity against the measles should get at least one dose of MMR vaccine.

References

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A New Source of Antibiotics?  
Wallace J. Henkelman, EdD, MSN, RN

With all of the concern regarding the rapid emergence of antibiotic resistant bacteria, there is at least one bright spot on the horizon. Not only is there a new antibiotic being tested, but it was developed using an entirely new technique which has the potential of producing many more drugs. Most existing antibiotics were developed as a result of culturing soil bacteria in the laboratory and testing their byproducts. However, about 99% of soil bacteria cannot be cultured, so their characteristics have not been studied to this point. A group of European scientists have developed a method, using specific growth factors, to study these organisms in situ. As a result they have extracted a new antibiotic, Teixobactin, which inhibits bacterial cell wall synthesis. The new drug has been shown to have excellent activity against gram-positive pathogens including all drug-resistant strains tested. Drug-resistant organisms tested included M. tuberculosis, Clostridium difficile, Bacillus anthracis, and Staph. aureus. Serial passage through several generations of bacteria did not demonstrate any mutations with drug resistance to Teixobactin. Use of this new study technique has the promise of producing a large number of additional new drugs.

Reference

A New Source of Antibiotics?  
Wallace J. Henkelman, EdD, MSN, RN

In order to catch the attention of the general public and of politicians, it is sometimes necessary to publicize worse-case scenarios. Hopefully, recent publications from the United Kingdom are just worse-case scenarios and not realistic predictions The U.K.’s Review on Antimicrobial Resistance has stated that by 2050 the continued rise in antimicrobial resistance could cause 10 million deaths per year and reduce Gross Domestic Products by 2% - 3.5%. Two scenarios were used to produce these predictions; RAND Europe assumed that drug resistance would rise to 100% over 15 years with the number of cases held constant; KPGM assumed that resistance would rise by 40% with the number of infections doubled. Both looked at six disease entities. They included three which already demonstrate significant drug resistance (Klebsiella pneumonia, E. coli, and Staph. aureus) and three which are continuing to experience rising drug resistance (HIV, tuberculosis, and malaria). Malaria resistance leads to the largest number of casualties while E.coli had the greatest economic impact.

Reference

Overuse of Antibiotics  
Dr. Scott W. Lamprecht, APRN, FNP-BC, RN

As nurses one of our many jobs is to educate patients. As an APRN, I work with patients in my clinic everyday with a wide variety of illnesses and conditions. Many of these are acute illnesses caused by viruses or bacteria. For many years, patients would get sick with a wide variety of “bugs” and get treated with antibiotics; many times these were viral illnesses. We are now reaping the benefits of antibiotic overuse. Many bacteria have become resistant to almost every antibiotic available. MRSA, VRE, and Klebsiella are just a few examples. How does this happen? The overuse of antibiotics is a major component. Antibiotics kill bacteria both good and bad but have no effect on viruses. By killing “good” bacteria, our bodies are at risk for opportunistic infections such as Candida albicans (yeast) or Clostridium difficile. Some bacteria after frequent exposure to antibiotics begin to change and become resistant. Patients tell me “Amoxicillin does not work on me.” Perhaps this is because they have taken it too many times for viral infections, or did not finish the full ten days of dosing.

The key as a provider is knowing when to use antibiotics. I have patients come to my clinic wanting antibiotics for a cold then get upset when I explain what they have is viral and antibiotics are not indicated. Patients have been conditioned to get a pill and feel better, rather than let our immune system take care of the issue and just manage the symptoms. Guidelines for using antibiotics include: temp greater than 101F, acute illness lasting greater than three days, purulent or exudate in the pharynx. I frequently have patients come to my office with complaints of congestion and cough for 24 hours or less. In these cases, a watchful waiting approach can be very helpful but requires patients to be aware of important signs/symptoms and when to notify the provider.

Another source of confusion is the color of nasal/respiratory secretions. For many years it was thought that yellow or green secretions indicated infection and required antibiotics. We now understand the color comes from normal flora sloughing off due to inflammation in the respiratory tract. Our body will generally kill a virus within three to four days, but symptoms persist because of the residual inflammatory response. Supportive care to manage symptoms is the key, not the use of antibiotics.

Antibiotics can save lives but can also cause other issues such as opportunistic infections, drug-resistant organisms, and hepato-renal damage. Knowing when to use antibiotics is the key and educating patients on antibiotic use is essential. Nurses play a pivotal role in educating patients about their conditions and therapies, including the use of antibiotics.

Antibiotic Resistance Predictions  
Wallace J. Henkelman, EdD, MSN, RN

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Antibiotics! Patients and Prescribers Speak Up in inappropriate prescriptions (Spelling, Bartlett, & Gilbert, 2015). Reasons clinicians gave for prescribing antibiotics included a high certainty that the antibiotics were needed (53%), an uncertainty that an infection might be bacterial (42%), patient was sick and labs would take too long (31%), patient refused or could not afford a lab test (19%), malpractice fears (15%), and that antibiotics would not harm and might help (10%). Clinicians’ uncertainty and fear of being wrong on diagnosis appear to be the main factor behind inappropriate prescriptions (Spelling, Bartlett, & Gilbert, 2015). Patient responses were interesting and controversial. Seventy-seven percent of patients denied asking for or having an expectation of getting antibiotics. Prescribers refute that statistic as not credible by citing a common perception that most patients expect to be given antibiotics. Twenty-three percent of patients believed antibiotics would not be harmful, therefore it was justified to request antibiotics. Some believed antibiotics would certainly cure an illness (85%); others believed antibiotics always worked (25%). Only 53% of patients said that the healthcare provider discussed or provided information on the dangers of antibiotic resistance from inappropriately prescribed antibiotics. How much influence patient demand for antibiotics has had on clinician prescribing habits is unclear. Clinicians commonly say patients regularly demand antibiotics and are unhappy with any other alternatives. Clinicians have also expressed concerns about getting poor patient satisfaction ratings after patients demand antibiotics and they decline to issue prescriptions (Zgierski & Rabago, 2014). Instead of persistent adherence to clinical evidence, patient satisfaction ratings appear to be negatively influencing antibiotic prescribing patterns. In one survey, 59% of prescribers said their compensation was linked to patient satisfaction scores; 20% said patient satisfaction scores were a threat to their employment and, 50% said the pressure to prescribe unnecessary antibiotics resulted in inappropriate care. Clinicians also said patient satisfaction got in the way of good medical practice.

A big challenge for clinicians when deciding whether or not to prescribe antibiotics is that they do not have complete certainty about which antibiotics resulted in inappropriate care. Clinicians commonly say patients regularly refused or could not afford a lab test (19%), malpractice fears (15%), and that antibiotics would not harm and might help (10%).

Effective approaches to change prescribing patterns could include, developing reasonably priced, better rapid diagnostics tests to diagnose and differentiate viral from bacterial infections with certainty, clearer clinical guidelines for diagnosing common viral illnesses like upper respiratory infection and bronchitis, increased access to antibiograms to educate prescribers, malpractice reform to mitigate lawsuits, and giving financial incentives such as pay-for-performance when guidelines are followed. Consistent adherence to guidelines among primary care and specialty care clinicians is needed. Emergency department and urgent care prescribers must be especially vigilant in evidence-based prescribing since patients frequently seek these venues for antibiotics. We must re-evaluate how the widespread utilization of patient satisfaction surveys as a quality-of-care metric are negatively impacting prescribing patterns and make adjustments in how these metrics are weighted. Clinicians need ongoing support and education that antibiotic prescribing practices should not be swayed by the perceived expectations of patients. Further still, ongoing education of the general public with more explicit and blunt messages on the growing threat from antibiotic resistance is needed at the national, state, and local community level.

References
New Committee to Focus on Rural and Frontier Nurses
Heidi Johnston MSN, RN, CNE
Great Basin College, Elko, NV

The Nevada Nurses Association has formed a new committee which will focus on needs of rural and frontier nurses. We would like to encourage nurses working in these areas to join us and help identify, create, and provide resources to meet the needs of nurses within these communities. Healthy People 2020 addresses access to healthcare with the goal of improving access to comprehensive, quality, health care services. By offering needed resources to nurses within these rural and frontier communities we are helping to maintain a workforce that in turn meets the Healthy People 2020 goal. For more information or to join this committee please email Heidi Johnston at heidi.johnston@gbcnv.edu.

New Kids in Town
New Antimicrobial Resistant Pathogens
Kathy Ryan, MSN, RN-BC, PHN

Poking your head outside your door can be risky business these days. In the aisle at the supermarket you may pick up the freebie known as community acquired pneumonia. In the isolation room at the hospital you may pick up the costly MRSA (methicillin resistant staphylococcus aureus). Of increasing concern, both nationally and internationally, is the ability of pathogens to resist the medications designed to neutralize them.

There are several agencies monitoring disease incidence and prevalence, and antimicrobial resistance; among them the Centers for Disease Control and Prevention (CDC) and the World Health Organization. The CDC’s Antibiotic Resistance Threat Report for 2013 lists their 18 greatest concerns categorized according to level of concern.

Hazard Level Urgent pathogens (3) pose significant risks, are considered “high-consequence,” and require public health attention to surveillance to prevent transmission.
Hazard Level Serious pathogens (12) require continuing public health monitoring and prevention activities.
Hazard Level Concerning pathogens (3) may cause serious illness and may require rapid interventions.

The CDC’s website offers links to both the full report and the “Biggest Threats” list. Public health education features include Protecting Yourself and Your Family, Protecting Patients and Stopping Outbreaks, and Protecting the Food Supply, with additional references and resources.

Please visit the CDC’s website at www.cdc.gov/drugresistance/index.html.
Vaccination is one of the greatest successes in public health history. In 1796 Dr. Edward Jenner began the modern vaccine era by developing a vaccine against smallpox, a disease which is now considered eradicated (Riedel, 2005). In 2000 the United States (U.S.) achieved measles elimination; however, measles continues to be imported into the U.S. (Centers for Disease Control and Prevention [CDC], 2012). Poliomyelitis is also on the verge of eradication, with the last indigenous case in the U.S. occurring in 1979 (Malone and Hinman, 2007).

Most vaccination-preventable diseases are transmitted from person to person (Malone and Hinman, 2007). Vaccination protects not only the individual who receives the vaccination but also the community. When a large proportion of the community receives vaccination, generally considered to be between 80% and 95% depending on the disease, vaccinated individuals serve as a barrier to transmission to others in the community, protecting people who cannot receive vaccination or who received vaccination but are not protected due to vaccination failure. This phenomenon is commonly referred to as "herd-immunity," or "community-immunity."

School vaccination requirements have been critical for vaccinating Americans for over a century. Massachusetts became the first state to require vaccination for school children in 1855 (Malone and Hinman, 2007). Almost half of the states had a requirement for children to be vaccinated by the beginning of the twentieth century. All 50 states had laws covering students first entering school, or preschool, by 1980.

Although all states have school vaccination requirements, many states provide exemptions for medical, religious, or philosophical reasons (Cole & Swendiman, 2014). All 50 states allow exemption from vaccination for medical reasons, such as permanent or temporary conditions that impair the child’s immune system (The College of Physicians of Philadelphia, 2015). Twenty states allow personal belief exemptions for parents and patients who have philosophical objections to vaccination. Nevada does not allow personal belief exemptions (The College of Physicians of Philadelphia, 2015). Twenty states allow personal belief exemptions for parents and patients who have philosophical objections to vaccination. Nevada does not allow personal belief exemptions. Nevada pupil vaccination and exemption laws are covered under Nevada Revised Statutes 392.435, 392.437, and 392.439, as well as others (National Conference of State Legislatures, 2015).

After addressing safety and efficacy studies, the Food and Drug Administration must license all vaccines to be administered in the U.S. (Malone and Hinman, 2007). In 1986 Congress approved the National Childhood Vaccine Injury Act (NCVIA), which established the National Vaccine Program within the U.S. Department of Health and Human Services (DHHS). The NCVIA allows the DHHS to supervise all activities within the U.S. government related to vaccine safety, research, development, and monitoring.

The Advisory Committee on Immunization Practices (ACIP), an advisory group to the CDC, determines which vaccines to be administered and the schedules for their use (Malone and Hinman, 2007). ACIP, commonly in coordination with the American Academy of Pediatrics and the American Academy of Family Physicians, issues recommendations for use of pediatric and adult vaccines and a schedule for administration of routine vaccines. These recommendations are often used by states to determine which vaccinations to require for school attendance. The CDC and other public health organizations have established vaccination registries to send parents and patients reminders when vaccines are due to help assure vaccinations are given according to schedule.

Vaccinations are generally safe and effective but have some risks. Vaccines have dramatically decreased infectious diseases in the U.S. The role of mandatory vaccination certainly helped achieve this impact.

References available upon request.
Limited patient demographics, and confounding due to trial limitations such as short duration, adverse events are undetectable in clinical trials. Often, evaluate serious adverse events and product over 20 years ago. Its purpose is to identify and adverse event reporting program was launched through the MedWatch program.

MedWatch, the FDA safety information and adverse event reporting program was launched over 20 years ago. Its purpose is to identify and evaluate serious adverse events and product quality issues related to the use of medical products in the post-market setting. Often, adverse events are undetectable in clinical trials due to trial limitations such as short duration, limited patient demographics, and confounding medications and disease states. Even a handful of MedWatch reports can trigger a safety signal that may result in a change in how a product is labeled and used.

The MedWatch program has two parts: receiving safety information in, and communicating safety information out. The first part is a process that seeks and accepts the voluntary reports of serious adverse events and product quality problems into the FDA. Because nurses are at the frontline of patient care, you are ideally positioned to identify and report events when they occur. There are also mandatory reporting requirements for user facilities for medical devices, and for manufacturers for other regulated products such as medical devices, biologics, and drugs.

Types of products to report
- Prescription and over-the-counter medications
- Nutrition products, including infant formulas, dietary supplements, and herbal remedies
- Medical devices, from contact lenses and breast implants to blood glucose meters and pacemakers
- Biologics, such as human cells and tissues for transplantation
- Cosmetics or make-up products

Examples of problems to report
A variety of events and problems can be reported through the FDA MedWatch program including serious adverse events, product quality problems, near misses, medication and device use errors, and therapeutic failures. Serious events would be something that resulted in death, was life-threatening, caused permanent disability, required hospitalization, caused a birth defect, or required some kind of help in order to prevent permanent harm. However, events are not limited to these categories. If you think that it an event is serious, please report.

How to complete a report
You can submit a report in several ways:
- The form can be completed manually by downloading and mailing by regular mail or faxing into 1-800-FDA-0178
- A paperless report can be submitted online
- You can also call 1-800-FDA-1088 between 8:00 am and 4:30 pm EST to request a form
- Provide as many details in your report as possible to improve the quality of report (be specific about timing, lab values, de-challenge and re-challenge information, etc.
- MedWatchLearn teaches students, health professionals, and consumers how to complete the forms necessary to report problems to FDA. Here, you have the opportunity to practice filling out FDA Form 3500 (for health professionals) or FDA Form 3500B (for consumers).

Evaluation of your report
Once a MedWatch report is submitted it is captured in a database and analyzed. If, after further evaluation, the FDA determines that the product is associated with a risk, we may take a variety of regulatory actions such as requiring an update to a product label or packaging, development of a RiskEvaluation and Mitigation Strategy (REMS), or send out an FDA Drug Safety Communication.

If a product risk is identified and a regulatory course of action is decided, FDA must communicate this information to health professionals and the public. This brings us to the second part of the MedWatch program, which is FDA providing clinically important, product-specific safety information. MedWatch gives health professionals and patients access to relevant safety information to share in their decision-making about therapeutic and diagnostic choices. The MedWatch web page, with over one million visitors each month, is your gateway into the FDA’s safety information for human medical products, including drugs, biologic products, medical devices, or dietary supplements. It is a useful resource for the busy professional, providing both individual product safety alerts and a monthly compilation of safety labeling changes for drugs and relevant biologic products.

Sign Up Today!
MedWatch offers several ways to help you stay informed about the medical products you prescribe, use, or dispense every day by sending safety alerts directly to you. Sign up for free MedWatch safety alerts by joining our MedWatch E-list. You can also follow us in Twitter @ FDAMedWatch or by RSS feed.
Implementing Nurse Residency Programs in Nevada
Susan Adamek PhD(c), RN, NEA-BC, FACHE, Nevada Action Coalition

In 2010 the Institute of Medicine (IOM) published its most widely read report to date, The Future of Nursing: Leading Change, Advancing Health (Institute of Medicine [IOM], 2010). The IOM recommended that nurse residency programs be implemented for nurses who are new to the profession, to advanced practice roles, and to new roles within nursing. These structured programs have been shown to enhance safety and quality of care as well as reducing employee turnover. However, there is widespread confusion about definitions and terminology used to describe residency programs. They vary in structure, in length, and in content.

At a national level there are several major initiatives in place. The National Council of State Boards of Nursing, in collaboration with more than 35 nursing organizations from both urban and rural areas, is considering a regulatory model. Results of this study are expected to be released later this year. The University Health System Consortium has also collaborated with the American Association of Colleges of Nursing (AACN) to develop a comprehensive nurse residency program which is one year in length and is designed to be adaptable across a variety of settings. AACN has created accreditation standards for residency programs.

The Nevada Action Coalition has identified the recommendation to implement nurse residency programs as one of its primary areas of focus. A Transition into Practice committee has been established using members from the Nevada Hospital Association (NHA), the Nevada Alliance for Nursing Excellence (NANE) and the Education Subcommittee of the Health Care Sector Council. This committee is gathering information about the current state of nurse residency programs in Nevada, with a goal of recommending a “best practice” standard residency curriculum. Both nursing and non-nursing champions have been identified to lead this effort.

In Nevada, acute care hospitals have been found to offer a wide range of programs for new nurses. Some of the rural hospitals are only able to offer two weeks with a preceptor before the new graduate must assume a patient assignment. At the other end of the spectrum, some facilities offer structured on-boarding programs with didactic content, precepted clinical experiences, simulation lab practice, and support groups that last for twelve months. The Nevada Action Coalition is still gathering information about nurse residency programs in our state, but it is already apparent that some of our smaller hospitals could benefit from additional resources to support their new graduate nurses during their first year of practice.

Another initiative planned by the Nevada Action Coalition is to ask the new graduates themselves about their needs and experiences. This survey will help us determine the efficacy of the current transition into practice programs in the state, and guide recommendations for best practices in the future.

For the past several years the Nevada Hospital Association Health Care Workforce Development has offered financial assistance to hospitals that hire newly licensed registered nurses. Through this program, a percentage of the new nurse’s salary for a designated period of time is reimbursed to the hospital. Simulation lab experiences have been funded. New nurses with financial need may also qualify for assistance with some of their individual expenses through this program, including uniforms, medical equipment, books, transportation, and child care. Although the funds allocated to this program are limited, they have allowed hospitals to afford bringing more new nurses into the workforce.

Another creative approach to transitioning newly licensed nurses into practice is being developed by the University of Nevada, Las Vegas Continuing Education Department. This non-hospital sponsored nurse residency program is being designed to assist new nurses who have been unable to find jobs in nursing. The program will include precepted clinical experiences, mentoring, leadership coaching, online learning activities, simulation experiences, technical skills practice, and assistance with interviewing techniques and resume development. Funding for this program will be provided by Workforce Connections.

The Nevada Action Coalition welcomes participation in our efforts to assure that effective nurse residency programs are available to new nurses in our state. If you are interested in assisting our Transition into Practice Committee, please contact Linda Paulic at (702) 522-7026 or linda_paulic@nshe.nevada.edu.

References

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Yerington, NV 89447
October 9–11, 2015

Carson High School
1111 N. Salinan Road
Carson City, NV 89701
October 16–18, 2015

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Infectious diseases present continuing challenges for those working in hospitals and national and international public health care settings. Although science and technology advance health care at turbo speed, infectious diseases persist as a leading cause of death.

The National Institute of Allergy and Infectious Diseases categorizes infectious diseases as emerging, re-emerging, and persistent intractable. Emerging infectious diseases “include outbreaks of previously unknown diseases or known diseases whose incidence in humans has significantly increased in the past two decades.” Epidemiologists investigate the first confusing constellation of signs and symptoms to define and describe previously unknown diseases. But they are also attuned to the evolution of known diseases resulting from changes in human interactions with animals and the environment. This alteration in “transmission dynamics” often increases both the ease and frequency of human exposure to pathogens, and the incidence and prevalence of illness. For example, the import of exotic animals as food sources and as pets links to recent monkey pox and SARS outbreaks.

- Re-emerging infectious diseases “are known diseases that have reappeared after a significant decline in incidence.” Pathogenic survival mechanisms such as adaptation and recombination present new strains of old diseases that elude human immune systems and produce new illness. Additional concerns include the inappropriate use and overuse of medications and pesticides (producing pathogens and illness resistant to chemical intervention), and an increasing noncompliance with immunization guidelines (allowing the re-emergence of previously controlled illness).
- Persistent intractable infectious diseases “have never been adequately controlled on either the national or international level” (such as HIV/AIDS, malaria, and tuberculosis). Given the ease of international travel, illness common in the third world may now manifest in the first world and be initially difficult to diagnose.

A final consideration is the intentional use of pathogens in bioterrorism. Widespread exposure to anthrax, smallpox, or other pathogens producing mass casualties may severely impair U.S. health care systems’ response, with catastrophic results.

The National Institute of Allergy and Infectious Diseases maintains a commitment to education and research with a focus on HIV/AIDS, malaria, and tuberculosis. Selected goals include understanding the relationships of host, environment, and pathogen in predicting and preventing illness, and developing diagnosis and treatment options (including vaccines). Please visit the National Institute of Allergy and Infectious Diseases website at www.niaid.nih.gov/topics/emerging/Pages/introduction.aspx.

The Infectious Diseases Society of America coordinates the Emerging Infections Network of over 1100 infectious disease specialists to assist public health entities with surveillance. Their website links include surveys, and tuberculosis. Selected goals include understanding the relationships of host, environment, and pathogen in predicting and preventing illness, and developing diagnosis and treatment options (including vaccines). Please visit the National Institute of Allergy and Infectious Diseases website at www.niaid.nih.gov/topics/emerging/Pages/introduction.aspx.

The Infectious Diseases Society of America coordinates the Emerging Infectious Diseases Network’s website at www.iceid.org.

The International Conference on Emerging Infectious Diseases serves as a forum for public health professionals to share scientific information on national and international infectious diseases. Discussion topics for the August 2015 conference include:

- Antimicrobial resistance
- Bioterrorism and preparedness
- Foodborne, waterborne, vectorborne, and zoonotic diseases
- Global health
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Bullying in Nursing: An Old Name for Horizontal Lateral Violence

Is Lateral Violence intentional or is the impact of it not understood or perceived by the instigator? Does the instigator of the lateral violence just want to feel more empowered? Do managers attack the problem, or is it swept under the carpet by saying “That’s just how she/he is.” Sometimes it is a little of everything.

In the five hospitals in the Valley Health System, it was heard in every class that someone was being yelled at in front of their patients and other staff. This was being done not only by physicians, but by charge and staff nurses as well. When nurses become discouraged and saddened by the lack of compassion and remembrance by seasoned nurses of how it was when they were new, it is easy to see how errors in the health system could be made. When nurses can’t keep their mind on the task at hand, errors happen.

In the Medical Surgical Internship program through VHS, something has been done to correct the problem. At one time a growing problem, it is one that has become less significant. When the program first started, nurses came in and cried about how bad they felt and how they wanted to give up on nursing because of the way someone in the profession had made them feel. Some nurses threatened to walk off the job because they didn’t deserve to be treated that way. As a nurse educator at the VHS, I began to think back to the class I taught by the Nevada Nurses Association about lateral violence and things began to click. I came up with a bit of an unorthodox way to present this to the nurses.

The first thing that is done is to place a tiara on my head and walk around with a “magic” wand in my hand. I stop and say to a nurse “If you could change anything at all on the floor on which you work, what would it be?” I usually pick a male nurse first, because if he opens up, everyone will. For the first several months it was always “For the nurses I work with to treat me like a peer instead of yell at me in front of everyone.” Once the discussion was started, it was evident that many nurses had the same feeling. I then brought that nurse up and placed them in what I call the “victim triangle” on the floor. In the triangle, I have three words on the points; one is victim, another passive, the other anger. I begin yelling at that person as if I am the person doing the bullying and ask them where they would start on the triangle. The answer is always at victim. Once on the victim spot we have a discussion with the class about how a victim feels. Then I have them move to the passive point. With this, I tell them that now they are thinking at a later time, that maybe this nurse just had a bad day, or a child is sick, so maybe it is OK and will change. Then they go to the other point which is anger. Here they talk about how they were made to feel and that it isn’t OK to be treated like this which in turn makes them a victim again. As the nurse bounces around in the triangle, I ask them how they are going to get out. They look at me and say they aren’t sure. I tell them, “Step out.”

Once the nurse steps out of the triangle, I have them sit and we start discussing the acronymCUS. C=I’m concerned, U=I understand and S=Stop, this is a safety issue. So I start filling in some verbiage for them to use when lateral violence happens. I am concerned about how and where you are presenting yourself at this time. I understand you are upset, but you need to stop and we can go into another room to talk out of the hearing range of everyone else, or maybe you would like to have this discussion in front of the manager. Then we discuss using the chain of command in our facility. If a nurse is the problem, go to the charge nurse, if the charge nurse is the problem, go to the manager. If results are not made from this point, continue higher.

Once the class is over and the evaluations are given, I read over and over again how the nurses now feel more empowered to stand up to the person who is doing the bullying. When I talked to some of the managers, they were shocked to think their new nurses would not come to tell them how they feel so things could be changed. Once this was relayed to the managers, meetings were begun and the policies that were already in place were discussed. An absolute “No tolerance for bullying” was enacted and things began to change.

This month was the time for Lateral Violence Class. I placed the tiara on my head, brought out my magic wand and the questions began. To my surprise, not one nurse in the room ever made me believe I was being bullied. It was all discussion on acuity of the patients, number of patients, and the usual voicing of not having the equipment they need. Once that discussion was made and some answers given, such as taking care of the equipment that is provided, we went more in-depth about the growing problem of lateral violence and how to stop it before it starts, even using scenarios of physicians yelling and what to do about that.
In 1962 I was a senior in high school. During Christmas break I went for an interview at the California Hospital School of Nursing (CHSN). CHSN was a three-year Diploma nursing school. Miss Barbara Jury interview me there. I thought her as older, but my guess now is that she was twenty-seven or twenty-eight years old. Oh, the perspective of youth.

In August of 1962 I entered the School of Nursing. We had orientation on Monday and Tuesday mornings bright and early at 7 AM and were placed on a nursing floor with “real” nurses and patients. The first day we were all assigned a patient with whom we were to talk; I remember feeling very nervous and extremely apprehensive. That started my 50 year journey in nursing, 53 years if I include nursing school.

The highlights of my nursing career were many. An example was my first injection. We only had glass syringes then that were reusable, as were the needles. They were delivered every day from Central Supply after being autoclaved. I also remember at a later date when the first box of disposable syringes arrived on the floor. That was true progress.

Another career highlight was our Capping Ceremony. We received our first stripe for our cap, a moment I remember it. We had finished our probationary period and were on the way to becoming nurses. A sad highlight occurred in November of 1963 when it was announced that President Kennedy had been shot. I was assigned a patient that day who was suffering from end-stage renal failure. The announcement of President Kennedy’s death came over the PA system as I was walking down the hall to my patient’s room. With tears in my eyes I walked into her room to find she had expired. That was my first death and produced new feeling of vulnerability to life events.

In our junior year we advanced to pediatric, maternity, and psychiatric nursing. We spent three months at the VA Hospital in Los Angeles, a very different experience for an 18-year-old. Finally, in our third year we accumulated three stripes on our cap. And what a year it was since we were then charge nurses, team leaders, and mentors to freshmen and junior nursing students. June 1965 finally came and we graduated in a beautiful ceremony and got our “black” stripe for our caps. It was then time to study for State Boards. In July 1965 we traveled to Long Beach, California and took tests in med-surgical, pediatric, maternity, and psychiatric nursing. Testing took two and half days. (I should mention that I had a nagy case of chicken pox at the time which made taking State Boards a true challenge). Then it was a waiting game; results took about six weeks and came in the mail. State Boards were only given twice a year, in July and January, so if one did not pass, they had to wait six months to take State Boards again.

In September I finally received my letter and was afraid to open it, but to my relief I had passed. In was then off on a job hunt. My first job was for a hospital in Burbank, California working the 3-11 PM shift in the float pool. We had no orientation to the hospital. My first evening I was assigned to a medical-surgical floor as the treatment nurse working with what I thought was an extremely seasoned nurse, but who was less than helpful. But I was prepared, I had the training, and knew I could do the job. That position was my start in the nursing profession.

Over the next five decades I worked in medical-surgical units, coronary care and intensive care units, emergency rooms, hemodialysis units, home health, and hospice. I also served as Staff Educator and Director of Nursing. Along the way I had two children and went back to school for Bachelors and Masters Degrees in nursing.

Ten years ago I accepted a position at Nevada State College as a new faculty member in a new school. I knew I liked to teach but this has turned out to be far more rewarding than I thought possible. I love teaching the students and being part of their success. I teach in the RN to BSN Program, and this has been very rewarding. Being an alumni of an RN to BSN program myself, I have a great appreciation for what these students go through.

As I look back over the last 50 years and the changes in nursing, the advances in diagnostic testing, technology, computerized charting, the diversity in nurses, as well as in the patient population, I am proud to be a part of such a rewarding, satisfying, and worthwhile profession as nursing.
While there are many key concepts within the framework of nursing, caring is a central construct within the discipline of our profession. As such, we should be concerned about the ethical implications of caring, its application and effect on our practice. Discussion on the theory of ethics of care has been well documented since the early 1980's. Beginning with the work of Dr. Jean Watson. Among the early conceptual frameworks in nursing, Dr. Watson's Theory of Caring is described as a moral ideal that involves mind, body, and soul engagement with another. Most of us consider caring to be something of a moral obligation to our patients from which action emanates. The ethics of caring considers three distinct elements that not only involve actions, but also a focus on relationships between power and caring practices as well as addressing the question, "What is the best way to care for this patient at this time?" Tronto (1993) postulates four elements of caring that include attentiveness, responsibility, competence, and responsiveness. The ethics of care considers responsibility of caring? There are four distinct phases within the ethics of caring model: (1) caring about, (2) taking care of, (3) care giving, and (4) care receiving.

Caring about implies recognizing a need. An example would be identifying/relating to what a patient needs at this particular time such as chills, fever, nausea, vomiting, pain, emotional distress, and includes obtaining a thorough history.

Taking care of implies a responsibility to take action. Responsibilities include providing reassurance and explanations, ordering diagnostic tests, starting IVs, preparing medication to be administered. In addition, these responsibilities include conducting a physical exam.

Examples of care giving include administering medications(s), providing warmth, keeping patients and families informed, and providing education. Taking action implies suggesting or implementing a change.

In care receiving we assess the success of a particular intervention.

Collectively, these strategies involve an interrelationship between cognition, emotion, and actions. For many of us this may represent the essence of the nursing process. However, for the patient to actually experience the ethics of caring, this can only be achieved by the implementation of the stated strategies listed.

Effective care is based upon our knowledge, skills, abilities, and attitudes. As you can see, a lack of any of these elements raises ethical issues that correlate directly to competency. Failing to acknowledge a lack of competency in a given situation could result in action against a nurse's license, malpractice actions, and detrimental outcomes for patients and families. According to the ANA (2001), "Continual professional growth, particularly in knowledge and skill, requires a commitment to lifelong learning."

Most nurses have been exposed to Watson’s caring theory, but many of us are not aware of the ethics of care. Dr. Watson’s caring theory contains three major elements: (1) the careative factors, (2) the transpersonal caring relationship, and (3) the caring occasion/caring moment. As we honor nursing’s work to care for patients, let us also remember that caring without action is essentially meaningless from an ethical perspective.

References

**The Ethics of Caring**

John Malek, PhD, MSN, APRN
Creating Serendipity continued from page 13

1. Be curious. Never stop asking questions. Always try to come up with connections. Ponder the "what ifs." Dig deeper into the task at hand to find the core of the problem. Keep studying, learning, listening.

2. Be alert. Live in the moment. Try to be engaged. Pay close attention to what you’re doing. Focus.


5. Be tenacious. Do not fear failure or getting Semmelweised (i.e. being ridiculed by your colleagues). The easy road is often the wrong one to take.

6. Be responsible. Work hard but don’t forget to take care of your basic needs.

7. Be wary of the status quo. If you’re not challenging the way things are by constantly asking yourself how things can be made faster, cheaper, easier, or better, then you won’t be mentally prepared when the opportunity strikes.

Alexander Fleming never expected that mold found in stale bread could have anti-bacterial properties, but because he was already engaged in the pursuit of finding a substance that could kill off Staphylococcus in culture—and because he was curious, tenacious, and disciplined—he immediately recognized the significance of finding the halos of growth inhibition in the contaminated media. As Louis Pasteur, the scientist originally credited with confirming that bacteria causes disease, best put it: “Chance only favors the prepared mind.”

Reference available upon request.

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