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The majority of diets lead to weight gain.

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Rural and Frontier Nurse Survey

Page 4

Annual NNA Walk Around Nevada Challenge!
3rd Annual NNA Step Challenge
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4th Annual NNA State Board Reception
January 29, 5-7:30, Reno

NNF Future of Nursing Awards Dinner
May 14, 2016

For more information, visit www.nvnurses.org

THANK YOU, DEBRA!

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NEW NNA JOB BOARD NOW AVAILABLE!

Would you like to receive notice about new job listings? It’s easy to join our Job Board mailing list! Just send your email address by text message: Text NNAJOBBOARD to 22828 to get started or email nnajobs@nvnurses.org.

Page 3
The Nevada Nurses Association promotes professional nursing practice through continuing education, community service, nursing leadership, and legislative activities to advocate for improved health and high quality health care for citizens of Nevada.

NNA Mission Statement

NNA State Board of Directors

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Are you interested in submitting an article for publication in RNFormation? Please send it in a Word document to us at nna@hdiss.net. Our Editorial Board will review the article and notify you whether it has been accepted for publication. Articles for our next edition are due by March 1, 2016.

If you wish to contact the author of an article published in RNFormation, please email us and we will be happy to forward your comments.

A Call to Action from ANA

Save Rural Hospitals Act

Background

It has been reported that 59 rural hospitals have closed with 283 more on the brink of closure. More have closed since 2013 than in the previous 10 years combined. Continued cuts in hospital payments have taken their toll. Medical deserts are appearing across rural America, leaving many of the nation’s most vulnerable populations without timely access to care.

Reps. Sam Graves (R-Mo.) and Dave Loebsack (D-IA) have introduced H.R. 3225, the Save Rural Hospitals Act.

Action

If you support this legislation, contact your elected federal Representatives and urge them to co-sponsor the legislation, and please know that ANA has signed on in support.

A Special Invitation To NNA Members – A Call to Serve

We invite you to be a candidate for office on one of the Boards of Directors in the Nevada Nurses Association. This is a way to share your ideas, work toward the realization of your personal and professional goals, and participate in shaping the future of health care in Nevada.

Most terms of office are two years, and most business is conducted by email or teleconference.

In Northern Nevada – District One – we are seeking candidates for President-Elect, Secretary, Director at Large (3).

In Southern Nevada – District Three – we are seeking candidates for Secretary, Treasurer, and Director-At-Large (1).

At the state level we are seeking candidates for President, Vice-President, Treasurer, Director at Large (1), Nominating Committee (3) and two representative to the annual Member Assembly.

We will be happy to send you a summary of the office you're interested in. If you'd like more information, please contact Margaret Curley at nna@hdiss.net.

Please begin to think about how you would like to participate. We welcome self-nominations. Campaigning is encouraged, especially for the offices of state president and vice-president. We will be glad to help you get started on the campaign process. Call Margaret at 775-747-2333 if you have questions.

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president’s corner

Debra Scott
Scott Lamprecht, DNP, RN, APN
President, Nevada Nurses Association

In 2005, I began working in academia and interacting with the Nevada State Board of Nursing (NSBN). At that time, Debra Scott was the Executive Director. We established a great working relationship which continued several years later while I completed my DNP. In 2012 I completed my Family Nurse Practitioner and Debra Scott was still the Executive Director. Nurses Day at the Legislature 2015 was a great success with a panel discussion on staffing issues; Debra was on the panel. Nevada is a unique environment of urban and rural areas where change is an inevitable constant. The other constant for nursing has been Debra Scott. Debra has been with the NSBN for nearly twenty years and has seen many changes in healthcare for Nevadans. The Mission Statement of the NSBN is “protecting the public’s health, safety and welfare through the effective regulation of nursing.” The scope of nursing practice in NV has changed greatly through the years, i.e. APRN Legislation, Staffing Legislation, School Nurse Epinephrine Pens, and many more. These proposed changes were brought forth by many organizations, all requiring insights and recommendations from the NSBN. Debra played an integral part in each of the scope of practice process changes. As many Nevadans are aware, Debra is retiring from the NSBN in January 2016 after a very distinguished tenure. On behalf of the Nevada Nurses Association, thank you, Debra, for your guidance and efforts throughout the last two decades.

NNA State Board Reception
You are invited to attend the NNA State Board Winter Reception in Reno on January 29 from 5-7:30 p.m. Join us for appetizers, wine, and networking. Meet the NNA State Board, learn about our goals and activities, and share your professional concerns and interests. We look forward to seeing you there!
Please RSVP at www.nvnurses.org or call 775-747-2333.

NEW NNA JOB BOARD NOW AVAILABLE!
Are you looking for a new nursing job in Nevada? Visit our website, www.nvnurses.org, and check out the listings on our Job Board.
Would you like to receive notice about new job listings? It’s easy to join our Job Board mailing list! Just send your email address by text message: Text NNAJOBBOARD to 22828 to get started or email nnajobs@nvnurses.org.
Employers, are you looking for a qualified nurse for a position in Nevada? Check out our competitive rates for job board postings, email blasts, and social media blasts at www.nvnurses.org or call Ian at 775-747-2333 for more information.
Cathy Dinauer, MSN, RN is newly appointed as Executive Director of the Nevada State Board of Nursing (NSBN)

-PRESS RELEASE- November 25, 2015

At its regularly scheduled November Board meeting, the NSBN appointed Ms. Dinauer to the position of Executive Director effective January 1, 2016. She currently serves as the Associate Director for Nursing Practice, a position she has held for the last 18 months. Ms. Dinauer held the position of Chief Nursing Officer for Carson-Tahoe Medical Center for the previous 15 years and has been a resident of Nevada for the past 20 years. Governor Brian Sandoval appointed Ms. Dinauer to serve on the NSBN in 2012. Ms. Dinauer’s interest in the work of the Board was piqued during her tenure as a chief nurse and her serving as a NSBN Board member.

Ms. Dinauer states, “I share the mission of the Nevada State Board of Nursing and am committed to facilitating a smooth transition with minimal disruption. In addition, I have established a plan to meet with various stake holders within the next 30-90 days.”

Board president, Dr. Jay Tan states, “With Ms. Dinauer’s proven track record as a nurse clinician and hospital administrator coupled with the support from Board staff, I am definite that the Nevada State Board of Nursing will achieve great heights and will continue to garner national accolades in promoting a culture of public health and safety as she ushers the Board in achieving and maintaining its mission for 93 years and beyond.”

Please join the Board members and staff of the Nevada State Board of Nursing in congratulating Cathy Dinauer for her appointment to this crucial position for the citizens of Nevada. We anticipate her leadership in the coming years will provide a strong foundation for nurses and other healthcare stakeholders to collaborate in providing the best possible environment for the wellbeing of Nevada citizens.

Nevada State Board Of Nursing

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References available on request.

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Rural & Frontier Nursing in Nevada

Heidi Johnston, MSN, RN
Elko, NV

Nurses are required to have the knowledge, skills, and attitudes necessary to care for increasingly complex patients across a variety of settings that include acute care, primary care, tertiary care, and community care while also providing services such as case management, health promotion, and disease prevention (National Advisory Council on Nurse Education and Practice [NACNEP], 2010). Nurses in rural areas also need additional knowledge and skills including the ability to practice autonomously in an environment that often involves close relationships and limited resources (Coyle & Narsavage, 2012). Access to healthcare in a rural environment is often challenging and signifies a gap within the current healthcare system, especially considering that one-fourth of the American population live in rural areas (Gorski, 2011). This population often has a higher percentage of uninsured individuals, qualify as medically underserved regions, experience increased poverty levels, and have limited healthcare resources (National Rural Health Association, n.d.).

Of the overall population in Nevada, 10.1% reside in rural areas, which spreads over 95,431 square miles, or 86.9% of the state’s land. These rural counties have a higher older adult population resulting in greater risk of death and disability. This in turn leads to a disproportionate share of healthcare resources used by this population. Services available to the rural areas include acute care hospitals, outpatient clinics, and medical offices, and are scattered throughout rural Nevada. The average distance between hospitals within rural Nevada is 114.7 miles with the average distance between towns 46.5 miles. Traveling in winter conditions and on lonely two lane roads between towns is often daunting, and at times perilous. Traveling often takes hours, not minutes (Griswold, Packham, Etchegoyhen, & Marchand, 2015) in rural Nevada.

This identified need has led to the exciting development of a new NNA committee, the Rural and Frontier Nursing Advisory Committee. This committee focuses on the needs of rural and frontier nurses including education, resources, and programs that promote collaboration with other healthcare professionals throughout the state. We are currently conducting a survey to help us identify your needs. Rural and frontier nurses, please participate in the survey. The link is available at www.nvnurses.org.

References available on request.
Orvis School of Nursing
www.unr.edu/nursing

- B.S. in Nursing
- RN to BSN
- M.S. in Nursing
  - Clinical Nurse Leader
  - Nurse Educator
  - Adult Gerontology Acute Care Nurse Practitioner
  - Family Nurse Practitioner
  - Psychiatric Mental Health Nurse Practitioner
- DNP (Doctor of Nursing Practice)
It’s Never too Early to be Prepared

Patti Crepps, MSN, RN, C., CCRN
Orvis School of Nursing,
University of Nevada Reno

The government and the Centers for Disease
Control and Prevention have recognized
that the nation’s ability to mitigate the
consequences of disasters is often dependent
on the preparedness of the individual and the
community - not necessarily the government or their agencies. One
of the Healthy People 2020 initiatives is to improve the nation’s ability
to prevent, prepare for, respond to, and recover from a major health
incident. This comes from the National Health Security Strategy
of the United States of America, which outlines the goal to create
community resilience and increase community and individual level
preparedness in light of natural and man-made disasters. This action
goal is important now because of the many threats that face all
countries: disease outbreaks, natural hazards, man-made disasters
and technological emergencies.

Many factors influence the ability of a household, a neighborhood,
a community, city or nation to be prepared in case a challenging
situation arises. This begins with emphasis on individual preparedness
and expands upwards to the national level. An emergency is generally
confined to a small situation. An individual emergency is forgetting to
pick up a child at soccer practice, or not making an important deadline,
and on a larger yet still small scale, being in a car accident involving
multiple people.

In contrast, a disaster overwhelms people and resources, thereby
generating generalized feelings of hopelessness in some areas of
service or aspects of life. Disaster indicates that resources are
overwhelmed and extra help is required to survive or rescue and to provide shelter or provisions.

Effects from disasters are longer lasting. People face life-long
emotional trauma and the recovery phase for the community may be
slow to never depending on the area and resilience of the community.
Natural disasters sometimes occur with warning, but often times
without. Hurricanes, extreme fluctuations in temperature, and a
threat for tornadoes are almost always forecasted ahead of time with
evacuations and preparations emphasized by local officials. Knowing
the type of natural occurrence that could happen in your community
is important. People living in hurricane regions versus the major
snow fall regions will have different needs. For example, living in the
tornado belt one would be concerned about having an underground shelter. In Nevada, we are more concerned about earthquakes and
having a safe reliable storage plan for supplies when the big quake
comes. During winter, heavy snow fall can take out power lines and
leave roads impassable. Across Nevada during dry periods, wild fires
can move quickly forcing evacuations or change the air quality within
hours. On the other hand, man-made disasters are generally not
predictable but one can be prepared to survive alone if cut off from
electricity, outside assistance and other resources.

Disasters are by their very nature devastating to communities,
often having significant and long-lasting individual and population-
level adverse effects on physical, mental, and social well-being.
When disasters occur in communities where health resources are
already suboptimal, effects can be severe. In addition to the tragic
loss of human life and devastating health consequences for survivors,
disasters often necessitate billions of dollars in public, private, and
philanthropic expenditures for recovery assistance.

Is America Prepared?

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your household have a 3 day supply of nonperishable food for everyone living there (food not requiring refrigeration or cooking)?</td>
<td>82.9%</td>
</tr>
<tr>
<td>Do you have a 3 day supply of drinking water for everyone living there (1 gallon of water per person per day)?</td>
<td>53.6%</td>
</tr>
<tr>
<td>Do you have 3 days of prescription medications for each person that requires them?</td>
<td>89.7%</td>
</tr>
<tr>
<td>Do you have a working battery operated radio and batteries for same if there was no electricity?</td>
<td>77.7%</td>
</tr>
<tr>
<td>Do you have a battery operated flashlight and working batteries for same if there was no electricity?</td>
<td>94.7%</td>
</tr>
<tr>
<td>Do you have a written evacuation plan if it was necessary to leave due to an emergency?</td>
<td>21.1%</td>
</tr>
</tbody>
</table>

(Source: Centers for Disease Control (2012) a review from the Behavioral Risk Factor Surveillance System survey of 14 states about household preparedness.)

These statistics reveal the strong and weak spots of overall
preparedness in America’s households. Securing enough water to
survive without assistance for 72 hours or more and a written plan
are obviously both lacking in the general population. Those more
prepared are those who have had previous encounters with disasters.
For example, the citizens of New York after the tragedy of 911 have
what is termed as flash bulb memories. They have been there, done
that and want to be ready next time. Research also points to people
who read, prepare lists and create a plan are those who can survive
without help far better than those relying on assistance from outside
resources. Hence, the more vigilant are well prepared. Having a fire
extinguisher, battery powered flashlights and radios (with working
batteries) is the least we can do and stockpiling extra water and
non-perishable food would be doing just a bit better. The Doomsday
Preppers have stockpiles of canned food and ready-to-eat meals.
They are the extreme, but we can all think about what we do have on
hand and make sure to have enough food, water, shelter and other
necessities if the time arises that we need them.

The reasons that people do not get ready are discussed by the
Red Cross:
1. Disregard for emergency preparedness
2. Lack of time to prepare a kit
3. Lack of knowledge of how to achieve preparedness
4. Belief that a disaster will not happen to their family
5. Belief that preparedness measures cannot prevent a disaster
6. Preferring not to think about the possibility of a disaster
    happening to their family

Nurses: role models of preparedness?

Nurses make up a large percentage of health care workers and
have the education and finances to afford at least the minimal amount
of preparatory items to be able to care for themselves if a disaster
arises.

Every movement starts with one person that makes a change or
embraces a different idea. If one person will be prepared, talk about
their goal of being prepared and then get another person to do the

An emergency is any extraordinary event that demands an intense, rapid
response that can generally be handled by resources already existing in
the community.

A disaster is a situation of greater magnitude that disrupts essential services (housing, transportation, communication, sanitation, water and energy services, health care), and requires assistance from outside
of the community. This term generally indicates unforeseen, serious and
immediate threats to public health.
same, the wave can continue until the tipping point is reached and everyone will want to be ready to take care of themselves. Providing all the information in a single place, the list of items necessary to be self-sustained for 72 hours or more, starting the discussion in how close your emergency shelter is located, and that the neighborhood urgent care centers would be open. This is another discussion to be started in the neighborhood before it is too late.

**Barriers for Nurses**

Would you be ready to report to work if a disaster occurred? Does your family know what to do without you? What things do you need to "put-in-place" so you can report to work or reach out and help your neighbors?

This article is aimed at lighting the fire to get prepared in your household, in mine, and in our neighborhoods. Being prepared is a goal we should strive to get done sooner rather than later. How is your plan progressing? It is human nature to avoid thinking about unpleasant things that can happen. It is normal to think it will be the other guy and not us. We can watch floods on television happen somewhere else, or see fires creep up to houses with the brave homeowners using a garden hose to fight off the flames and think, that won't happen here. We see people standing on roof tops waiting to be rescued because they did not evacuate for many reasons and are now counting on someone to come and save them, provide food and shelter for them and help them recover. There is anger when help is "too slow" and recovery creeps along. We know this is not being prepared, that is depending on government and other agencies to come to the rescue. Do we want to be those people? No, we want to be ready and resourceful people that can take care of ourselves and families in case of a situation. As nurses, we are used to taking care of others. Yet, we should also be concerned with taking care of ourselves and families and role modeling the population that the Health Initiative is working to achieve. We want to be part of the solution, not part of the problem. It is never too early to be prepared, but it can always be too late!

**References & Resources**


American Red Cross: http://www.redcross.org/prepare/


Board on Health Sciences Policy; Institute of Medicine, Healthy, Resilient, and Sustainable Communities after Disasters: Strategies, Opportunities, and Planning for Recovery (2015).


Centers for Disease Control and Prevention. Link: http://www.cdc.gov


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Contact: Vicki Pearce, vicki@wbrhely.org 775-236-3487 Ext. 309, or apply online at www.wbrhely.org
As medical practitioners, we have to stop telling patients to diet and exercise. It’s demeaning, it’s ineffective, and it’s medically unsound advice. Diets don’t work. The literature is full of studies showing that most diets don’t encourage long-term weight loss. In fact, the majority of diets lead to weight gain. Most people end up gaining back the few pounds they’ve lost within a year of dieting—plus a few extra pounds on top of that.

There are many theories for why this happens. An article from the New England Journal of Medicine points out that months after initial weight loss, “levels of the circulating mediators of appetite that encourage weight regain after diet-induced weight loss do not revert to the levels recorded before weight loss.” Another study demonstrated that low calorie diets lead to increased cortisol levels and psychological stress, two factors directly linked to weight gain. Their conclusion was that dieting “may be deleterious to psychological well-being and biological functioning.”

The current guidelines for exercising are just as ineffective. Most medical practitioners tell their patients to walk thirty to forty minutes, three to four times a week. The American Heart Association takes a more rigorous approach to exercising by recommending “at least 30 minutes of moderate-intensity aerobic activity at least 5 days per week for a total of 150 minutes.”

If you think about it, though, this is the wrong advice. An exercise program is a good start, but it doesn’t go far enough. If a patient spends eight hours a day, five days a week, sitting in front of a computer at work, and an additional three or four hours sitting in front of a television at home, a thirty minute work out five times a week is not going to be good enough.

Studies out of Blue Zones, regions in the world with high concentrations of centenarians, show that longevity and health are related to eating the right foods and leading an active lifestyle, not dieting and exercising. These robust, energetic, and highly functioning elderly populations eat the right things (e.g. fruits, vegetables, whole grains) and stay away from the wrong things (e.g. processed foods, soda, fried cooking). They don’t necessarily engage in a regimented exercise program, but rather engage in constant moderate physical activity. They lead social and spiritual lives. They integrate themselves into their communities. They put family ahead of everything else.

The concept of losing weight by limiting a person’s caloric intake never made sense. If you starve yourself by consuming half the calories your body requires in an attempt to lose weight, you’re going to be too tired to be active. But if you eat the right things and don’t focus on the exact number of calories you’re consuming, then you’re likely to have enough energy to lead an active and social life.

We shouldn’t recommend that our patients “diet and exercise.” Rather, we should encourage them to engage in healthy living. The concept of healthy living is about following simple daily habits.

There are concrete, simple steps we can instruct our patients to follow that are incredibly effective:

1. **Don’t smoke.** Smoking causes half of all cancers and increases your risk for heart attacks and strokes.
2. **If you’re thirsty, drink water.** Sodas have chemicals, and if you’ve switched from regular to diet, sugar-free, or zero-calorie drinks, you’ve been fooled. It is not the calories you need to avoid, it’s the chemicals.
3. **Limit your alcohol intake.** Theoretically, you shouldn’t be drinking at all. But if you don’t want to deprive yourself, limit yourself to ONE glass of red wine. The antioxidants and resveratrol in red wine are believed to increase HDL (the good cholesterol), decrease LDL (the bad cholesterol), protect your body from arterial damage, and reduce inflammation and blood clotting.
4. **Exercise.** If you eat every day, you should be active every day. It doesn’t have to be strenuous exercise; as long as you engage in some type of physical activity and vary your workouts, you’ll be on your way to a healthy life.
5. **Eat Smart.** If it lives in a vending machine, don’t eat it. Stay away from processed foods. Eat locally grown organic fruits and vegetables. Have as much salad as you want, but limit the amount of dressing. If you crave carbohydrates, have some nuts or whole grain bread; avoid the animal-protein you ingest.
6. **Sleep.** Shoot for eight hours of sleep, but at the minimum make sure you get six hours. The less you sleep, the higher your risk for accidents, weight gain, infection, and depression. Lack of sleep has also been linked to a decreased libido.
7. **Minimize stress.** Keep in mind that what gets filtered into your brain will eventually affect your health and outlook on life. Simplify your life. Keep your time checking email, watching television, talking on your cell phone, Tweeting, and updating your Facebook status to a minimum. Less is best. Have a positive attitude. If watching the news gives you angina, stop watching.

As practitioners, we want our patients to lead happy and healthy lives. But telling them to simply “diet and exercise” is irresponsible and inefficient. We need to provide our patients with concrete goals, like those listed above, in order for them to start taking control of their own lives. We need to remind our patients that an ounce of prevention is worth a pound of cure. We need to encourage them to put down the soda and reach for a glass of water, to put down the sandwich and grab a salad, and to put down the remote control and go for a walk.

Their future depends on it.

—Alberto Hazan is an emergency physician in Las Vegas. He is the author of the medical thriller Limit the Damage and the preteen urban fantasy series The League of Freaks.

—Jordana Haber is an emergency physician at University Medical Center in Las Vegas. She has a master’s degree in medical education.
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Highlights:
- Presentation by Pam Cipriano, PhD, RN - President of the American Nurses Association and one of the top 25 most influential women in healthcare in America
- Forty Under 40 Awards - Join us in recognizing forty nurses under the age of forty who have demonstrated excellence in practice and leadership. Nominations are open.
- Professional Progression Awards – All nurses who have completed advanced degrees and specialty certifications in the previous year will be honored. Let us know of colleagues successes.
- Recognition of Nightingale Scholarship and Grant Donors – we will honor 50 named scholarship/grant donors. These individual/corporate donors have set aside funds from their charitable giving to create a personal/professional legacy by donating a $1000 scholarship/grant in their individual/corporate names or after someone they wish to honor. With this naming opportunity comes the privilege of deciding the named scholarship/grant criteria. They will be recognized at all NNA, NNF, NANE and NAC sponsored events and their websites for one year. Tax exempt donations can be made to the Nevada Nurses Foundation.
- Find great items at the silent auction! Silent auction item donations gratefully accepted.

Checks may be made payable to:
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P.O. Box 34047, Reno, Nevada 89533-4047
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Credit card payments may be made through the Nevada Nurses Association Foundation PayPal account. Visit www.nvnurses.orgFoundation for the link.

Questions?
Call: 775-560-1118
Email NNF@nvnurses.org

Presented by the Nevada Nurses Foundation, the Nevada Nurses Association (NNA), the Nevada Action Coalition (NAC), the Nevada Association for Nursing Excellence (NANE), the Nevada Organization of Nursing Leaders (NONL), the Nevada State Board of Nursing (NSBN), the Southern Black Nurses Association, the Philippine Nurses Association, and the Nevada Association of Nurse Practitioners (NAPNA).

All proceeds will benefit the Nevada Nurses Foundation, a 501(c)3.
Debra Scott is "Nursing in Nevada". She has dedicated her career with the Board to ensure safe patient care. She has spent many hours traveling the state teaching Registered Nurses, Certified Nursing Assistants, and students. Her involvement on a national level has allowed Nevada to be a role model for many Boards across the country. I will miss her knowledge, kindness, and support greatly.

Debra Scott: Nursing Leadership

Mary Mackenzie, MSN, RN

Debra Scott is an exceptional nurse whose professional achievements and national recognition can make all of Nevada’s nurses proud. Debra Scott, MSN, RN, FRE, currently holds the position of Executive Director of the Nevada State Board of Nursing (NSBN). Beginning in 1996 Debra served as Associate Executive Director for Nursing Practice and became the Executive Director in 2002. Debra plans to retire from the NSBN in January 2016. Debra was licensed initially as an RN in California where she practiced for several years before coming to Nevada. Debra earned her Bachelor’s and Master’s degrees in nursing from California State University, Fresno. She graduated Cum Laude and was inducted into Sigma Theta Tau, Nursing’s Honor Society.

In addition to her Nevada RN license, Debra was recognized as a Clinical Nurse Specialist in Psychiatric Nursing and held a license as an Advanced Practitioner of Nursing which is currently inactive. During her time at the Nevada State Board of Nursing, Debra served as chair on various committees at the state, national, and international level. She was editor for the Board's nursing magazine.

As Executive Director of the Nevada State Board of Nursing, Debra has provided Nevada’s nurses and health care consumers with outstanding care and concern for the last several years. Debra’s leadership style stems from her belief that nursing leadership is based in stewardship; that is, choosing service to the greater good over self-interest, particularly in relation to honesty, integrity, and courage. As Executive Director, Debra expresses her stewardship ideal by protecting healthcare consumers as well as supporting nurses to practice safely and to acknowledge nurses have a legitimate role as patient advocates. Debra favors an honest and straightforward approach to creating, nurturing, and supporting relationships.

Her strong belief in communication, integrity, and trust provided her courage in an atmosphere often prejudiced toward regulators. Debra continues: "Not only did I espouse those qualities in my own interactions, but [I] provided an environment and established the expectation for changing how my agency interfaced with the citizens of our state, patients and nurses alike."

Debra lists the following as special highlights during her time with the Nevada State Board of Nursing

1. Passage of AB170 which gave full practice authority to Advance Practice RNs (APRNs) and brought Nevada more in line with the APRN Consensus Model for Regulation of APRNs
2. Participation in the first Global Nursing Leaders Institute in 2009 in Geneva, Switzerland
3. Receiving the Award of Fellowship in the Institute of Regulatory Excellence in 2008
4. Receiving the National Council of State Boards of Nursing (NCSBN) Meritorious Service Award in 2012
5. Receiving the AANP (American Academy of Nurse Practitioners) State Award for Excellence in 2013
6. Serving on the NCSBN Board of Directors from 2009-2013
7. Serving on the Governor’s Healthcare and Medical Services Sector Council as vice chair
8. Serving as one of the founding members of the Nevada Action Coalition and the Nevada Alliance for Nursing Excellence

Debra was instrumental in providing research and rationale to the Board of Nursing allowing for decisions to remove regulatory by NNA. We talked about issues that were problematic for Nurses and APRNs Debra inspired me to become politically active in the state by sharing her stories of how she started with the Nevada State Board of Nursing. I realized that I could be part of the change that needed to occur in Nevada and I served for many years on the Advanced Practice Registered Nurse Advisory Committee where I met many other Nursing leaders. Collaboration with other nursing leaders and hard work helped us to influence many changes within our state. Debra has always strived to advance the practice of Nursing in the State of Nevada by recommending adoption of national standards. It is no surprise that Debra has also been recognized by the National Council of State Boards of Nursing for the hard work she has done for the State of Nevada but we already knew she was a superstar in Nevada! Debra will truly miss you at the Board of Nursing but you have earned a chance to relax and enjoy your retirement! Thank you for all you have done for the State of Nevada! Dr Matthew Khan, APRN, FNP- BC

Former President / Co-Founder of NAPNA
Former NNA/SPG Northern Co-Chair

Debra Scott's leadership at the Nevada State Board of Nursing has been truly outstanding and words would not describe her contributions. I am very proud to say the Nevada State Board of Nursing is a leader in the country and the residents of Nevada can rest assured their safety is always at the forefront because of Debra Scott.

Jeff Stout, MSN, RN, NEA-BC
Renown Health Vice President, Chief Nursing Officer, Acute Care Services

I have known Debra Scott for many years before she became executive director for the Nevada State Board of Nursing (BON). I had the opportunity to work with Debra as a member of...
barriers and to strengthen nursing law so that Nevadans may benefit safely from innovation in nursing practice and education. As a nurse, Debra is proud that those interventions resulted in her agency’s [Nevada’s State Board of Nursing] being better positioned and equipped to pursue its mission in an environment where, she says, “previously there was fear and distrust.” Continuing to comment on things in which she takes pride, Debra adds that “personally, as a nurse, I am most proud of being an example for those searching to fulfill their potential. The pursuit of my profession through education and licensure made me the master of my own destiny, providing unlimited opportunity and experience. What a gift to be able to share with those who seek to fulfill their professional meaning in life. Before me, my grandmother, my great-aunt, my many mentors, and after me, my niece, and my friend have joined me in this lifelong adventure of sharing life’s most precious moments, from birth to death, with all who call us “nurse.”

Debra’s advice to anyone considering becoming a nurse is that “you will never imagine the overwhelming gift that will be yours each and every time you choose your patients’ greater good over self-interest. Treasure it each time it is given.” Debra describes nursing as an e-ticket ride. It’s worth the hard work to become a nurse and to stay a nurse. Never stop learning and never think you know it all. Humility is an essential part of greatness.

Debra describes her contribution to the Nevada State Board of Nursing (NSBN) with her characteristic humility and collaborative focus. “My contribution to the NSBN really is that I have been a Board employee for almost 20 years and showed up to work regularly. During those years, Board staff accomplished many things. We collaborated with the Long Term Care Association to enact the bill which created Medication Aides-certified, and collaborated with the Nevada Advanced Practice Nursing Association to enact AB170 which gave full practice authority to APRNs. I oversaw the hiring of all but one of my 25 staff members who are currently employed by the Board. We supported increased nursing programs to meet the needs of Nevada’s citizens. We initiated a Clinical Schedule and Software System so that all nursing programs could utilize all available clinical sites. NSBN was recognized nationally in 2014 by being awarded the NCSBN Regulatory Achievement Award and named one of the top 5 member boards in the area of Disciplinary Processes and Licensure.

Debra’s advice to her replacement is not to “take yourself too seriously, keep a sense of humor, always do the right thing no matter who might not like it, and know that nothing happens in a vacuum. You are only as good as those you surround yourself with…and above all, remember that your relationships are the number one resource to make great things happen.”

After she retires Debra plans to first, sleep in, visit her grandchildren, babies, children, dad, brother and sister, and long time friends. Then she is going to do some travel for fun rather than for work. And, then, she hopes to find new challenges to serve…and have fun along the way.

As Executive Director of the Nevada State Board of Nursing, Debra Scott’s dedicated commitment to serve as a role model displaying integrity and honesty, while maintaining a nurturing environment for her staff, has served to provide Nevada’s nurses and health care consumers many treasured gifts. Nevada’s nurses wish Debra well in her retirement from the NSBN and express gratitude for her numerous contributions to Nevada’s nurses and citizens.

While I am sad to see Debra stepping down from the Board of Nursing, I recognize the incredible legacy her tenure has brought us. She provided a calming and guiding presence through multiple challenges. Her faith in the community of nursing and the role of the Board as a force to improve the environment for Nursing will stand as its own testament for decades to come. Debra, you have the deep gratitude of the APRN community, thank you for a job well done.

Tomas Walker
President / Co-founder of NAPNA

In my ten years as a nurse and nurse leader, I have always looked up to the Nevada State Board of Nursing leadership and Debra Scott. Debra has been a true leader in every sense who has guided the Nursing Profession in Nevada to a superior level of performance.

Dave I. Tyrrell

As one of her greatest opponents, I have had the pleasure of working with and against Debra for many years in a variety of situations. Whether we agreed or not in the moment, I have always been impressed by Debra’s integrity, strength, and ability to maintain incredible focus and dedication to protecting the public in any setting. I have learned so much from Debra and she has always inspired me to improve both personally and professionally. Simply put, Debra is an amazing woman with unwavering passion and infinite wisdom…she will be sorely missed.

Tracy L. Singh, RN, JD

We pay tribute to Debra Scott’s many initiatives and outreach programs which has benefited the public and community. For two decades, her stellar contributions and iconic achievements are a testament to her selfless dedication and service and continued support to the PNANV.

Amelia Abello
President, PNA-NV

I’m thinking it’s not possible to write a tribute to Debra Scott in 50 words or less. I knew Debra before she became the executive director. She was reluctant to take the position, because she thought following Kathy Apple would be a challenge…Debra exceeded all expectations, in every way possible! I will always treasure our memories,

Doreen Begley, MS, RN, FRE
Past Board President, NSBN

Debra Scott has been an excellent leader in nursing regulation for Nevada and a positive influence at UNLV School of Nursing. Her dedication to education from undergraduate to graduate level students is manifested in her keen guidance, support and responsiveness to any questions we have had for the Nevada State Board of Nursing. We wish her well as she moves into retirement, but know we will miss her leadership in the Nursing profession.

On behalf of the UNLV School of Nursing faculty, Carolyn Yucha, RN, PhD, FAAN
Dean and Professor
University of Nevada, Las Vegas

On behalf of the Executive Board of The Nevada Organization of Nurse Leaders (NONL), we want to express our utmost gratitude to Debra Scott, MSN, RN, FRE, Executive Director, Nevada State Board of Nursing for exemplary performance in the protection of the citizens of Nevada through vision and excellence in the Regulatory & Standards of Nursing Practice. A warm and sincere "Thank You Debra." Best Wishes Always,

John A. Coldsmit, RN, MSN, DNP (c) 2014 ~ 2015 President of NONL
Avoid Malpractice & Protect Your License: Listen Not Doubt
Tracy L. Singh, RN, JD

In the “practice” of medicine, regardless of how advanced technology becomes, patients will remain at risk for substandard care as long as they are dealing with humans with an ego.

The bigger the ego…the bigger the risk!

Patients are taking more personal responsibility for their own health ever than before. They may not be much better at taking care of themselves but, patients do know more about their symptoms, what they can mean and even how to avoid or prevent them due to the world wide web.

When patients first started coming in announcing, “I read on the internet that I should have (fill in the blank) and I’d like to try this medication…or take this test,” they met great resistance. Most providers seemed to instantly stop listening and start doubting whatever their patients had to say next. The transition in their providers’ minds could be read on their faces as their hands went up and their heads shifted as they would step and say, “well, you can’t believe everything you read on the internet…let’s try this instead…”

Unfortunately, this is still happening today. The last thing providers with years of training and experience want is an uneducated layperson coming in to tell them how to do their jobs.

When patients walk into a doctor’s office or Urgent Care, they may not know exactly what’s wrong but they at least have a pretty good idea that something is not right. Now, many patients actually have a clue about what could be causing their symptoms. When patients are suffering, they looking for help, not judgment. They are not interested in competing with their providers over who knows more about their condition…they just want relief. The last thing patients with pain, fatigue and anxiety want is for someone to tell them they are perfectly healthy and it’s all in their heads.

Wrongful or dismissive advice causes frustration, confusion and a willful disconnect between providers and their patients, especially when egos get involved. After all, a highly-trained professional who has spent many years in training may rightfully believe they know more about a patient’s health than they do; but, no one knows their own bodies better than patients do.

Recently, one woman with a lifetime history of asthma went to the doctor for help complaining that she couldn’t breathe. He told her it was all in her head and that she was just having panic attacks. He gave her a prescription for Xanax and sent her on her way…she died in her sleep two days later next to her boyfriend, a close family friend. She was 47 years old. Another young woman has been complaining of sinus pressure, headaches and fogginess for the past six months. She too was told it was all in her head; only to finally be diagnosed with hydrocephalus. The morning she was scheduled for a spinal tap, her neurologist advised the test would be cancelled…that she should just take medications, that her symptoms had nothing to do with hydrocephalus and that her migraines should go away once she hits menopause. She is back on the search for a provider who can properly manage her hydrocephalus and address her symptoms.

When a healthcare provider at any level dismisses the complaints of a patient simply because they do not understand, cannot identify, or relate to what the patient is describing, that is when providers need to pay closer attention, not dismiss their complaints.

While it is important to verify patient’s complaints or suspicions, patients who are simply told they are wrong, that they are fine, that there is nothing wrong with what’s all in their head, will not only leave frustrated and angry…they may actually continue to get worse and could suffer dire consequences. When a patient complains to a nurse either in a doctor’s office or in an inpatient setting and those complaints are ignored, dismissed or forgotten without communication to the healthcare provider, that nurse will have had the last opportunity in that situation to make a difference.

If symptoms worsen, significant harm or death can occur, and even if malpractice cannot be established, termination and formal disciplinary action against the nurse’s license is probable.

Even when patients’ statements fail to make sense, or they claim to have “read it on the internet,” as advocates, nurses need to listen…not doubt what patients and their families have to say. As difficult as it can be, nurses must figure out a way to align themselves with their patients and not fall into the temptation of some providers’ ego by agreeing that a patient must be imagining things. Nurses who insist that their patients need more attention or follow-up than the providers are willing to offer may meet resistance, become subjects of bullying in hostile workplace environments and even face termination…but at least their patients will have a chance at a better outcome and their licenses will be less at risk. Remember, nurses are patients, too! You will want your providers to listen, not doubt you as well. Oftentimes, patients have already gotten a jump-start on the research needed…lead by example and work together to find the answers.

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The Grey Muse: Who Cares...For the Elderly?

Val Wedler, MSN, RN
UNR Orvis

Approximately 88% of older adults have at least one chronic disease, and 50% of those over age 85 have cognitive impairments. Problems of chronic pain, inadequate nutrition and urinary incontinence are common. When hospitalized, the elderly are more prone to falls, infection, and pressure ulcers, thus putting them at risk for complications, longer lengths of stay, and repeated readmission.

The Institute of Medicine (IOM) published a report in 2011 saying, “High-quality care for older adults, many of whom have multiple complex chronic conditions, requires a diverse range of skills for addressing their physical, mental, cognitive and behavioral needs.” The IOM report cites “lack of faculty, lack of funding, lack of time in already-busy curricula, and the lack of recognition of the importance of geriatrics training” as the main barriers to the appropriate levels of training. The report goes on to caution that unless nurses and other health care workers develop competence in the care of older adults, our nurses and other health care workers develop competence in the care of older adults, only one quarter of psychologists are exposed to geropsychology in graduate coursework.

Although 87 percent of physical therapists report working with older adults, less than one percent of practicing physical therapists are certified as geriatric clinical specialists.

Less than half of pharmacy schools have a distinct course in geriatrics despite the fact that per capita prescription drug use by people 65 and older is triple that of younger individuals.

Less than one-fifth of schools training oral-health workers, including dentists and dental hygienists, offer a course in geriatrics practice.

Going forward, nurses will play a pivotal role in the health promotion and risk reduction of the elderly. They will need education and training on geriatric principles and gerontology, two areas that have been greatly underrepresented in the current healthcare curricula and clinical training environments. As healthcare consumers and providers, we must recognize that older adults are the main users of healthcare services and have become the “core business” of nursing in most clinical settings. By re-designing nursing education to produce nurses who understand the necessities of this increasing population, it is entirely possible that we will be able to meet the needs of the elderly in the future.

Other statistics reported by the IOM:

- Less than 3 percent of students in medical schools choose to take geriatrics electives. [1]
- Although 75 percent of social workers report working with older adults, social work training and competency requirements lack focus on this population. Only four percent of social workers report receiving geriatrics training and only 24 percent of Bachelors of Social Work programs offer a certificate in aging or gerontology. [2]
- Less than one percent of all registered nurses are certified as gerontological and the vast majority of schools of nursing had no faculty members who were certified in gerontological nursing by the American Nurses Credentialing Center. [3]
- Less than one percent of pharmacists are certified in geriatrics.[iii]
- Although 69 percent of all practicing psychologists provide some services to older adults, only three percent view geriatric patients as their primary professional target. Only one quarter of psychologists are exposed to geropsychology in graduate coursework.

References


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Nurses think globally, care about humanity, and act each day to make the world a better place. In 2000, the United Nations (UN) released the Millennium Declaration, which affirmed a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. Leavers of the bonds committed to eight action-targeted objectives called the Millennium Development Goals (MDGs). The campaign sought to inspire the world for collaborative actions to eradicate extreme poverty, thereby ending hunger and reducing malnutrition. Nurses, as caregivers, can care for those experiencing alcohol withdrawal. How many are we able to effectively transfer into rehabilitation services? What efforts are occurring for Nevada’s youth to prevent first-time use of methamphetamine, heroin, alcohol and other mood-altering substances. Unfortunately, electronic cigarettes or “vaping” substances is becoming socially acceptable with teens. For nurses, learning and then using the evidence-based intervention called SBIRT (screen, brief intervention and referral to treatment) is a helpful start to achieving this goal. Target 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents. Nurses treat and counsel traffic victims and their families. Our efforts and voice as a profession can influence the general public and legislation for efforts to protect drivers, passengers and pedestrians. We have come a long way from the days of not wearing seatbelts or having infant car seats, but deaths continue to occur including new distracting behaviors such as “texting.” There are more than 3,500 distraction-related crashes for food to share every year (ZeroFatalitiesnv.com).

SDG #4 Quality Education – Target 4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes. Sadly, Nevada is ranked last in the nation for completion of high school (60% completion; 50th rank nationally; United Health Foundation). As nurses we understand the importance of early childhood development (SDG 13-15), and finally a focus on national and global partnerships (SDG 16-17). See Figure 1. Nurses in Nevada can be aware and become involved with achieving these goals. Our voices and actions can make a difference right here in our state and beyond. Here’s a few examples of MDGs that relate to Nevada:

SDG #2 Zero Hunger – Target 2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round.

Currently in Nevada, we have 1 in 6 people struggling with hunger and others in nutritionally insecure situations, including kids, safe, nutritious and sufficient food all year round.

In Las Vegas, 2,229 victims of sex trafficking have been saved by the police since 1994 (Nevada Attorney General Report). A call is made to all citizens of Nevada to end the exploitation of these victims. We as nurses are the caring persons who these victims may seek for help. Many courses are available to nurses that teach how to identify these victims, better understand the issue, and offer training in effective communication techniques to use with this vulnerable population. This new competency for all nurses, regardless of role, demonstrates how our profession continues to meet the needs of an ever-changing society.

SDG #11 Sustainable Cities and Communities - Target 11.7 By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities. How close is a green space from your home? Nurses understand the importance of healthy healing environments. Let’s continue to voice the need and support initiatives that create access for all to beautiful parks and recreation areas for all neighborhoods across Nevada.

SDG #12 Responsible Consumption and Production - Target 12.5 By 2030, substantially reduce waste generation through prevention, reduction, recycling and reuse. In previous editions of RNFORMATION we have learned how recycling in Nevada is limited to the urban areas. Nurses can advocate to make recycling available across our state, and influence our own hospitals and clinics to adopt or enhance recycling programs.

References:

The World We Want – Video on the Sustainable Development Goals, Link: https://www.youtube.com/watch?v=Q5aG8pr6tS8
Zero Fatalities Nevada. Link: http://www.zerofatalitiesnev.org/focus-on-the-road/
America’s Health Rankings, United Health Foundation. Link: http://www.americashealthrankings.org/NV/Graduation
Office of the Nevada Attorney General; Human Trafficking in Nevada. Link: http://ag.nv.gov/Human-Trafficking/HT_Home/
Is Your Hospital Hemorrhaging Human and Financial Resources?: A Preliminary Look at Lateral and Vertical Violence in Nursing

Stephen Hayden, DNP, MSN, APRN, RN

In 2011, a Nevada State Collaborative on Lateral Violence in Nursing Committee (Committee) was formed under the auspices of the Nevada Nurses Association. The purpose of the Committee was to seek solutions for the issues surrounding lateral/vertical violence (L/VV) in nursing as found in Nevada healthcare institutions. The initial goal of the Committee culminated with the September 2013 “Train-the-Trainer” seminars titled “Lateral Violence: Let’s Get Rid of It!” During 2014 a number of “Train-the-Trainer” seminars were conducted. The training of staff nurses began in 2015.

Data collected to date from the Committee’s current Disruptive Behaviors Seminars suggest that a failure of leadership contributes to disruptive behaviors by staff nurses. 69% of the surveyed nurses indicate that vertical violence directed downward ranges from somewhat serious to very serious. Further, 69% of participants in these seminars indicate agreement or strong agreement that “Leaders [are] not willing to intervene in lateral or vertical violence in my work area” with 73% of respondents indicating that targeted nurses were not willing to stand up to L/VV. Nearly half of the nurses feared retaliation if they reported vertical violence directed downward. Further, 12.4% of the respondents reported leaving a nursing position because of vertical violence. The 2013 national voluntary nurse turnover rate was 13.1%.

In a personal communication, the author of the Instrument being used in this program stated:

“I believe that the nurse manager is the key person for controlling the negative behaviors on nursing units. If it isn’t addressed constantly, it will continue and will worsen. Staff turnover can be both a consequence of and resources to actually keep a program going and if trainers are given the time and other factors play a role in the availability of personnel, top leadership is on board, if the trainers are problems to solve. I have done train-the-trainer sessions and they can be effective if top leadership is on board, if the trainers are really dedicated to solving this problem, and if trainers are given the time and resources to actually keep a program going over time. These are big “ifs” in this cost-cutting era for health care.”

The ideal length of the L/VV seminar for staff nurses is 3-4 hours, yet 55% of respondents indicated their training session was less than 3 hours with 33.7% reporting the training session as one hour. Some institutions appear quite committed to the program with nearly 20% reporting training sessions of the desired 3-4 hours. Obviously, size of institution, staffing requirements, scheduling and other factors may play a role in the availability of personnel, time and resources. However, as we examine area of cost-cutting in healthcare institutions, the costs of L/VV should be examined with the same scrutiny as other cost factors. For many hospitals, this does not appear to be the case.

Disruptive behaviors incur significant costs if it leads to attrition of nursing staff. Oyeleye et al. (2013) estimate nurse replacement costs of between $22,000 and $64,000. The American Nurses Association (ANA) (n.d.) indicates that replacement costs of an RN are 1.1 to 1.6 times a nurse’s annual salary which the ANA reported as $66,530 in 2010. Krsek (2011) estimates turnover costs at $88,000 per position.

There is considerable literature on the cost of voluntary nurse turnover with widely varying estimates of the costs, perhaps due to some studies not including costs contained in the more comprehensive studies. Costs of overtime due to vacancy, recruitment, training, lost productivity and other factors are generally included in the studies. Colosi (2013) reports that the national bedside nurse turnover rate for 2013 was 13.1%, an increase from 2012’s 11.2%; the rate for Med/Surg nurses was 16.8%. The voluntary turnover rate for first year RNs was an eye-catching 27.1% (Krsek, 2011). If nurse turnover is 13% and the cost of replacement is estimated at $50,000, a simple calculation indicates that a loss of 13 nurses per hundred would cost a healthcare institution $650,000. When larger hospitals have hundreds to thousands of nurses, the staggering costs are self-evident. However, Colosi (2013) states: “The cost of turnover can have a profound impact on the already diminishing hospital margin. The overwhelming majority [of hospitals] (83.9%) does not track this cost” (p. 7).

Without knowing the cost of nursing turnover in one’s institution, how can nursing management make the case for the “time and resources” necessary to implement a comprehensive program of “Lateral Violence: Let’s Get Rid of It!” Institutions need to track these costs if they wish to meaningfully implement programs to reduce voluntary nurse turnover due to L/VV.

The study on which this article is based is a Doctor of Nursing Practice Capstone Project. It will be continued as a post-doctoral multi-year longitudinal study to examine the effectiveness of this program to reduce L/VV. References are available on request.

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Compassion Fatigue
Mary Bemker, PhD, MSN, CADC, LPCC, RN

Compassion Fatigue occurs when a nurse experiences indirect trauma when while helping others who are in distress. Nursing, a profession focusing on helping others, is one that often places the nurse at risk for developing this secondary victimization (Figley, 1995). Differing from burnout, compassion fatigue has a more acute onset and results from the emotional connection that the nurse has with a patient or client who has been traumatized (Anewalt, 2009). Symptoms of Compassion Fatigue include:

- Avoidance or dread
- Inability or a reduced ability to feel empathy
- Restlessness
- Difficulty sleeping
- Anxiety
- Poor concentration
- Anger, resentment and other negative emotions
- Sleep disturbances
- Headaches
- Hyperarousal or heightened reactions
- Impairment, such as psychological difficulty with functioning, chemical impairment, or lethargy (Figley, 1995)

While any one of these symptoms could apply to a variety of conditions, it is important for the nurse to look at the symptoms and relate them to the work environment. Is the nurse:

- Dealing with many patients or clients who have or currently are experiencing trauma?
- Identifying with or connected to one patient or client who is experiencing a traumatic event in their lives?
- One with a long history of caring for individuals who are going through traumatic events?
- Getting extremely involved (enmeshed) with patients or clients?

So what is a nurse to do if she or he believes that they are prone to compassion fatigue? First, a nurse could look for or organize a support group to talk about their issues and get mutual guidance and support in dealing with the day-to-day issues of being a nurse. A nurse could also seek out an individual who seems to be balancing the demands of the profession, and ask if they would be willing to serve as an unofficial sponsor. In other words, this person could provide guidance and direction for the nurse so that “feelings are left at work.” Journaling, writing poetry or some other artistic means of expression could also be used to get feelings out and provide a perspective.

Balance of work and private life is also extremely important, and the nurse needs to develop a means of having outside activities to draw thoughts away from work and work-related concerns.

If feelings seem to be debilitating, then professional counseling is a must. Employers often have counselors through their Employee Assistance Programs. Insurance companies may be able to recommend therapists that specialize in compassion fatigue. The nurse’s primary health care provider might also be a good resource in seeking out a professional counselor. If a nurse has thoughts of suicide, help is available 24/7 at the Suicide Prevention Helpline 1-800-273-TALK (8255).

For further information, please see the following:
- Compassion Fatigue Awareness Project - http://www.compassionfatigue.org
- Mental Health Association of Palm Beach County - http://www.mhapp聘用/CompassionFatigue

References

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For as long as I can remember, I wanted to be involved in caring for underserved populations. Over the summer, I was finally given that opportunity as a nursing student. For one week, I went on a medical mission to Guatemala with my nursing class. Spending time at the clinic each day and assisting in delivering health care to people who otherwise rarely receive it was an experience I will never forget. Every day, we opened the clinic to hundreds of people who would sit for up to 10 hours just to see a doctor and get a small prescription. The second day at the clinic while working with a nursing student from another school, I witnessed something remarkable, but its meaning would only become evident to me later on. The student spoke fluent Spanish and was familiar with Latin culture. I sat with her in triage and took patients’ vitals while she listened to and documented their complaints. One by one, she took note of their symptoms and asked the same questions. But there was something quite different about her approach when she was speaking to women. When a woman would finish listing her complaints, the student would lean in closer to her, make direct eye contact and very quietly ask, “Que mas?” (“What else?”). At this point, almost every woman or adolescent girl would pause, take a breath, and lean in before quietly asking, “What else?” how many conditions might have been left untreated? How many women received antibiotics for an infection; medications to ease their discomfort, or were given a pregnancy test that otherwise may not have been?

Reflecting on my personal experiences with the women in Guatemala caused me to contemplate the bigger picture in terms of culturally competent care and communication here in the United States. We are taught as nursing students to be aware of cultural differences in our patient population, but there is not a lot of emphasis on effective communication with these patients. In fact, there is not much preparation for future nurses to properly communicate with patients in general. In a study done by Sheldon, Barnett and Ellington, researchers concluded that nurses felt they were not educated properly to effectively communicate with their patients given the wide variety of situations nurses encounter in their practice (Sheldon, Barnett and Ellington, 2006). This is troubling considering how important a role proper communication plays in patient care.

According to Hearnden (2008), “Although effective communication is an essential skill for healthcare professionals and arguably the most essential aspect of nursing practice, it is often overlooked.”

I continue to wonder, “Que Mas?” What else can we be doing to guarantee the absolute best care to our diverse population? How can we make sure that each individual is receiving the most comprehensive treatment? Knowing how to elicit the most and best information from our patients is the first step to ensuring proper care, but it is not enough if we only know how to do it with those familiar to us. It is well understood that individuals have their own set of issues which depend upon their age, gender, race or culture, and as such, should receive specialized care, but we tend to overlook these factors when we are attempting to communicate. Small changes in nursing curriculum by adding emphasis on cultural communication could eventually lead to more adequate care for all. While it might be impossible to anticipate the differences in communication style of every culture or situation we may encounter, it stands to reason that nurses and nursing educators can and should make effective communication a larger priority.

References


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“Que mas?” (What Else?): Culture and Communication in Nursing

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Winner 2015 Arthur L. Davis Publishing Agency, Inc. $1,000 Scholarship
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I went to NNBA’s website, www.nnbanow.com, and discovered what is this conference going to be about? Is it worth my time? I had to do some research about what exactly I was signing up to attend. What is NNBA? When I received the email inquiry, I had to do some research on the 2015 National Nurses in Business Association (NNBA) Conference. Las Vegas’s Student Nurses Association (SNA) was invited to the 2015 NNBA Conference which was held on October 3rd at the Westgate Resort & Casino in Las Vegas, NV. My classmate and I were greeted, signed in, badged, and seated for the NNBA President’s Welcome. We had the pleasure to hear from established speakers on a variety of topics such as: “Independent RN Patient Advocacy,” Business Planning Roadmap,” and “How You Can Serve as an Expert Witness.” After a break for lunch, we had the opportunity to visit the round table sessions of our choosing to ask questions, receive feedback, and further discuss ideas. We all reconvened to the main conference room to watch the 2015 NNBA Shark Tank Competition where several individuals showcased their business concepts to a panel of judges for a grand prize. I left the conference on that first day feeling absolutely awestruck by the accomplishments of the nurses that surrounded me. Everyone was open to sharing of their ideas and encouraging one another’s efforts. The entire conference room was filled with the excitement of members on the edge of their next great idea, expanding upon a current idea, and sharing their successes.

On the second and final day, I was eager to return to the conference and hear from the remaining speakers. Our keynote speaker for the morning played her guitar and sang songs, making the entire room laugh. Deb Gauldin did a great job of energizing the room for the speakers to follow. We observed presentations on exciting topics such as: “Speaking for Fun & Profit,” B is for Balance,” and “Communication Essentials for Today’s Business Owner.” Michelle Podlesni closed the conference with goals for the year to come and announced the date of next year’s conference, October 14th-16th, 2016.

To answer my final question thoroughly after attending the 2015 NNBA Conference, “Is this worth my time?” I can attest to the extreme value of each item on the agenda. The resources that NNBA provides to their members are abundant and it was an amazing experience for me to be there as a student nurse. One word sums up the 2015 NNBA Conference perfectly: inspiring.
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