New Mexico Nurses and Child Abuse Prevention

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Introduction – Child Abuse

Child abuse and neglect are two of New Mexico's most serious concerns. With over 30,000 nurses licensed in New Mexico, we can help prevent both. "Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations." Using evidence-based practice, nurses can strive to ensure the safety, permanency and well-being of all children.

According to the Centers for Disease Control and Prevention, child maltreatment is "any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child. There is physical, sexual and/or psychological abuse." More than 10 million children younger than 18 years experience some form of maltreatment from a caregiver, ranging from neglect to sexual abuse, but only a small percentage of these violent incidents are reported to law enforcement, health care clinicians, or child protective agencies.

Moreover, exposure to violence increases vulnerability to a broad range of mental and physical health problems over the life course; for example, meta-analyses indicate that exposure to physical abuse in childhood is associated with a 54% increased odds of depressive disorder, a 78% increased odds of sexually transmitted illness or risky sexual behavior, and a 32% increased odds of obesity. Rates of violence vary by age, geographic location, sex, and race/ethnicity, and significant disparities exist. Child neglect is an "act of omission that is a failure to provide for a child's basic physical, emotional, or educational needs or to protect a child from harm or potential harm." The following types of maltreatment involve acts of omission: physical, emotional, medical and dental, educational neglect, inadequate supervision, and exposure to violent environments.

Shaken Baby Syndrome (SBS) is a type of Abusive Head Trauma (AHT) and the leading cause of child abuse death. At least one of every four babies who are violently shaken dies from this form of child maltreatment. The estimated rate of SBS is 30 cases per 100,000 children aged one year or younger or between 1,200 and 1,600 children every year. In a 10 year retrospective study in Canada Dr. King and colleagues found that 19% of children, with a median age of 4.6 months, died from SBS. Survivors of a shaking injury often have long-term disabilities. More than 80% of those abused have lifelong brain injuries. The majority of the survivors are left with handicaps ranging from mild learning disabilities. More than 80% of those abused have lifelong brain injuries. The majority of the survivors are left with handicaps ranging from mild learning disabilities.

It is estimated that child abuse cost the health care system approximately $124 billion. The initial and long-term cost of medical care for children who are victims of SBS is $47,952 per patient. These mortality and morbidity statistics demonstrate the seriousness of SBS and the need to prevent this form of child abuse. At the University of New Mexico Hospital (UNMH), the nurses have implemented an evidence-based, parental educational program that has excellent results in reducing child abuse known as SBS and they are initiating a legislative bill to require that all new parents are educated on the prevention of child abuse before leaving a maternity ward.

Nurses Educating Parents on Triggers for SBS

Nurses working in the neonatal units explain to parents that infant crying is a normal behavior of infants that often serves as a trigger that contributes to parental frustration and the act of shaking. The highest incidence for SBS occur in infants under one year of age, infants of multiple birth, prematurity, low birth weight, those exposed to substance abuse and also in male infants. Just as there are high-risk categories for those infants that are abused there are categories that place adults at a higher risk to
Hey, I've got a couple of interesting reads for you today. First up, we've got a staffing announcement from Molina Healthcare, who are hiring for several positions like Care Review Clinicians and Field Case Managers. They're located in Albuquerque and they're offering competitive salaries with a comprehensive benefit package. To learn more about the positions and how to apply, you can check out their website at [www.molinahealthcare.com](http://www.molinahealthcare.com).

Next, we've got an announcement from New Mexico Nurses Association about the need for RNs in New Mexico. They're actively recruiting Registered Nurses for various positions including L&D/Post Part/Nursery, Med/Surg, Emergency Room, and ICU. They're located in a resort community at 7000’ elevation, and the area offers recreational activities like downhill skiing in the winter and quarter horse racing in the summer. And don't forget about the cultural arts in the summer! For complete information, you can visit [www.nmna.org](http://www.nmna.org).

Lastly, we've got some information from Colvig Silver Camps about a summer camp position for nurses. They're hiring a Nurse for the summer camp in the Colorado Rockies. The camp offers a fun community and an opportunity to spend a summer in the Colorado Rockies. For more information, you can contact Tyler Dixon at 970-247-2804 or visit [colvigsilvercamps.com](http://colvigsilvercamps.com).

Enjoy your reading!
President’s Message

Leigh DeRoos BSN, MS
President New Mexico Nurses Association

Thank you for your support over the last two years and for re-electing me to serve my second term as President of the New Mexico Nurses Association. At the recent NMNA annual meeting, I informed the members that the state of our association is solid and I am very happy to say that the New Mexico Nurses Association (NMNA) has seen not only an increase in membership but, more importantly, an increase in member involvement. It is because of this member engagement that we continue to expand our voice and our advocacy in New Mexico.

Nurses in New Mexico, through NMNA, have a history of a strong lobbying presence and have therefore long enjoyed a progressive practice environment still not achieved in many states. Nurses have had a voice at the national level through the American Nurses Association (ANA): “When nurses talk Washington listens.”

National Lobby Day for nurses is held in Washington DC in conjunction with the ANA Membership Assembly. NMNA was well represented on the Hill this year. Nurses who attend the DC lobbying event overwhelmingly state how beneficial and educational it is to meet with their elected officials to discuss issues that impact nurses and their states. They return to their respective states re-invigorated with a proactive mindset and a willingness to become more involved in health care policy issues that impact their states. The nurses who attend also come away with an increased understanding of Congressional staff in Washington. In addition, NMNA members have served on initiatives at the national level that allow them to impact health care policy issues nationally. This year we were fortunate enough to send two of our members to the ANA’s American Nurse Advocacy Institute (ANAI), a year-long mentoring program “designed to develop a strong cadre of registered nurses equipped to influence health policy at the local, state and national levels.” (American Nurse Advocacy Institute, n. d.). See Nurses in our News for more information.

At the state level, we continue nursing’s voice on a range of fronts. We engage our elected representatives through both our contracted lobbyist, Linda Siegel, and through our Executive Director and registered lobbyist, Deborah Walker. In addition, at Capitol Challenge (Nurses’ Lobby Day February 2, 2016), our annual legislative conference, nurses throughout our state have the unique opportunity to meet with their elected representatives and use their voice to promote issues that impact nurses and their communities. NMNA, working with nurse producedirector Camille Adar, has developed a diversity video which complements the Nursing Diversity Institute chaired by Lisa-Marie Turk. If you have not seen the video, you can access it at NMNA’s website - www.nmna.org. Also, mirroring national affiliation between ANA and specialty associations, we have nursing organizations that have affiliated with NMNA, such as the NM Native American Nurse Association, the NM chapter of Oncology Nurses, the NM Holistic Health Nurses, the NM Nurse Practitioner Council and the NM Nephrology Nurses. At the annual meeting, many of the specialty nursing organizations came together for a Nursing Issues Forum and the consensus was that, regardless of the organization we, as a profession, have many issues in common and the issues forums need to continue.

To continue our increasing member involvement and to provide options for members regardless of geographic location, the New Mexico Nurses Association is developing interest groups that address your issues and your concerns. One of our interest groups is health councils. Presently, we have members actively engaged in health councils throughout the state to lend their expertise. In our larger cities, we also have nurses monitoring city council and county commission meeting agendas and attending when appropriate. We have NMNA members participating in the Task Force for Health Care Transitions in our state. Not only do NMNA members serve on healthcare committees, such as the Team Pregnancy Prevention Work Group in Las Cruces, I was recently asked by Congressman Pearce’s office to participate in a roundtable discussion on the impact of the Affordable Care Act on New Mexicans.

NMNA is focusing on developing programs for the unique needs of the new RN. There is a new graduate advisory committee composed of recent new graduate nurses who advise NMNA on concerns and issues of new RNs. Under the leadership of Ed Chacon, BSN and Jason Bloomer BSN, NMNA has developed a Welcome to the Profession program to help new RNs to transition into the profession of nursing. In addition, NMNA is rolling out a mentoring project based on ANA’s mentoring program, but tweaking it to reflect the needs of new RNs working in New Mexico. This mentoring program is a member-only benefit designed to match new RNs with a nurse having more than 5 years of experience. NMNA understands the importance of a new RN having a supportive and nurturing relationship with an experienced RN during the crucial transition from nursing school to nursing practice. Our mentoring program is designed to facilitate this. If any members are interested in helping with this mentoring project, please go the ANA website and register at www.ana.org.

As I begin my new term, I asked that if you are a member please consider becoming involved in one of the interest groups. Volunteer to become involved in health councils in your area or if you have a concern or issue that an interest group could address, please contact me or Deborah Walker in our Santa Fe office at 505-471-3324. Your active involvement is invaluable and we want to be meeting member needs. We provide orientation for most of the volunteer opportunities. If you are not member, please join and become a voice at the table. We are 3 million strong and we can make a difference. With your involvement, we will continue to expand our influence throughout the state. I always welcome your comments and questions at nursesempowerme@gmail.com.

Reference

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be perpetrators. Perpetrators are more often males with less formal education, younger, unmarried, part of a dysfunctional family or who experienced previous abuse and were frequently identified as being the mother’s boyfriend, the father or stepfather.\(^1\) It is important to know that parental risk factors for abuse identified include substance abuse (53%), domestic violence (42%), criminal history (32%), unrealistic expectations (42%) and attachment problems (32%).\(^1\)

### Evidence-Based Interventions to Prevent Child Abuse

Research has demonstrated that hospital-based education to parents is effective in improving parental education about SBS.\(^2\) At UNMH, 802 parents of newborns in the Intensive Care Nursery (ICN) or Neonatal Intensive Care Unit (NICU) received a short educational session about infant crying and SBS, a pamphlet, saw a video and gave written permission for a 7-month follow-up call to find out what they remembered. This study demonstrated that 99% parents found this information to be helpful and 17% stated that this was the first time they had heard that shaking a baby is dangerous. From January 2012 to September 2014 there were 39 incidences of diagnosed SBS in New Mexican infants who were discharged from units outside of the ICN and NICU at UNMH. During the same time period there were zero infants who were discharged from ICN and NICU that were subsequently diagnosed with SBS (p <0.05).

The most effective violence prevention strategies include parent and family-focused programs, early childhood education, school-based programs, therapeutic or counseling interventions, and public policy. For example, a systematic review of early childhood home visitation programs found a 38.9% reduction in episodes of child maltreatment in intervention participants compared with control participants.

### Nursing Prevention Strategies for Child Abuse

Some evidence-based interventions that nurses can implement to reduce child abuse include the Nurse-Family Partnership, Child-Parent Centers (CPC), Safe Environment for Every Kid and Parent-child Interaction Therapy.\(^3\) New Mexico has the Nurse-Family Partnership that is a home visitation program that can be used for evidence-based public policy with more than 37 years of evidence of effectiveness. The CPC also has data of its comprehensive educational support of economically disadvantaged children and their parents which followed 1,539 low-income minority students for 19 years and found that they out performed, had higher school retention, lower felony convictions and were less depressed than the control group.\(^4\)

There are many programs that can help prevent child abuse and if every nurse in New Mexico worked with families, health institutions, schools, day care centers and other organizations to increase the awareness and provide education and needed support for families, we could prevent this unnecessary child maltreatment. Understanding child abuse prevention and what to do when children are at risk is an important part of nursing care. There is much information on child and family well-being and resources on protective factors including marriage, fatherhood and parenting. Nurses are the leaders for sharing a child abuse prevention message with communities and building community support.

All nurses are welcome to use the tools, resources and information on the UNM Hospital SBS website. This website has the script for education of SBS prevention, ways to cope with crying, babysitter information as well as the hand out and a link to the video “When Babies Cry” by the Shaken Baby Alliance. If you have any questions or concerns, please feel free to contact the author and/or contact the web-site:

http://hospitals.unm.edu/shakenbaby/professionals/child-abuse.html

### References

1. [http://www.nursingworld.org/SpecialtyYo/What-is-Nursing](http://www.nursingworld.org/SpecialtyYo/What-is-Nursing)
2. [http://www.cdc.gov/childabuseprevention/childmaltreatment/definitions.html](http://www.cdc.gov/childabuseprevention/childmaltreatment/definitions.html)
7. [http://datacenter.kidsdata.org/data/NM/20](http://datacenter.kidsdata.org/data/NM/20)

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October 17, 2015—The University of New Mexico College of Nursing Level 3 students showing their spirited side as they volunteer administering flu shots at the Health Sciences Student Council Drive Flu Shot Clinic to the public. Increasing the ‘herd immunity’ by vaccinating students, employees, and residents of Albuquerque, New Mexico; these students practiced safe administration of vaccines, directed traffic, and exercised interpersonal communication. By working with pharmacy students, medical students, emergency medical students, and other nursing schools, more than 2,000 individuals were prepared for the upcoming season.

NEW MEXICO NURSING EDUCATION CONSORTIUM Graduates First Cohort

The NMNEC statewide program designed to increase the number of nurses earning pre-licensure BSN degrees in New Mexico graduated its first cohort August 21. UNM and CNM students stood side-by-side as the first graduating cohort. CNM students earned their baccalaureate degrees through a partnership with UNM allowing the students dual-enrollment.

“The to congratulate our first graduates and see the impact that they will have on their communities is a great source of pride for me and the entire state of New Mexico,” said Nancy Ridenour, PhD, RN, Dean of the UNM College of Nursing.

The common nursing curriculum encourages students to not only pursue their BSN degrees in their home communities, it encourages them to seek employment and provide health care in their own communities.

Diane Evans-Prior, DNP(c), RN, CNM Academic Affairs Director of Nursing commented, “The partnerships that are being forged between the community colleges and the universities are reshaping the landscape of nursing education and bringing baccalaureate education to students who might not have had the opportunity before. It is an exciting time to be a nursing student in New Mexico.”

The common curriculum is now taught in eleven locations throughout the state. Ten of those locations offer the pre-licensure BSN. By 2019, it is projected that every ADN and pre-licensure BSN state-funded nursing program will be teaching the common curriculum paving the way to seamless transfer as well as offering BSNs in rural communities throughout New Mexico.

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Leigh DeRoos

Interest Group Chairs
Camille Adair
Fran A’hern Smith
Jason Bloomer
Ed Chacon
Lisa Marie Turk

Elected and Continuing Members
Chair of Nominating Committee
Congratulations to the Newly Elected Members of the Board of Directors, Membership Assembly
Interest Group Chairs
Secretary/Treasurer
President of NMNA
Board of Directors
Fran A’hern Smith
Representatives
Romona Scholder
Suzanne Canfield
Edward Chacon
Lisa Marie Turk

REGISTRATION FORM: CAPITOL CHALLENGE 2016
NURSES DAY AT THE NEW MEXICO STATE CAPITOL

Tuesday, February 2, 2016
7:30 am - 4:00 pm
Hotel Santa Fe, Santa Fe, NM

This continuing education activity has been approved by the Montana Nurses Association Accredited Approver Unit, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. Participants will receive 6.25 contact hours.

Name ______________________________
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REGISTRATION FEES
“I’m a member of NMNA or NMNA affiliated association” – $90
“I’m not yet a member” – $125

Fee is inclusive of breakfast, breaks, lunch, and continuing nursing education contact hours.

Hotel Santa Fe reservations: 1-505-982-1200. Parking is free at Hotel Santa Fe and room fee is inclusive of deluxe continental breakfast.

Contact Deborah Walker RN, MSN with any questions at: dwalker@nmna.org; or call (505) 660-3890 for immediate assistance.

• Mail registration form and check made payable to NMNA by January 25, 2016 to:
NMNA
P.O. Box 418
Santa Fe, NM 87504

PLEASE NOTE: Any cancellations must be received no later than January 26th.
Criteria for Successful Completion: You must register, sign in, attend the entire workshop, complete and submit an evaluation form at the conclusion of the workshop in order to receive CNE contact hours.

First Nations Community HealthSource is a local non-profit community based healthcare facility located in SE Albuquerque.

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“Tuberculosis (TB) is a unique disease. For most other disorders, achieving a cure is primarily the patient’s concern. With TB, the responsibility for cure rests with the health care profession, and ultimately with society.” Lee Reichman, MD

The New Mexico Department of Health TB program is a nursing-led platform that provides patient centered nurse case management for all patients diagnosed with TB. Around 50 persons with infectious TB are diagnosed each year in New Mexico. In addition, we treat several hundred people each year with TB infection. Despite the low number of cases the mortality rate is close to 20% every year (compared to 4% nationally).

Nurse Case Management (NCM), a core public health activity is provided by public health nurses from more than 50 health offices across the state. Since the turn of the century public health nurses have been providing complete care for the patient with tuberculosis. Today, these nurses would be called case managers. The American Nurses Association supports “the use of a nursing case management model in TB care to coordinate inpatient and outpatient services; facilitate the safe delivery of medications to patients in the community; assure completion of therapy; and limit the transmission of the disease by identifying newly infected persons through contact investigations procedures.”

Upon diagnosis each patient is assigned a TB Nurse Case Manager to coordinate and ensure all aspects of their care through completion of treatment. Each nurse case manager provides an initial patient centered nursing assessment. Each month the nurse will re-assess the patient until completion of treatment, which can last a minimum of six months or longer. The nursing assessment consists of a standardized series of questions to evaluate the effectiveness of therapy. This includes assessing favorable responses to TB medications, potential drug-drug interactions and side effects that often occur. One essential nurse led activity is directly observed therapy. The Centers for Disease Control and Prevention defines directly observed therapy as “an adherence-enhancing strategy in which a health care worker or other trained person watches a patient swallow each dose of medications. Directly observed therapy is the standard of care for all patients with TB disease.” New Mexico Department of Health provides directly observed therapy for 100% of persons diagnosed with TB. In 2014, 97% of the persons diagnosed with TB in New Mexico, completed a course of treatment (compared to the national average of 70%). This is a direct testimony to the excellent nursing care delivered by New Mexico public health nurses (PHNs).

Social support and wrap-around services for persons diagnosed with TB allow the patient the opportunity to focus on returning to health. Patients at times are isolated for weeks to months and are unable to provide for basic day-to-day needs for themselves and their families. The TB program provides support in a variety of forms such as housing assistance, gas money, groceries, etc. that help to meet those basic needs of the patient and ultimately increase adherence to TB treatment.

To break the chain of transmission, every person with infectious TB has a contact investigation completed to determine if transmission has occurred to friends and/or family members. The local nurse case manager together with the state TB nurse consultants identify, test and offer treatment for individuals infected with TB. Since 2012, New Mexico has been utilizing a “new” 12 week treatment regimen of Isoniazid (INH) and Rifapentine given by directly observed therapy as the primary treatment for TB infection. Persons receiving this regimen have experienced increased adherence and completion of treatment from around 60% to over 80%. Finding and treating contacts thorough contact investigation is second only in priority to providing treatment for persons with active TB.

Project TB ECHO, initiated in April 2015, provides an opportunity for PHNs from across the state to come together on a monthly basis across a video network to review all active TB cases in New Mexico. Since the inception there have been 104 TB case presentations (31 unique patients) by 18 nurse case managers. The objective of the monthly TB ECHO clinic is to ensure effective nurse case management of all patients with active TB in New Mexico by empowering the PHN with the knowledge and skills needed to ensure effective completion of treatment for each patient. A self-efficacy study was just completed to measure the nurses perceived level of nursing efficacy following seven months of TB ECHO clinics. ECHO utilizes case-based learning, promotion of best practices and monitoring of outcomes to support the nursing community of learning and practice. There are been 152 participants on the United States and Mexico with 502 CMEs awarded. During TB ECHO clinic expert medical services are provided by TB Medical Director, Marcos Burgos MD and Carlos Pastrana MD. Each patient with a diagnosis of TB in New Mexico is followed by one of the TB medical specialist.

Nurse case management is not a simple process, it takes dedicated, knowledgeable nurses with programmatic and leadership support. Nurse case management is “THE” essential link for effective completion of treatment for persons with TB.

Diana Fortune RN, BSN works for the New Mexico Department of Health and serves as the TB Program Manager. Ms. Fortune is recognized nationally as a nurse leader with a passion for this area of study and for this patient population.

EDITOR’S NOTE: Diana Fortune recently travelled to South Africa, where she was asked to present at the global meeting of the International Union against Tuberculosis and Lung Disease given her role in the New Mexico ECHO group presentation and her focus on training nurses via telemedicine. Her program is the second of its kind in the world. The meeting she attended is the premier global meeting on tuberculosis and it is an honor for New Mexico to be so well represented by Diana!
Death with Dignity: The Debate Broadens

Barak Wolff, MPH

Introduction:
In the past several issues of The NM Nurse we’ve traced the roots of our current system for dealing with the inevitability that as human beings our life span is limited and we all die. We’ve traced the historical roots of our current end of life system and identified the institutions and health professionals who work every day providing care within it. We have also reviewed the various legal safeguards within our system which are supposed to help ensure that we all have the kind of care and the kind of death that we choose. Given our current demographic the health care system will continue to devote increasing resources to the treatment and care of the elderly, including those at the very end of life. Although there has been extraordinary progress in the treatment of life threatening diseases and other serious conditions, sometimes these intensive interventions do little for the quality or even the length of life that remains, particularly for the elderly. Too often, due to a variety of personal and health system issues, people still do not have the kind of death that they had envisioned and hoped for.

As a society we’ve agreed and enacted laws to ensure that each individual has the right to decide about his or her medical care and choose what treatments to have…or not to have. We also have the right to appoint someone to speak and act on our behalf if we can no longer articulate our choices due to infirmity, dementia or coma. This “advance care planning” has evolved as a way for individuals to legally articulate in writing their values and wishes for end of life treatment and care.

But we don’t agree on everything…that’s for sure. Given our relatively free, open and pluralistic society we often have differing views on what is ethical, what is legal, and what is appropriate when it comes to issues of death and dying. The current debate about Death with Dignity laws which enable the practice of physician aid in dying is one such issue.

Recent Events:
A few years ago a young, zestful 29-year old California woman, Brittany Maynard, was diagnosed with life threatening brain cancer and moved to Oregon to be able to take advantage of their Death with Dignity law. As her health declined she spoke publicly about her choice to legally end her life rather than succumb more slowly to the ravages of her disease. The media coverage of her situation and her self -administered death stimulated an evolving national debate that continues today in courts and state legislatures throughout our country as those supporting or opposing death with dignity fight for their position.

According to the DeathwithDignity.org website, in 2015 Death with Dignity legislation was introduced in 25 states, 17 of which are first time submissions. In some cases these bills were not even given a hearing and in others they died in their first committee. Many are expected to be introduced again in 2016. In addition to legislative efforts, lawsuits challenging the constitutionality of existing statutes have been filed in New York, California, and Tennessee.

In California their contentious and hard fought proposal, the End of Life Options Act, finally passed both their General Assembly and Senate in early September, 2015 as part of a special legislative session. In early October California Governor Jerry Brown signed the bill indicating, “I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn’t deny that right to others.” Interestingly, the California Medical Association which had historically opposed physician aid in dying had officially withdrawn that opposition earlier this year and is now “neutral” on Death with Dignity.

This article will describe aid in dying, look at some of the data about its’ usage where it is currently legal, provide an update about where it currently stands here in the United States and finally offers a discussion of the current legal and ethical status of the Death with Dignity movement in New Mexico.

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Death with Dignity continued from page 8

What Exactly is Physician Aid in Dying? And How Does it Work?

Physician aid in dying specifically refers to the practice of allowing a mentally competent, terminally ill adult to request and self-administer a prescription from a physician for a life-ending medication to control the time and manner of his or her own death. Supporters maintain that it is important to distinguish this act of thoughtful compassion from assisted suicide or euthanasia which are both illegal in the US, although euthanasia is legally permitted in a few countries around the globe including Belgium, the Netherlands, Colombia and Luxembourg. Assisted suicide has been legal in Switzerland since 1942, as long as there is no selfish motive involved.

In the US the way it generally works in states where it is legally permitted is that a patient with a terminal diagnosis (generally expected to live six months or less) can approach a willing physician to assess their suitability to receive a lethal script. The concept of “conscientious objection” is applied to aid in dying in those states where the legislator has ensured that any provider may opt out of providing this service for any reason, although they are ethically required to refer requesting patients to other providers who will assist. In most cases the willing physician will confirm the terminal diagnosis and the mental competency of the requesting patient and a second opinion will be obtained that confirms the diagnosis and that the patient remains decisionally capable.

Care is taken through a thoughtful protocol to ensure that the patient has had access to palliative care interventions to control pain and symptoms, and that the patient is clear about the process and implications of their request. The protocol can be canceled at any time by the patient. Family members, friends, and/or supporters are often brought into the discussion.

In some states a two week waiting period is required and the patient must return to the physician’s office to make their request a second time. These protections have been developed to ensure the integrity of the process.

Once all steps are completed the patient is given a script for a lethal dose of medication (generally a short-acting barbiturate such as secobarbital or pentobarbital) with explicit instructions for how it should be obtained, stored and utilized. Well-trained helping volunteers often work with providers, patients and their families to help ensure that all goes as intended.

The Data Thus Far:

There is substantial experience with aid in dying through the ground breaking Death with Dignity Act in Oregon initially enacted in 1994 and finally implemented in 1997 following a series of contentious challenges in the courts and the legislature. The public health agency in Oregon has been maintaining excellent data on their program for the last 17 years. The annual data reports answer many questions about how they function programs, who it serves, and counters some of the myths and heartfelt concerns from some opponents about a “slippery slope” and possibilities of misuse of this capability. Based upon this public health data aid in dying is recognized as a safe and efficacious procedure. The Oregon Health Authority maintains a robust website with annual reports and full program information at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/ Pages/index. aspx. It shows that about 90% of those who request aid are on hospice, the vast majority with a cancer diagnosis. The data also shows very clearly that almost all who request the protocol are well-educated, insured and have economic means. They are not generally disabled or vulnerable individuals.

Oregon was followed by Washington State that enacted a program in 2008 through a popular referendum. Washington has five full years of data that can be viewed at: http://www.doh.wa.gov/YouandYourFamily/illnessandDisease/DeathwithDignityAct. In 2009 the Montana state Supreme Court ruled that aid in dying was not “assisting suicide” but was a legal medical protocol that is now currently available in Montana. And finally, in 2013 the Vermont legislature enacted a law with a state managed program for the first 3 years which then sunsets to become a regular part of medical practice, although that has now been amended so that the program will continue with state oversight.

For a more personal and visual view of the Oregon and Washington laws, in 2011 HBO produced a documentary called “How to Die in Oregon” which follows a specific aid in dying case over several years.

Death with Dignity continued on page 10
It also documents the effort to pass the ballot initiative in Washington State. This excellent film is available from Netflix and other outlets both in DVD and streaming.

Perhaps the most noteworthy finding from both Oregon and Washington is how infrequently the aid in dying protocol is requested. Oregon with a population of about 4 million has averaged about 110 requests a year for the past 5 years. There was less usage in the early years of the program. Washington with a population of about 7 million has averaged the same in its first 5 years of data. This means that the aid in dying protocol is used less than ¼ of 1% of the time. It’s also important to note that in Oregon only about 65-70% of those who receive the script for lethal medication actually use it. For a variety of good reasons when the fear of dying alone and/or in pain is relieved, sometimes the medication is just not needed and nature takes its course. Thus, aid in dying is targeted for a very small subset of terminal patients. While some cannot be adequately helped by pain management and other palliative care efforts, only 25% say pain is their primary motivation. Rather, data from Oregon indicates that 80-90% of those who initiate the protocol cite loss of control and loss of dignity as major factors contributing to their decision. (1)

Status in New Mexico:

Here in NM a lawsuit was brought forward by three plaintiffs, two Albuquerque physicians and a Santa Fe cancer patient, requesting that the court clarify that aid in dying 1) is not “assisted suicide” under our statute that makes it a 4th degree felony and 2) is a fundamental right guaranteed under the NM Constitution. The initial trial in District 2 court was held in December, 2013. Judge Jan Nash issued her eloquent ruling a month later in January affirming aid in dying on constitutional grounds:

“This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying. If decisions made in the shadow of one’s imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of these constitutional guarantees, then [sic] what decisions are? … The Court therefore declares that the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution.”

That decision was appealed to a three judge Appellate Court which ruled on a split decision earlier this summer to overturn the district court’s ruling and halt the practice in Bernalillo County. This decision was immediately appealed to the NM Supreme Court which quickly decided to give the issue an expedited hearing that took place on Oct. 26th.

Thus, today in NM, aid in dying is awaiting the decision of the Supreme Court which might come in weeks or months. In the meantime, supporters and advocates
are working to identify, train and support willing physicians and pharmacists to provide this service. There are also efforts to identify and train support volunteers to assist in the homes of those who choose to use the protocol. If aid in dying is affirmed by the Supreme Court full statewide implementation will proceed in NM. What Does the Public Think about Aid?

In general, a healthy majority of public opinion is supportive of physician aid in dying as a choice by eligible individuals who wish to ensure a death of their choosing. Although national polls by Gallup and Harris in 2014 vary a bit by how the questions are asked, about 60-70% indicate support for the concept. (2) A 2012 poll conducted specifically in NM by the well respected Research & Polling Inc., indicated that >65% agree with Aid. Medscape, a web-based resource for health professionals, conducted a national online survey involving 17,000 U.S. doctors representing 28 medical specialties. Respondents agreed by a 23% margin (54% to 31%) that they would support a patient’s decision to end their life provided there is no shred of doubt that the disease is incurable and terminal. (3)

To further support aid in dying advocates point out that under current law an individual (or his or her designated health care decision maker) can legally choose to not receive treatment or to stop treatment that has been initiated. Further, physicians can (and some do routinely) initiate lethal treatment to stop intractable pain, sometimes called palliative or terminal sedation. Additionally, it is legal in every state for individuals to voluntarily stop eating and drinking at any time to hasten their death. Supporters question why physician aid in dying should be thought about or treated any differently. They feel that it is a safe and compassionate practice that should be part of the choices available for eligible patients and those providers who wish to support them.

Strong opposition to aid in dying comes from many perspectives as reflected in the current debates taking place in a number of state legislatures and in the courts. Some of the concerns are legal, some ethical, some religious and some arise from deep concerns about possible abuse/misuse towards vulnerable populations. Phrases like “it demeans the value of human life” or “it violates the Hippocratic oath” or “miracle cures or recoveries can and do occur” or “there may be undue pressure by government and insurance companies to avoid heroic measures due to the expense” or “better to invest resources and ensure access to excellent palliative, rehabilitative” or “it demeans the value of human life” or “it violates the Hippocratic oath” or “miracle cures or recoveries can and do occur” or “there may be undue pressure by government and insurance companies to avoid heroic measures due to the expense” or “better to invest resources and ensure access to excellent palliative, rehabilitative and hospice care” are all frequently used to express concerns in these debates.

A Few Final Thoughts:

It is difficult to predict where the balance of opinion will get to in the next few years, but it is clear that the increased aging population will push hard for the freedom of individuals to choose among a wide range of options and have more control over their care. In regards to aid in dying specifically, given the very small numbers of dying patients who actually use the lethal medications in those states where it is already legal, one might ask why it is so critical to affirm this as a legal option and broaden its’ availability in other states. Supporters feel that it’s so important because dying is universal and compelling, both as we experience it with loved ones and as we contemplate our own trajectory. They feel that control at the end of life is a fundamental right. In the absence of aid in dying being legal it increases the likelihood for more painful deaths, additional desperate suicides and/or for those compassionately assisting with death to be prosecuted.

Physician aid in dying, whether or not actually used, contributes to peace of mind and greatly reduces the fear of losing control, dying alone and/or in pain. And finally, aid in dying seems to stimulate the broader conversations, public discourse, and individual actions about end of life choices. It also seems to encourage health professionals to incorporate greater collaboration, understanding and responsiveness into their end of life care...and that is a win-win for all involved.

References:

Conscientious Objection
When Care Collides with Nurses’ Morals, Ethics

Susan Trossman

Last winter, two high-profile — and very tragic — cases pitted family members against hospital administrations and stirred debates nationwide about brain death, policies and laws, and ethics. No matter where they practice, nurses may have wondered what they would do if they found themselves in similar circumstances — whether they could object to providing patient care. The answer is a qualified “yes.”

First, the Two Cases
According to published reports, Jahi McMath, 13, was admitted into a California children’s hospital for surgical procedures to address sleep apnea. Following surgery, she developed a complication, went into cardiac arrest, and was declared brain dead by two hospital-associated physicians and ultimately a court-ordered physician. Her family fought to have her remain on a ventilator until she could be transferred to an undisclosed facility where she could be given additional “life-sustaining” measures.

Marilse Munoz was 14 weeks pregnant when she was found unconscious at home. She was declared brain dead and carrying a nonviable fetus; her family wanted her taken off life support, noting her wishes, the media reported. But this time, the hospital where she could be given additional “life-sustaining” measures.

were not aware of whether or not RNs objected to providing care in these specific cases. However, nurse ethicists did find it crucial to ensure that all RNs understand that they can conscientiously object to participating in interventions if certain criteria are met.

Confronting Difficult Decisions
Nurse ethicist Anita Catlin, DNSc, FNP, FAAN, followed the Munoz case in the national press. “Nurses have a right to conscientiously object to participate in technologically supported treatment of a brain-dead person,” shared Catlin, a member of ANA’s ethics advisory board. “Additionally, when a woman and her surrogate have made their wishes known, it is unethical to go against these wishes as stated in ANA’s Code of Ethics for Nurses with Interpretive Statements.

“If members of the nursing staff wished to be excused from participating in this patient’s care for anything other than palliative care and comfort measures, they have every right to do so.

When it comes to conscientious objection, there are two broad categories in which RNs can conscientiously object to participate — based on provisions addressed in the Code of Ethics, according to Marshia Fowler, PhD, MS, MDiv, RN, FAAN, a member of the ANA’s professional issues panel steering committee, which has been leading a revision of the Code.

Nurses can refuse to participate in all instances of an intervention — such as an abortion or sexual reassignment surgery — based on religious or moral grounds, said Fowler, an ANA California member. RNs who hold these strong beliefs should make their objections to participate in these types of interventions or procedures known at the time of hiring, Fowler said.

When it comes to participating in interventions that are legally bound to care for that patient until another nurse is available to assume responsibility for the patient — particularly given some workplace cultures — not doing so can have dire consequences for the individual nurse and for the nursing profession.

Most of the time, nurses just remain silent and do not make their objections known. They also worry that their objections will place a burden on colleagues by giving them more work,” Lachman said.

And although it may take courage to conscientiously object — particularly given some workplace cultures — doing so can have dire consequences for the individual nurse and for the nursing profession.

If nurses cannot move away from these conflicts with their beliefs, Lachman said. “If nurses cannot move away from these conflicts with their beliefs, the Code does not allow nurses to refuse care based on religious or moral grounds, nurses ideally should practice in settings where they are less likely to be confronted with interventions — such as abortions, cardiac transplants or palliative sedation — that conflict with their beliefs, Lachman said.

The other broad category in which nurses can conscientiously object involves a specific intervention with a specific patient, Fowler said. A common example of this ethically sound objection is when a nurse is asked to participate in an intervention that goes against a patient’s autonomy and expressed desires, as in the patient’s not wanting a blood transfusion, antibiotics or other lifesaving measures.

Given the fast pace of technology and other advances, nurses may increasingly find themselves in ethically challenging situations, Lachman noted.

Additionally, many sensitive cases that might have been kept private in decades past are now being played out in the media, according to Fowler.

Parting Words
To make a conscientious objection, Fowler said nurses should follow the lines of authority and the structures that are in place in their facilities. They also can contact their organization’s ethics committee or patient ombudsman.

“They also must be aware of an obligation not to abandon a patient. “Once a nurse begins treating a patient, she or he is legally bound to care for that patient until another nurse is available to assume responsibility for the patient,” Lachman said.

And although it may take courage to conscientiously object — particularly given some workplace cultures — doing so can have dire consequences for the individual nurse and for the nursing profession.

Most of the time, nurses just remain silent and do not make their objections known. They also worry that their objections will place a burden on colleagues by giving them more work,” Lachman said.

“If nurses cannot move away from these situations, it becomes intolerable. They experience moral distress, emotional and physical fatigue, and burnout. Therefore, organizations must provide nurses with the staffing necessary to maintain their moral integrity, and nurses need to participate only in patient care that is not morally compromising,” Fowler added. “Nurses need to accommodate and support colleagues who conscientiously object and provide an environment that preserves professional integrity.”

— Susan Trossman is the senior reporter for The American Nurse.

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ANA News

ANA and Association of Nurses in AIDS Care Call for Repeal of HIV Criminalization Laws

SILVER SPRING, MD – As global communities mark Dec. 1 as World AIDS Day, the American Nurses Association (ANA) and the Association of Nurses in AIDS Care (ANAC) are calling for the elimination of outdated HIV criminalization laws in a new position statement.

“It’s clearly time to repeal laws that unfairly punish people living with HIV,” said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. “HIV is a treatable medical condition and laws need to reflect advances in our understanding of the disease, its treatment and transmission risk.”

The ANAC position statement, endorsed by ANA, describes HIV criminalization as the use of criminal law to arrest and penalize HIV-positive people for perceived or potential HIV exposure or transmission through consensual sexual contact and where nondisclosure of their HIV-positive status is alleged. More than 30 states in the U.S. have legislation that criminalizes HIV exposure without transmission; a significant number of these laws include exposures that are now known to pose no risk of transmission, such as spitting.

Most of these laws were adopted decades ago, in an era of limited understanding of HIV and in an environment of fear and discrimination.

“This is why the Association of Nurses in AIDS Care has called for the reform and/or repeal of unjust and harmful HIV criminalization statutes. Nurses know from our ethical code that singling out HIV status or any other diagnosis or disability as criteria for criminal charges is unjust and contrary to evidence-based public health approaches,” said ANAC Executive Director Kimberly Carbaugh.

The ANAC position statement also outlines how criminalization can hinder HIV prevention, care and treatment. For example, outdated laws that sanction HIV discrimination cause and support stigma. People with HIV may internalize the judgment and misperception of HIV as highly infectious and fear getting tested, disclosing their status, or even accessing health care due to internalized stigma.

There is a growing consensus about the need to reform HIV-specific laws. The Centers for Disease Control and Prevention (CDC), the U.S. Department of Justice and the National HIV AIDS Strategy have all called for a review and modernization of HIV-specific criminal statutes to ensure they are consistent with current knowledge of HIV transmission and to support public health approaches to preventing and treating HIV.

ANA and ANAC support the following actions:

• Reform of all state and federal policies, laws, regulations and statutes to ensure that they are based on scientifically accurate information regarding HIV transmission routes and risk.

• Repeal of punitive laws that single out HIV infection or any other communicable disease and that include inappropriate or enhanced penalties for alleged nondisclosure, exposure and transmission.

• Education about the negative clinical and public health consequences of current HIV criminalization statutes, arrests and prosecutions and their contribution to HIV-related stigma and discrimination.

Additionally, ANA and ANAC encourage nurses to support the Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act of 2015 or the REPEAL HIV Discrimination Act. Sponsored by Rep. Barbara Lee (D-CA), the bill requires a review of laws by federal, state and local stakeholders that impose criminal liability on people with HIV. The bill also provides states with guidance on best practices for revising HIV criminalization laws.

For more information, visit www.nursesinaidscare.org.

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New American Nurses Association Resource Helps RNs Make the Case for Optimal Nurse Staffing

SILVER SPRING, MD – To achieve quality care, better patient outcomes and financial stability, optimal nurse staffing should be viewed by health care employers as a necessity rather than an option—particularly as health care reforms and new regulations take hold.

That is a key message reflected in a new white paper commissioned by the American Nurses Association (ANA) and developed by Avalere Health, LLC in collaboration with nurses and policy experts.

Nurses at all levels and in all settings can use the white paper, “Optimal Nurse Staffing to Improve Quality of Care and Patient Outcomes,” as a resource to advocate for and implement sound, evidence-based staffing plans.

“Nurses on the front lines are in the best position to determine the staffing needed for safe and equitable, quality care, but they consistently tell us they must fight for optimal nurse staffing. This white paper is our way of providing evidence to support the need for changes in nurse staffing across all health care settings,” said Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, president of the American Nurses Association.

The white paper highlights studies that demonstrate how appropriate nurse staffing helps to achieve both clinical and economic improvements, from reducing medication and other errors to shortening patients’ hospital length of stay.

“Nurses on the front lines are in the best position to determine the staffing needed for safe and equitable, quality care, but they consistently tell us they must fight for optimal nurse staffing. This white paper is our way of providing evidence to support the need for changes in nurse staffing across all health care settings,” said Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, president of the American Nurses Association.

The evidence from hundreds of studies—and the white paper—make it clear that there is a relationship between staffing and patient outcomes,” said Matthew McHugh, PhD, JD, MPH, RN, FAAN, an associate professor at the University of Pennsylvania School of Nursing who helped develop the paper. “If there are not enough nurses at the bedside, bad things are likely to happen.”

The white paper also examines the various forces that have impacted discussions about nurse staffing and health care, from Affordable Care Act provisions and Institute of Medicine reports to changing patient demographics.

This paper specifically notes that existing staffing systems are often antiquated and lack flexibility to adjust to factors such as patient complexity, a rise in admissions, discharges and transfers, and the physical layout of the unit. It further addresses efforts by ANA and other organizations to advocate for federal regulation and legislation promoting flexible staffing plans, and highlights ANA activities to support transparency and public reporting of staffing data.

For example, the Registered Nurse Safe Staffing Act (H.R. 2083/ S.1132), endorsed by ANA, would require Medicare-participating hospitals to establish registered nurse (RN) staffing plans using a committee, comprised of a majority of direct-care nurses, to ensure patient safety, reduce readmissions and improve nurse retention.

“We in nurse leadership have to be able to defend our budgets for optimal staffing,” said Bob Dent, DNP, MBA, RN, NEA-BC, CENP, FACHE, senior vice president and chief operating officer at Midland Memorial Hospital in Texas. “We need to be able to tell our boards of trustees and other Administrators: ‘If we want to be able to deliver quality care to our community, then here is the staffing we need and here is the evidence [that supports that decision].’”

The paper is the first in a series aimed at addressing the value of nursing care and services.

Individuals can learn more and access the white paper executive summary here. Members of the media can obtain the full white paper by sending a request to Ms. Jemarion Jones at jemarion.jones@ana.org.

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5 Considerations for RNs Facing Ethical Challenges on the Job

The American Nurses Association has declared 2015 to be the Year of Ethics and in January released a revised edition of its Code of Ethics for Nurses with Interpretive Statements, so now is the perfect time for RNs to re-examine the essential role ethics plays in the nursing profession. Having a strong ethical foundation is a key component to a successful career. Yet, even the best nurses may find themselves struggling with ethical concerns on the job.

Here are five considerations for nurses when facing ethical challenges.

**Know yourself**

It’s important to have a strong sense of personal ethics to build upon in your profession. “Knowing who you are and what you stand for personally and professionally provides a foundation to speak up and speak out about issues that support or compromise your values,” said Cynda Hylton Rushton, PhD, RN, FAAN, Anne and George L. Bunting Professor of Clinical Ethics at the Berman Institute of Bioethics/School of Nursing and a professor of nursing and pediatrics at Johns Hopkins University, and a Maryland Nurses Association member. “Without this clarity, your responses may be reactive, unreflective and potentially damaging to you and to others.”

**Live your values**

Just knowing your values and ethics isn’t enough, Rushton said. “We are required to speak up and live them in our daily actions. This takes courage, wisdom and resilience. Living our values means that we have to take seriously the fifth provision of the ANA Code — our obligation to care for ourselves so that we can care for others.” Because ethical issues are part of daily nursing practice, every nurse has an obligation to have the knowledge, skills and abilities to recognize and address them.

**Check in with others**

Having said that, Shannon said it’s important to remember that the gut is “a great barometer but a lousy compass.” Just because you know you’re in an ethical quandary doesn’t mean you know what the next step is. Consult with others, such as your shift manager or head of nursing, when a sticky ethical situation arises.

Translating ethical decision-making into everyday nursing practice is challenging. Building a network of colleagues who can help you think through ethical situations is a priceless resource. A great place to connect with experts and building your network is the 2015 ANA Ethics Symposium being held in Baltimore, MD, June 4-5.

**Practice with respect**

The first provision of the revised Code highlights each nurse’s responsibility to practice with “respect for the inherent dignity, worth, unique attributes and human rights of all individuals,” said Carol Taylor, PhD, RN, professor of nursing at Georgetown University and senior clinical scholar at the Kennedy Institute of Ethics, and an ANA member. Upholding that worth can provide a foundation for ethical action.

“Taken seriously, this means that each of us must practice with zero tolerance for disrespect, for our patients, their family members, our colleagues and ourselves,” Taylor said. Taylor recommended practicing responding to a colleague who describes a patient in negative terms to make it easier to speak up next time, such as by saying, “I’m no goody two-shoes, but I’m trying hard to meet each patient with respect.” If disrespect is a widespread problem, huddle and call attention to your organization’s zero-tolerance policy for disrespect to empower everyone to bring quick attention to violations.

For additional resources go to ANA’s Career Center at http://careers.ana.org.

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