Inside

focus

8 Suicide Prevention is Not Just for Patients
9 Suicide Prevention and Support: A Look at Resources
10 Veterans, Guilt, and Suicide Risk
11 Suicide Prevention Resources for Military Veterans
12 The Joint Commission Sentinel Event Alert. Detecting and treating suicide ideation in all settings: Implications for Nursing

in this issue

3 Antibiotic and Medication Stewardship
4 Nevada Public Health Training Center
5 Antibiotic Stewardship: A Call to Action
6 ANA President’s Nevada Visit a Big Success
7 Nurses Week at Northern Nevada Medical Center
7 UNR Orvis Student Poster Presentation
7 Where Imaginations and Journeys Meet
14 Pharmaceutical Waste Disposal
16 Nevada Nurses Foundation
18 Healthy Nevada Nurses: Exercise for Nurses
18 Domestic Violence Awareness and Intervention
20 State of the Air in Nevada 2016 Report Card
21 The Grey Muse: Listen Up!
22 Ensuring a Better Death for our Loved Ones
23 NNA Membership Application
23 A Special Message To NNA Members

NNA’s Dr. Elizabeth Fildes elected to the American Nurses Association Board of Directors!

Page 3

ANA President Pam Cipriano Visits Nevada

Page 6

The Joint Commission, recognizing the urgency of the suicide problem, issued a Sentinel Event Alert on February 24, 2016. What is the role of nursing in controlling this problem?

Page 12

Mark Your Calendars

• August 27, 2016, Rural Nurses Symposium, Elko
• September 10, 2016, District 3’s Annual Education Summit
• September 17, 2016, District 1 Symposium, Reno
• September 22, 2016, Free CE – Alzheimer’s and Dementia Related Diseases
• October 15, 2016, NNA Annual Meeting
• February 22, 2017, Nurses Day at the Legislature
NNA Mission Statement

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.

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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 September 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.

Calling ALL NURSES and INTERESTED SIGNIFICANT OTHERS!

Nevada Nurses Association Delegation is going to CUBA March 27 – April 1, 2017. Visit with the Cuban Nursing Society, hospitals, and clinics, and meet nurses to discuss their role and responsibilities. Space is limited to 10-15 participants, nurses and significant others. If interested please direct your questions to solguin@nvnurses.org.

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The overuse of opiates and other medications in US Healthcare has become a serious issue. The number of opiate overdose related deaths is climbing throughout the country. Many of these deaths are accidental deaths from illicit or prescription drugs. Some deaths are intentional suicide attempts. This issue of RNFormation will look at the risk factors and rates for suicide in the US and contributing factors such as the over-prescribing of opiates/controlled substances. The DEA changed Norco to Schedule II in 2015 to tighten control on overprescribing for these very reasons.

Over-prescribing is also an issue with antibiotics. The CDC recently released the statement: “Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics and at least 23,000 people die each year as a direct result of these infections.” The Nevada Antimicrobial Stewardship Program has been created to increase communication between Acute Care, Sub-Acute, Long-Term Care, and Home Health Providers and staff. Many times prior antimicrobial therapy does not get communicated, and new antibiotic therapy is started. The frequent changing of therapy has lead to organisms becoming Multi-Drug Resistant. Nurses are the front-line force in patient care and we need to be protecting our patients from potentially dangerous therapies. A complete medication history is needed for every patient we care for, and must include all prior therapies. Through comprehensive care management, coordination, and education, nurses can save lives.

If you would like to contact NNA or President Lamprecht, please call 775-747-2333 or email nvnursesassn@mvqn.net.

NNA’s Dr. Elizabeth Fildes Elected to the American Nurses Association Board of Directors

Dr. Elizabeth Fildes, Vice-President of the Nevada Nurses Association for the past 4 years, was elected to the American Nurses Association Board of Directors on Saturday, June 25, at the ANA Membership Assembly in Washington, DC. Dr. Fildes will serve as a Director-At-Large on the Board.

This is the first time that NNA has been represented on the ANA Board. I spoke with Dr. Fildes about the advantages she sees this opportunity bringing to the Nevada Nurses Association. She feels we will gain:

1. Recognition of the work we are doing in Nevada. “The work that NNA is doing is foundational, we are growing leaders for national leadership.”

2. Elizabeth will always be introduced as from NNA, increasing our visibility nationally, especially for our work that falls under Healthy Nurse, Healthy Nation, and on other projects that are in sync with national priorities, such as lateral violence. Dr. Fildes indicates that Nevada is already valued for collaboration, for passing autonomous practice and safe staffing. She feels that will grow as the country learns more about us.

3. Elizabeth looks forward to this opportunity for learning and professional development. She expects to learn much about the national picture, and how to represent nurses at the national level—fill the needs of nurses nationally. She is excited about being able to access resources and connections that will benefit NNA and Nevada nurses.

Dr. Fildes believes a staff nurse in Elko or Sparks will gain the same benefits as the organization. Resources available to the association will transfer to members.

Dr. Fildes will be available through NNA. If you wish to contact Elizabeth, please call or email Margaret Curley at MCurley@nvnurses.org, 775-747-2333. You can also contact her through NNA officers and committees.

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What is the #1 reason nurses are revoked? Failing to respond to COMPLAINTS!
The Nevada Public Health Training Center (NvPHTC) provides in-person and online trainings for current and future community health workers and health professionals nationwide. The mission of the NvPHTC is to improve the competencies of aspiring and current public health professionals by researching, designing, implementing, and evaluating training programs which target prioritized educational and skill-based needs in the public health workforce. The NvPHTC is housed in the UNR School of Community Health Sciences and works collaboratively with the University of Nevada School of Medicine’s Office of Statewide Initiatives. NvPHTC engages with traditional and non-traditional public health partners throughout the state in order to conduct trainings in the key target areas of eliminating health disparities, promoting nutrition and physical activity, and the effective use of behavioral health interventions.

The NvPHTC collaborates with Project ECHO (Extension for Community Healthcare Outcomes), a collaborative model of medical education and care management that empowers clinicians to provide care and increase access to specialty treatment in rural and underserved areas. With this collaboration, the NvPHTC provides live webinars the second Tuesday of every month from 12-1 pm.

Upcoming Project ECHO webinars will include:

- July 12th 12-1 pm, Intimate Partner Violence: What is it? How Can I Help? Including how to screen, intervene, document, and provide appropriate referrals to community-based advocacy programs, by Judy Henderson
- August 9th 12-1 pm, Introduction to Disease Forecasting, by Jim Wilson

To learn more about Project ECHO Nevada, please visit: http://medicine.nevada.edu/echo/about.

The NvPHTC is part of the Western Region Public Health Training Center (WRPHTC), funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. The WRPHTC consists of works to support the public health workforce in HRSA Region 9, including: Nevada, Arizona, California, Hawaii and US Associated Pacific Islands.

The vision of the WRPHTC is to have a strong collaborative public health network and public health workforce that collectively works towards the development of healthy and public health workforce that collectively works towards the development of healthy communities in HRSA Region 9 and the Nation. The mission of the WRPHTC is to develop, provide and monitor need-based trainings for current and future community health workers and to strengthen their public health competencies. Also, the WRPHTC specifically works to provide additional expertise on nutrition, physical activity and obesity to the Public Health Learning Network.

The WRPHTC collaborates with the University of Arizona, College of Nursing to provide Continuing Nursing Education (CNE) Credits as an approved provider of CNEs by the Western Multi-State Division, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

Some of the WRPHTC current self-paced online trainings that are offered online free of charge and approved for CNE credits include:

- **Public Health Essentials Online**, an interactive module to help you learn more about public health, find where you fit in, and why you are essential for Public Health (0.91 CNE)
- **Weight Loss and Weight Management: Current Theories and Best Practices**, a four session, archived webinar series bringing together national leaders in nutrition, exercise and bariatric medicine who address what is needed to have a successful weight loss and management program for children and adults in family and community practice settings (each session individually approved for 1.0 CNE)
- **Tools and Approaches to Optimizing Nutrition Education**, Participants will learn strategies to make nutrition education more meaningful and effective in their communities (0.58 CNE)

Take advantage of the opportunity to build your skills and access these trainings and others. Please visit us at: WRPHTC webpage: http://wrphtc.arizona.edu/

- WRPHTC Facebook: https://www.facebook.com/arizonaPHTC
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Antibiotic Stewardship: A Call to Action!

Norman Wright, RN, MS

According to the CDC, “Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics and at least 23,000 people die each year as a direct result of these infections.”

APIC (Association of Professionals in Infection Control) states, “Misuse and overuse of antimicrobials is one of the world’s most pressing public health problems. Infectious organisms adapt to the antimicrobials designed to kill them, making the drugs ineffective.”

When asked what an MDRO (Multiple Drug Resistant Organism) is, many respond - MRSA (Methicillin-Resistant Staphylococcus Aureus), or, VRE (Vancomycin-Resistant Enterococci). Beyond these well-known MDRO pathogens, the CDC also identifies urgent/serious threats as: CRE (carabapenem-resistant Enterobacteriaceae), ESBL-producing Enterobacteriaceae (Extended-Spectrum ß-lactamases), Multi-Drug Resistant Pseudomonas, and Multi-Drug Resistant Acinetobacter.

As this article was being written a news headline highlighted, “The superbug that doctors have been dreading just reached the U.S.” This headline refers to a CRE E-coli strain that is resistant to all antibiotics, even Colistin.

CRE stands for carabapenem-resistant Enterobacteriaceae. Enterobacteriaceae are a family of bacteria that include Salmonella, E.coli, Klebsiella, and Shigella. You may be thinking, “Well this pathogen is in Pennsylvania, not here.”

But consider this: All of the above listed CDC MDRO pathogens are currently present in Nevada and empiric data shows we have MDRO Acinetobacter strains resistant to all recently developed antibiotics - and they, too, are only sensitive to Colistin, an antibiotic first introduced in 1952. If Colistin resistance develops in Nevada’s Acinetobacter we now have another PDR (Pan Drug Resistant Organism) immune to all antibiotics.

The Nevada Antibacterial Stewardship Program (NVASP) is a statewide consortium of health care providers, and consumers, working together to tackle the problem. Sponsoring Organizations include, The Nevada Division of Public and Behavioral Health, The Nevada Hospital Association, HealthInsight, with additional support from the Nevada State Infectious Disease Forecast Station at UNR, Nevada APIC, MGM and other organizations.

NVASP’s mission is: “To optimize antibiotic use, improve patient outcomes and maximize resources to decrease antibiotic resistance.” To accomplish these goals NVASP strives to educate both the health care industry and consumers.

One roadblock to antibiotic stewardship is the lack of communication between Nevada’s various health care providers. Patients who are shuttled from one hospital to home health care, back to another hospital and then to a few LTC nursing facilities have little to no prior antibiotic or MDRO history communicated between the various facilities. One of NVASP’s missions is to advance the “MDRO/Antibiotic History Transfer Form,” originated by the CDC.

Mountainview Hospital has taken the initiative to “personalize” the form to Nevada and it is now being prototype tested between the hospital and participating LTAC and Long Term Care facilities. The goal is to create a communication system that all hospitals, LTC and home health agencies use across Nevada. (copy of the form to be provided)

The question is how do we, as nurses, become a part of the solution to stem the rising tide of MDRO? First we must educate ourselves about the growing MDRO danger. Second, educate other nurses, physicians and the patients we serve about antibiotic stewardship. Third, as intermidaries who communicate the health concerns of the patients we serve to the doctors we take orders from - we must act responsibly. This responsibility includes accurately reporting symptoms and questioning orders when they are not appropriate or if a superior treatment is available. Depending on the doctor, questioning a physicians’ order may be uncomfortable, and at times nearly impossible, but legally, and morally, as nurses we must advocate for the most appropriate treatment.

Antibiotic stewardship includes 1) ensuring that an antibiotic is truly needed, 2) absent overt life threatening symptoms do not order an antibiotic without the culture and sensitivity results, and 3) do not use antibiotics that are broad spectrum unless absolutely necessary based on the C&S results and the resistance pattern of the pathogen.

Advocating for antibiotic stewardship not only benefits the individual patient by preventing resistance in them, but it also benefits our society by forestalling and hopefully averting the creation of another MDRO.

The Nevada Division of Public and Behavioral Health (DPBH) is a primary force motivating NVASP’s goals. Kimisha Causey, our State Healthcare Associated Infection (HAI) Coordinator works along with the CDC to assist with guiding Nevada’s HAI prevention initiatives. In addition to working with the CDC, DPBH collaborates with NVASP to educate the healthcare worker population along with the general public on antibiotic stewardship, proper use of antibiotics, best practices to prevent HAIs and other topics. Together both, the Nevada Antimicrobial Stewardship Program and the Nevada Division of Public and Behavioral Health, host an annual conference for healthcare workers throughout the state. This annual training brings together healthcare workers from different disciplines to learn the latest in infection prevention and control methods to decrease MRDOs in our state.

This year’s annual conference dates are scheduled for: August 11th from 8-4:30 at Truckee Meadows Community College in Reno (7000 Dandini Blvd, Reno, NV 89512 and University of Nevada Cooperative Extension in Las Vegas (8050 Paradise Road, Las Vegas, 89123).

NVASP encourages your support and invites all nurses, and the health care agencies/organizations they are employed by, to become a part of the solution to end antimicrobial resistance.

For information on how to become involved with our initiative please visit our website: WWW.NVASP.NET.

Mr. Wright graduated with a BSN in Nursing in 1979. In 2000 he earned a Master’s Degree in Human Services Administration while working in various nursing areas until 2003 when he became the Infection Preventionist at a 180 bed long term care facility located in New Jersey. In 2007 he became the Director of Nursing and continued to work as a DON in NJ LTC facilities until 2013 when he moved to Nevada. Returning to his infection prevention roots he currently works as Director of Infection Prevention at Royal Springs Health Care, a 225 bed LTC facility located in Las Vegas.
The Nevada Nurses Association was honored to host American Nurses Association President Pam Cipriano when she visited Nevada on May 14. We started out the day with a breakfast at the home of Dr. Elizabeth Fildes for Dr. Cipriano and NNA, NNF, NVSNA, and southern Nevada nurse leaders.

At lunchtime, Nevada State College Student Nurses Association hosted an area-wide event for students and faculty to meet with Dr. Cipriano. She gave an interesting and provocative talk about Safety360, the ANA initiative for 2016, then spent time becoming acquainted with students and faculty. Many thanks to the NSC SNA and Dr. Rosenberg for making this possible.

In the evening, Dr. Cipriano was the keynote speaker for the Future of Nursing in Nevada Awards dinner, and helped to recognize the 40 under 40 winners, as well as the Professional Progression Awards winners.

We at NNA are grateful to President Cipriano for taking time out of her very busy schedule to visit Nevada and celebrate Nurses Week with us. She is an outstanding leader and made us all proud that she is representing us.
Student Corner

Where Imaginations and Journeys Meet!
NSNA National Convention
Orlando, FL

Karen Bearer, MA Ed, BSN, RN

On March 29th – April 3rd four College of Southern Nevada (CSN) nursing students Mayra Rivera, David Alvarez, Dawn Gonzalez, and Regie Layog and a faculty advisor Karen Bearer presented at the National Student Nurses’ Association (NSNA) Convention in Orlando, FL. This year the national convention was attended by 2,793 nursing students and over 300 faculty members from across the country. Students had the opportunity to network with students and faculty, visit with hiring hospitals, meet leaders of various nursing organizations. This included meeting and talking with the current President of the Hispanic Nurses’ Association, Daniel M. Suarez. The students attended meetings and workshops on multiple topics such as disaster preparedness, improving their writing skills, how to build their career and resume writing, weaving NSNA into curriculum, and pharmacology. They also had exposure to research and projects done by other NSNA students via the poster presentations. Mayra Rivera representing CSN and the state of Nevada in the House of Delegates. CSN was one of only two schools to represent Nevada in the House of Delegates, the other being Nevada State College. This bond helped bring our students together and the decision has been made to reestablish our state chapter of NSNA. The students were able to meet with Ryan Bannan, the outgoing President of NSNA, to get his advice and support of this new endeavor.

A first in CSN School of Nursing’s history was accomplished during the convention. It was the first time CSN presented a resolution to the NSNA’s House of Delegates. The resolution presented to the NSNA was “In Support of Increasing Awareness and Education Regarding Injection Safety for Patients.” It was unanimously passed and is now adopted by the NSNA.

The students had a great experience with exposure to the running of a national organization, which they can now bring back to Southern Nevada and share with our membership.

Nurses Week at Northern Nevada Medical Center
Rob Johnston, RN

Northern Nevada Medical Center elevated Nurses Week recognition to a new level this year. Instead of co-celebrating it with Hospital Week as in the past, NNMC recognized the traditional week following Florence Nightingale’s birthday (May 9th through the 13th) to expressly focus on their Nurses’ contributions to their facility and to their profession.

Nurses were treated to a different themed complimentary breakfast every day of the week. This benefitted both night shift nurses coming off shift, as well as day shift nurses coming on. Selections from scones, oatmeal, fresh fruit, and a breakfast burrito bar provided enticing choices the entire week.

Prior to the week-long celebration, nurses were provided with a questionnaire and the option of answering a few questions on what special meanings nursing provided to them, special memories they had, other staff nurses they looked up to, or simply why they went into nursing or have stayed in nursing. These responses were collaborated with their photos and created into a scrolling power-point presentation that was projected onto a screen in the hospital’s main lobby, as well as serving as a computer screen-saver throughout the hospital for a two week period. Additionally, NNMC’s own “Nurses of Achievement” were also recognized through this same medium. This looped presentation provided poignant testimonials that keenly reflected the essence of nursing and why they were celebrating and recognizing it as a profession.

NNMC’s theme this year was “Celebrating Healing Hands.” To compliment this theme, nurses were treated to hand massages provided throughout the week. An outside bakery provided an elaborate assortment of baked goods to all nursing units. The dietary department supplied strawberry shortcake one afternoon and administration provided each nurse with a gift.

Many nurses remarked on how this week stood out from prior years. It will stand as the model for future years in recognizing and thanking nurses at NNMC.

UNR Orvis Student Poster Presentation
Patient Obesity and Nurses Perspectives

Mayra Rivera
Presenting CSN’s resolution to the House of Delegates

Amy Heston, Amanda Caudell, Josh Cardinal, Morgan Pisane

“What are the attitudes of nurses towards obese adult patients, and how does this affect their care?”

Abstract:
The field of healthcare is a profession focused on patient outcomes. Nurses are expected to play a major role in the achievement of these improved outcomes through the use of evidence-based practice and through the act of being an advocate for their patient. According to the 2014 Gallop poll, U.S. citizens trust nurses above all other professions to be both honest and ethical (Riffkin, 2014). Studies suggest, however, that obese patients’ do not perceive that they receive the same empathy and care as their average weight counterparts (Cree & Tillman, 2011). Nurses, as well, have been shown to harbor negative attitudes towards their obese patients (Mold & Forbes, 2013). Nurses represent a great influence towards the experience of patients should therefore be educated on how to provide the best possible care for this growing population. Suggestions for improving patient care include awareness of one’s own biases towards obese patients, being mindful of nonverbal communication, and encouraging these patients to seek treatment (Buxton & Snethen, 2013).

For further information regarding identifying personal bias, Yale has published a module for improving care through bias identification. The citation is listed below:


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Tracy L. Singh, RN, JD

When nurses talk about suicide, they are usually discussing their patients...signs and symptoms of depression vs. suicidal ideations, how to care for suicidal patients, and what steps are needed to prevent suicide in the in-patient setting. Rarely, however, do we speak about the fact that nurses are human too, and they struggle with the same fears, self-doubt and inscrutable despair as our patients do.

Society tends to have negative opinions of those who commit suicide; questioning their motives, asking, “How could they be so selfish?” or believing there must have been “something wrong” with them to have done such a thing. Shame can often bring people to suicide, but suicide can also bring shame to those who are left behind. This general sense of disgrace creates an oppressive environment for those who are struggling, leading them into silence and isolation.

In healthcare, there can be an even stronger stigma against those with suicidal thoughts. Nurses are held to a higher standard. They are expected to know better, to use their critical thinking skills and to keep their personal problems to themselves. Simply put, nurses must be fit to work in the full scope of nursing at all times to avoid putting their patients at risk.

In many jurisdictions, people are placed under “legal hold” for merely mentioning thoughts of self-harm...locked away from family and/or loved ones, ignored by anyone who passes by, until an evaluator eventually comes in to determine whether they may go home or must remain locked up for further evaluation and/or treatment. Little is done to actually help those in need during the initial 72-hour period; leaving them alone to sort through their emotions. Many will quickly figure out that they must take back what they may have said or explain away whatever actions they took so they can go home because anything is better than being held against their will.

Nurses are all too familiar with this scenario and in their darkest hour, instead of reaching out for help, they may prefer to suffer in silence. Many self-medicate with prescription medications, illegal drugs or alcohol as they desperately try to cope on their own. But, not everyone who contemplates suicide falls prey to mood altering substances.

Life can be cruel at times for all of us and while it may be easy to judge from the outside, no one really knows how they will respond in certain situations until they occur. Loved ones die, friends move away, children get sick, debts get too high, people are abusive...And just when nurses think matters can’t get any worse, they receive notice of a complaint...and the life they knew as a nurse comes crashing down around them.

Most nurses pending investigation are also recently terminated; some will lose their homes, get divorced, even lose their children before the nursing board is able to complete its investigation. For some, the punishment of waiting is the final outcome. This is especially true when matters are closed without disciplinary action. While awaiting their fate, nurses have reported experiencing migraines, panic attacks, gall bladder attacks, ulcers, PTSD, anxiety, sleeplessness, depression, feelings of betrayal, abandonment, loss of interest in nursing, and general hopelessness. Even when complaints are ultimately closed, nurses are often significantly impacted by the experience and some will have difficulty re-acclimating back into the nursing environment due to their sense of shame, lack of confidence and fears of further ridicule.

Nursing is not just a job; it’s a part of who we are. While nurses definitely need to learn all they can about caring for the suicidal patient, they should also be aware of the warning signs for themselves and their colleagues. We lost one of our own to suicide recently...she was a nurse for over 37 years when she was terminated and reported to the board. Within weeks, while the investigation was barely underway, she took her own life leaving her husband, children, grand-children and friends behind. This came as a shock to all who knew her and we can only hope that the tragic ending of her life can help save the lives of others.

If you or someone you know is struggling with thoughts of self-harm or suicide, please don’t hesitate to reach out for help. The Nevada State Board of Nursing accepts anonymous calls and there is a list of mental health providers available for nurses. My practice is dedicated to caring for those who care for others and our answering service is available 24/7 at (702) 444-5520. The suicide hotline is also available 24/7 at 1-877-885-4673. Nurses matter too...please be kind to yourself and others.

If you or someone you know is in crisis, please call:

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In 2013, the Centers for Disease Control and Prevention reported 41,149 people commit suicide the United States (US). Suicide was the 10th leading cause of death in 2013, with a suicide occurring approximately every 13 minutes. Suicide rates among the 15 to 24 age group was 11.1 per 100,000 population in 2013. In 2013, the State of Nevada had a suicide rate of 19.8% and ranked sixth in the US for the highest suicide rates. Prior to 2000, Nevada ranked number one in suicides for a decade. In 2015, suicide was the third leading cause of death among the 10-14 age group and second among the 15-34 age group.

Male suicide rates were four times higher than females. Among ethnic groups (non-Hispanic white, non-Hispanic black, Hispanic, Asian or Pacific Islander (API), American Indian or Alaska Native (AIAN), AIAN had the highest suicide rate for both males and females (19.5 per 100,000 population), 1.5 times the national average. It is estimated that each suicide leaves at least six bereaved survivors. Consequently, over 245,000 persons are dramatically impacted yearly, and over 6 million Americans have been affected by suicide over the last 25 years.

The cost of suicide to society is significant. In 2010, the CDC estimated suicide at $44.6 billion per year in direct medical and work-related costs. Suicide is preventable. Most often, people need to know about the available resources that focus on suicide prevention as well as provide support to survivors. Given Nevada's high ranking in suicide rates, suicide prevention education at the state and local level must increase and public awareness of the resources available for survivor support must be emphasized.

National Resources:
- National Suicide Prevention Lifeline – The 1-800-273-TALK (8255) hotline to speak with a trained counselor is available 24 hours per day, seven days per week. The website is: http://www.suicidepreventionlifeline.org.
- US Department of Health and Human Service – The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services provides a toolkit for high schools consisting of suicide facts, prevention activities, screening tools, protocols to help at risk students, after-suicide tools, and staff education and training. The website is: http://www.samhsa.gov.
- Suicide Prevention Resource Center (SPRC) – SPRC is the only federally supported suicide resource center. It is funded under SAMHSA and is dedicated to the advancement of the National Strategy for Suicide Prevention through technical assistance, training, and materials to increase the knowledge and expertise among suicide prevention practitioners and other professionals managing people at risk for suicide. SPRC also collaborates with various organizations in developing the field of suicide prevention. The website is: http://www.sprc.org.

Nevada Resources:
The Nevada Division of Public Behavioral Health, Office of Suicide Prevention has several useful resources. The website is: http://suicideprevention.nv.gov/Survivors/
- Suicide Prevention Training:
  - ASIST (Applied Suicide Intervention Skills Training) – ASIST is a two-day interactive course designed to familiarize caregivers with suicide risks, and assist them with recognizing warning signs, as well as facilitating interventions.
  - Nevada Gatekeeper Training Program – This program is designed to increase knowledge and understanding of suicide, including identifying warning signs, risk and protective factors, increasing willingness and ability to intervene with a person at risk for suicide, and identifying referral resources. Course length varies: 1 1/2 hours, 2 hours, 4 hours and 8 hours (Train the Trainer).
  - safeTALK—Suicide Alertness for Everyone – This is a 3-to 4-hour community alertness course to help participants recognize a person at risk for suicide and to ensure individual safety by providing resources to connect to a person trained in suicide first-aid interventions.

Survivor Support Groups

References:
Veterans, Guilt, and Suicide Risk

Cindy LeVee MSN, RN-BC, Clinical Nurse Leader
Veterans Health Administration

Suicidal behavior is complex, multifaceted, and linked to genetic, neurologic, psychological, social, and cultural factors (Kopacz et. al, 2016).

Guilt has been linked to risk of suicide in veterans. In one study, close to 75% of veterans who had thought about suicide said they frequently experienced guilt about having violated the precepts of their faith groups, family, God, life, or the military (Kopacz et. al, 2016).

Assessing for and addressing certain complex emotions, such as guilt and shame, is an important part of suicide prevention efforts. Guilt is defined as a “controllable psychological state that is typically linked to a specific action or behavior, which entails regret or remorse (Kopacz et. al, 2016).”

In addressing and assessing guilt in veterans at risk of suicide, clinicians should try to recognize the source and clinical implications of this emotion. As with other negative emotions, the affective component of guilt is often the result of cognitive distortions made as the person tries to make sense of what has occurred or to reconcile beliefs of right and wrong with the guilt-inducing behavior. The common cognitive errors associated with guilt include:

- Hindsight bias (a belief that one should have known what was going to happen as a result of one’s actions)
- Responsibility distortion (a belief that one’s actions directly caused an adverse event)
- Justification distortion (a belief that one’s actions were not justified by the situation)
- Wrongdoing distortion (a belief that one violated one’s own standards of right and wrong) (Kopacz et. al, 2016)

Cognitive therapy can counter the cognitive distortions that drive feelings of guilt. The goal is to guide patients to examine the evidence, process the event, and realize that their behavior was appropriate for the given situation (Kopacz et. al, 2016).

Suicidal behavior is a major cause of morbidity and mortality in the United States, and reserve military personnel and veterans account for nearly 18% of suicide deaths. By one estimate, as many as 22 veterans die by suicide each day. These rates are thought to be due to a higher incidence of mental illness in certain veteran populations relative to the general population (Kopacz et. al, 2016).

VHA has been progressive in addressing this very serious issue for the veteran population. The following are a few of the initiatives.

VA National Initiatives
- Research in suicide prevention
- Best practices in identification and treatment
- Educating employees at every level
- Partnering with community-based organizations and the armed forces
- Veterans Suicide Hotline/Chat Line

The National Veterans Suicide Prevention Hotline or Veterans Crisis Line has been a very effective tool that has helped veterans and their families who are dealing with this difficult challenge. The National Veterans Suicide Prevention Hotline was renamed the Veteran’s Crisis Line in 2011. This was to encourage not only Veterans but also, their families and friends to make the call. People who know a Veteran best may be the first to recognize emotional distress and reach out for support when issues reach a crisis point well before a Veteran is at risk of suicide.

No matter what problems you are dealing with, we want to help you find a reason to keep living. By calling 1-800-273-TALK (8255) you’ll be connected to a skilled, trained counselor at a crisis center in your area, anytime 24/7.
The suicide rate among military veterans is significantly higher than the rate in non-veterans. Statistics show that there are 17 veteran suicides a day (6205 a year) which accounts for 20% of all suicides in the U.S. (Veterans Support Organization, n.d.). Female military veterans commit suicide at six times the rate of other women. Suicide rates are usually expressed as the annual number of deaths per 100,000 people. The following table shows the rates found in a study of 173,969 suicides reported in the L.A. Times. (Zarembo, 2015)

Suicide Rates for Veterans and Non-Veterans (per 100,000 Population)

<table>
<thead>
<tr>
<th>Group</th>
<th>Veterans</th>
<th>Non-Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>32.1</td>
<td>20.9</td>
</tr>
<tr>
<td>Women</td>
<td>28.7</td>
<td>5.2</td>
</tr>
<tr>
<td>Men age 18-29</td>
<td>83.3</td>
<td>17.6</td>
</tr>
<tr>
<td>Women age 18-29</td>
<td>39.6</td>
<td>3.4</td>
</tr>
</tbody>
</table>

In the general population, women attempt suicide more often than men, but are less likely to be successful since they are more likely to use pills rather than a gun. Women veterans, however, are more likely to own a gun than are non-veterans. (Zarembo, 2015).

Some factors that probably influence the suicide rate are homelessness and substance abuse. About 33% of homeless in the U.S. are veterans (about 200,000 veterans) and 76% of them suffer from alcohol or drug abuse or mental health issues. PTSD is probably another factor and nearly 20% of veterans returning from Iraq and Afghanistan (about 300,000) have PTSD or major depression. (Veterans Support Organization, n.d.)

There are a number of resources available for veterans experiencing a crisis. All VA Medical Centers have a specially trained Suicide Prevention Coordinator as well as acute care and community-based services including mental health care. VA Outpatient Clinics provide many services including counselling. (Veterans Crisis Line, n.d.). There are VA Medical Centers in Las Vegas and Reno and community-based Outpatient Clinics in Elko, Ely, Fallon, Gardnerville, Las Vegas, and Pahrump. (U.S. Department of Veterans Affairs, n.d.). There is also a Veterans Crisis Line which promises an immediate response available at 1-800-273-8255 by pressing 1 after the answer. (U.S. Department of Veterans Affairs, 2016).

References

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Increasing suicide rates in the U.S are an urgent public health concern; suicide is the 10th leading cause of death and accounts for more lives lost than traffic accidents and homicides. In the state of Nevada, suicide is the 6th leading cause of death overall and the 2nd leading cause of death for our youth and young adults ages 10-34. Up to 45% of people who die by suicide had contact with their primary care provider (PCP) in the month prior to their death. Nurses make up a large portion of healthcare professionals in this country and most likely see patients who are considering suicide. Because of the unique relationship nurses have with patients, our part in assessing and screening of patients with suicide ideation is imperative.

The Joint Commission (formerly the JCAHO-Joint Commission on Accreditation of Healthcare Organizations) recognizing the urgency of the suicide problem, issued a Sentinel Event Alert on February 24, 2016. (https://www.jointcommission.org/sentinel_event.aspx). In summary, the Joint Commission’s aim is to assist healthcare organizations, both inpatient and outpatient, to better screen and identify, then treat and provide follow-up care to individuals with suicide ideation. The focus of the Sentinel Event Alert was on healthcare workers in the emergency, primary, and behavioral health areas, both inpatient and outpatient, and actions that could be taken to ensure workers are being trained to assess and care for patients who are at risk for suicide.

The following recommendations were brought forward by the Joint Commission on detecting and treating patients at risk for suicide.

A. Detecting suicide ideation in non-acute and acute care settings
   1. Review patient and family history of suicide risk factors
   2. Screen all patients using a brief, evidence-based tool
   3. Review the screening tool prior to the patient leaving the appointment, clinic or hospital

B. Taking immediate action and safety planning
   4. Take action based on assessment results in order to inform level of safety measures needed and provided

C. Behavioral health treatment and discharge
   5. Establish collaborative and ongoing care
   6. Improve outcomes for at-risk patients

D. Education and documentation
   7. Educate all staff in assessing for suicide ideation
   8. Document decisions regarding care

Nurses are directly impacted by patients with suicide ideation. We are often the first healthcare professionals patients see. We are with patients in acute care settings 24 hours a day, and in non-acute settings we often see patients more regularly or have more contact with them than other healthcare professionals. While this is never...
an easy subject to broach with our patients, the nature of what we do as professionals allow us to be well-positioned to meet the recommendations of the Joint Commission.

The most common evidenced-based tool for suicide ideation, the PHQ-9 (Patient Health Questionnaire 9), has been used successfully to screen for Depression. This 9 item self-administered questionnaire asks about symptoms of depression but also contains a question specifically about suicide; “thoughts that you would be better off dead or wanting to hurt yourself in some way.” The questionnaire is available in the public domain at www.phqscreeners.com/sites/q/files/g10016261/f/201412/PHQ-9_English.pdf.

Here are risk factors for suicide:
• Previous suicide attempt(s)
• History of depression or other mental illness
• Alcohol or drug abuse
• Family history of suicide or violence
• Physical illness
• Feeling alone

Here are specific ways nurses can take action to raise awareness of suicide and help in decreasing rates of suicide.
• Advocate for systems in your healthcare setting to support nurses in assessing and responding to patients with suicide ideation.
• Advocate for training on use of evidence-based screening tools to assess for suicide ideation.
• Become familiar with organizational, agency, and area resources in place to assist the patient with suicide ideation.
• Universally screen for depression
• Aggressively treat depression.
• Screen patients with key risk factors for suicide.
• Educate patients on warning signs for suicide.
• Educate patients and caregivers on reducing access to lethal means.
• Refer patients to the National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Finally, nurses need to know about resources available for patients with suicide ideation.

References

The Washoe Tribal Health Center is Now Hiring:
Registered Nurse II | Nurse Practitioner/Nursing Director
For more information about these positions, contact Ben Johnson – Health Center Director, Washoe Tribal Health Center – 775-265-8621.
Why do we dispose of medications differently?

Medications must be sorted based on their chemical make-up and properties. The Resource Conservation and Recovery Act (RCRA) has created lists of specific waste organized by their characteristics. A medication can be on more than one list. Because of the complexity of the interactions, it is vital that medications and any container with trace medication be sorted and disposed of properly.

- D-list: ignitable, corrosive, containing heavy metal (i.e. mercury, silver), or reactive.
- U-list:“toxic” chemicals
- P-list: “acutely toxic” chemicals

One of the primary criteria for including a drug on the P-list as acutely hazardous is an oral lethal dose of 50 mg/kg (LD50) or less. LD50 is the amount of a material, given all at once, which causes the death of 50% of a group of test animals. Eight chemicals on the P-list are used as pharmaceuticals (Healthcare Environmental Resource Center, 2008).

Most water treatment and sewage treatment facilities are not able to filter out medication waste (EPA, 2011). In homes or clinics that use septic tanks, prescription and over-the-counter drugs flushed down the toilet can leach into the groundwater. In cities and towns where drains are connected to main water sources, medication waste can enter streams and rivers when poured down the drain or flushed down the toilet. Medication waste can also make its way into the soil, where it can leach into groundwater.

How does the disposal method for medications matter?

Proper waste disposal of medications:
- Protects the environment, including water supplies (medicines enter streams and rivers when poured down the drain or flushed down the toilet)
- Protects people from inadvertent ingestion or exposure
- Keeps medications away from those who would misuse medications
- Protects pets and wildlife
- Protects waste handlers' health and safety
- Prevents mixing of incompatible materials
- Reduces potential for antibiotic resistance due to antibiotic presence in water

Pharmaceutical Waste Management, such as:
- Maintains regulatory compliance
- Prevents mixing of incompatible materials
- Reduces potential for antibiotic resistance
- Protects pets and wildlife
- Protects waste handlers' health and safety
- Prevents mixing of incompatible materials
- Reduces potential for antibiotic resistance due to antibiotic presence in water
- Keeps medications away from those who would misuse medications
- Protects pets and wildlife
- Protects waste handlers' health and safety
- Prevents mixing of incompatible materials
- Reduces potential for antibiotic resistance due to antibiotic presence in water

What is Pharmaceutical Waste?

Pharmaceutical waste is any type of medical waste (from animals or humans) that can also include unused medications and the containers that hold or prepare the medications (including syringes, wrappers, partially-used vials, I.V. bags, empty containers that still contain trace elements of the medication, etc.). It can be generated through IV preparation, compounding, spills or breakage, outdated products, or partially used products (Healthcare Environmental Resource Center, 2008).

What agencies deal with the disposal of pharmaceutical waste?

Many regulatory bodies oversee Pharmaceutical Waste Management, such as:
- The Environmental Protection Agency (EPA), Department of Transportation (DOT), The U.S. Drug Enforcement Administration (DEA), The Joint Commission, the Occupational Safety and Health Administration (OSHA), publically owned treatment works, state pharmacy boards, as well as state and federal laws and regulations. Healthcare facilities should have policies and procedures that are in compliance with these regulating bodies.

Does just a little bit “down the drain” or in the trash really matter?

Yes! Even very minute concentrations of certain pharmaceuticals can cause injurious effects (Healthcare Environmental Resource Center, 2008) (Snyder & Benotti, 2010). No medications should be casually discarded, but there are some medications that are specifically identified as hazardous by the Resource Conservation and Recovery Act (RCRA) (Healthcare Environmental Resource Center, 2008). Examples of commonly used drugs that are considered hazardous waste include Warfarin/Coumadin, nicotine, chemotherapy drugs, etc. Because of this they need to be managed differently than other solid waste. Many drugs are also considered endocrine disruptors, immune-suppressives, marine pollutants, potential carcinogens, and reproductive toxins (Healthcare Environmental Resource Center, 2008) (Snyder & Benotti, 2010).

How bad is the problem?

“A study conducted by the U.S. Geological Survey in 1999 and 2000 found measurable amounts of one or more medications in 80% of the water samples drawn from a network of 139 streams in 30 states. The drugs identified included a witches’ brew of antibiotics, antidepressants, blood thinners, heart medications (ACE inhibitors, calcium-channel blockers, digoxin), hormones (estrogen, progesterone, testosterone), and painkillers. Scores of studies have been done since. Other drugs that have been found include caffeine (which, of course, comes from many other sources besides medications); carbamazepine, an antiseizure drug; fibrates, which improve cholesterol levels; and some fragrance chemicals (galaxolide and tonalide) (Harvard Health Publications, 2011).”

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Most water treatment and sewage treatment facilities are not able to filter out medication waste (EPA, 2011). In homes or clinics that use septic tanks, prescription and over-the-counter drugs flushed down the toilet can leach into the ground and seep into ground water. In cities and towns where drains are connected to main water sources, medication waste can enter streams and rivers when poured down the drain or flushed down the toilet.
wastewater treatment plants, medications poured down the sink or flushed down the toilet can pass through the treatment system and enter rivers and lakes. They may flow downstream to serve as sources for community drinking water supplies (EPA, 2011)."

How much is too much in the water?
Many challenges exist with tracking pharmaceuticals in water, and knowing just “what is too much.” These include:
• Not all water treatment laboratories have the correct equipment for testing
• Data on pharmaceuticals in source drinking water is out of date (testing too infrequent)
• Safe ranges have not been established for test results for all pharmaceuticals or endocrine disrupting compounds (EDCs)

How do I dispose of medications properly?
Current regulations indicate that medications should be discarded in a way that makes them non-retrievable and chemically digested (metabolized).

Each healthcare facility should have a waste segregation plan in place. Once it is segregated, it can then be disposed of properly. An example of the waste segregation may look like this:

Medication disposal at home:
The first choice is to utilize a drug take-back program. The second choice is to dispose per EPA recommendations. A patient hand-out (figure 4) that discusses these steps can be found here: https://www.epa.gov/sites/production/files/2015-06/documents/how-to-dispose-medicines.pdf

Need more information about pharmaceutical waste management? Consider the following resources:

How to Dispose of Medicines Properly

DO:
Flush expired or unneeded prescription and over-the-counter drugs down the toilet or drain unless the label or accompanying patient information specifically instructs you to do so.

DON’T:
Return unneeded or expired prescription and over-the-counter drugs to a drug take-back program or follow the disposal instructions on the package.

1ST ROUND: DRUG TAKE-BACK EVENTS
All pharmacies of all sizes and all over the world are encouraged to take the lead and ensure that patients and consumers dispose properly.

2ND ROUND: HOUSEHOLD DISPOSAL STRATEGIES

How Proper Disposal of Medications Protects You and the Earth:

• Prevents poisoning of all beings and pets
• Decreases river and stream pollution
• Protects water bodies from receiving the wrong medicines, too much of the wrong medicine, or a medicine that should not reach the water system

How Improper Disposal of Medications May End Up in Our Drinking Water Sources

• Hydrologic factors (sediment and water), weather conditions and stream flows, and human activities can all contribute to improper disposal (a healthcare professional may also choose to dispose of certain medications before administration)
• Medications in drinking water can cause harm to humans and other living species, harm ecosystems, and affect the aquatic environment itself.


Southern Nevada Water Authority Information: https://www.snwa.com/wq/facts_pharma.html

References:


Figure 1: A simplified illustration showing how medications down the drain can end up in the water supply (full document available on figure 4; Resource list).

Figure 3: An example of waste and pharmaceutical segregation

Figure 4: Patient handouts from the EPA that discuss proper home medication disposal

Northern Nevada Water Authority Information: https://tmwa.com/
Passion, according to Webster’s Dictionary, is “a strong feeling of enthusiasm or excitement for something or about doing something.” The Nevada Nurses Foundation supports the passion to help others succeed by recognizing nurses and awarding scholarships and grants throughout Nevada. Scholarships change lives and reduce stress by offsetting financial burdens. Without the help of generous donors and the Nevada Nurses Association, the Nevada Nurses Foundation would not be able to award scholarships, honor nurses, and support the mission to increase access to quality healthcare. Four 2016 NNF Spring Scholarships, in the amount of $1,000.00, were awarded in May to several very deserving nurses and one student nurse. Congratulations to Katie Bruels attending Graceland University, Melissa Washabaugh attending Great Basin College, and Patricia Carrion, EdD, MSN/ED, MSHS, RN-BC, CRRN, attending Great Basin College, and Patricia Carrion, EdD, MSN/ED, MSHS, RN-BC, CRRN, Wallace J. Henkelman, EdD, MSN, RN, Donna B. Daniel-Collins, EdD, EdS, RN, and Debra Toney, PhD, supporting the mission to increase access to quality healthcare.

The following scholarships will be open August 1, 2016. Awards in September 2016.

$1,000.00:

- Arthur L. Davis Publishing Scholarship
- Dr. Jami-Sue Coleman Scholarship
- Donated by Ian Choe
- Southwest Medical On-Demand Scholarship donated by Eugene Somphone
- Kat Cykle Scholarship
- Martha Drohobyczzer Scholarship
- Elizabeth Fildes
- Nevada Alliiance for Nursing Excellence
- Nevada Advanced Practice Nurses Association
- Denise Ogletree Scholarship
- Olguin Scholarship
- Debra Scott Scholarship
- Sandra M. Olguin, DNP, RN
- Chief Executive Officer
- Nevada Nurses Foundation

Other:

- Two Rosemary Witt Scholarships, $300 each donated by NNA District 3
- Betty Razor Scholarship, $1,200 and growing
- Name of Scholarship??, $500 donated by Dr. Susan Michael and spouse
- Rural and Frontier Nurse Scholarship, $500 and growing
- Other named scholarships pending

On Saturday, May 14, 2016, Nevada celebrated the inaugural Future of Nursing in Nevada Awards Dinner. Leading this spectacular event was the Nevada Nurses Foundation Director, Dr. Elizabeth Fildes. Dr. Fildes removed barriers and built a cohesive and collaborative team of nurses, professional organizations, health care institutions, and community members to celebrate Nevada’s Future of Nursing. The team of nurses and student nurses are exceptional individuals who worked in concert creating a night to remember! Thank you Elizabeth Fildes and your team; David Alvarez, Patrick Argarin, Brian Barrett, Doris Bauer, Debra Collins, Margaret Curley, Katharine “Kat” Cykle, Erick De La Cruz, Jennifer Dove, Edgar Escobar, Glenn Hagerstrom, Jazmine Hammad, Mary Kuan, Peggy Lee, Erik Nunez, Denise Ogletree McGuinn, Arvin Operario, Lisa Pacheco, Lowen Patigayon, Linda Paul, Dolores Perez, Mariana Peterson, Lyle Pritchett, Jennifer Ramos, Rosemary Thuetty, and Mindy Triola.

The Nevada Nurses Foundation thanks everyone for their wonderful contributions. American Nurses Association President, Dr. Pam Cipriano’s participation as our esteemed guest, stems from her unwavering support and loyalty to nurses. Dr. Cipriano, a phenomenal leader in health care, exudes professionalism, sophistication, and expertise. What most impressed me, after spending nearly an entire day with her, was despite all of her accomplishments, awards, and success, she is a nurse first! Thank you Dr. Cipriano for your time, expertise, and support.

Future of Nursing in Nevada Event

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Thank you to the Nevada Nurses Foundation Bronze Level Sponsors ($1,000)

- Nevada State College
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Congratulations 40 Under 40 nurse leaders! Thank you for giving us a bright future!

Congratulations to the Professional Progression honored nurses. Thanks for caring enough to advance your education and the nursing profession!

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Darnell Dobbins
Dawn Zaratiegui
Deanna Ferrari-Leong
Denise Angst
Diana Rodriguez
Dolly Covert
Thank you Governor Sandoval, Senator Dean Heller, Senator Harry Reid, Honorable Carolyn G. Goodman, Assemblyman James Oscarson, and Assemblyman Tyrone Thompson for your participation. Thank you to the professional nursing organization partners.

SAVE THE DATE!

Mark your calendars for May 20, 2017 for the next Future of Nursing in Nevada Awards dinner. If you have any questions, please share them at Futures@nvnursesfoundation.org.

The 2016 NNF Big Hat High Tea packed with delightful entertainment, and decadent treats, enchanting décor, and fanciful servers is on Saturday, October 1, 2016 at the Governor’s Mansion in Carson City. Be there at noon, jump into a chalk painted picture and enjoy the experience of a High Tea with Mary Poppins. For individual/table tickets and sponsoring/advertising opportunities, please visit nvnursesfoundation.org. If you would like to more information or be involved, please contact me, Sandy Olguin at solguin@nvnurses.org.
Healthy Nevada Nurses

We appreciate our business partners who are providing significant discounts to help Nevada nurses stay healthy. Please thank them when you go in!

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[Medical Spa]
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10% discount for nurses

Renew MD Medical Spa
730 Sandhill Rd Ste 200 Reno, NV 89521
15% discount on any medical

Club Pilates Las Vegas
8665 W Flamingo Rd, Suite 118, Las Vegas NV 89147
10% discount to RN/RF readers

Club Pilates Reno
6815 Sierra Center Parkway, Suite 500 Reno, NV 89511

Orangetheory Fitness
9326 W. Sahara Suite 4, Las Vegas, NV 89117
One free initial class and special rates for nurses

Eagle Fitness
6295 Sharlars Ave. Reno NV, 775-787-8686
5265 Vista Blvd Sparks, NV, 775-626-8686
FREE joining fee and only $12.95 a month! ($79 value)
Free Kids Club and classes
No contracts
24 hour access

Orangetheory Fitness
8056 S. Virginia St. Reno, NV, 775-800-2308
$30 off the monthly membership AND $40 off their own heart monitor! Classes offered 7 days a week Results guaranteed!
https://www.youtube.com/watch?v=uav59JBTlEw

Exercise for Nurses
Casey Fry, NASM Certified Personal Trainer

There are plenty of reasons for everyone to work out on a consistent basis. Studies have shown that working out:

- Lowers our risk of heart disease
- Makes us happy by releasing endorphins
- Improves sleep
- Supports our immune system
- While working out is beneficial to all of us, it can be especially beneficial to nurses. A consistent workout routine helps you:
  - Fight stress
  - Improve energy levels
  - Prevent pain and injury
  - Set a positive example for your patients

As a nurse, you spend long hours on your feet, bending over patients or hunched over a computer. Here are a few exercises to help relieve pain and tension in the neck, shoulders and lower back.

**Wall Arm Slide**
This exercise helps relieve pain in the neck, shoulders and upper back. It also helps improve posture.
Stand with your back up against a wall. Your heels should be no more than 6 inches from the wall, your butt, upper back, arms and head should be touching the wall.
Start with your arms above your head in a “Y” shape. Take a deep inhale through your nose. As you exhale (through your nose), slide your arms down the wall by pulling your elbows in towards your ribcage. Then take another deep inhale through your nose as you slide your arms up and return to the starting position. That is one repetition.

**Glute Bridge**
This exercise helps relieve pain in the lower back and can help relieve some knee pain as well.
Lie on your back, with your knees bent and the soles of your feet flat on the ground. Your feet should be approximately 6 inches apart and the tips of your middle finger should be able to graze the back of your heels. Remove the curve in your spine by bracing your abs and lifting your pelvis forward. Inhale through your nose, as your exhale, push through your heels, bringing your hips off the ground. Squeeze your butt at the top of the movement, then inhale as you return to the starting position.

**Legs on the Wall**
This exercise helps stretch your calves, hamstrings, glutes and lower back. It also helps improve circulation, relieve lower back pain and increase energy.
Sit with one side of your body touching a wall. Roll onto your back, with your legs in the air, then rotate so the back of your legs and your butt are up against the wall and your back is on the ground, perpendicular to the wall. Tuck your chin slightly to ensure your spine is neutral. Gently push the back of your legs towards the wall throughout the exercise. You want to stay in this pose for a minimum of 5 minutes and for as long as you can.

If you would like more information on health and fitness (nutrition advice, pain relief, personal training sessions), please email me at Casey@Eighty20.fit.

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Domestic Violence Awareness and Intervention
Sandy Olguin, DNP, RN

The Nevada Network Against Domestic Violence (NNADV); Advocating change, educating the community, and supporting services. Did you know Nevada has one of the highest rates of domestic and intimate partner violence (IPV)? “No one deserves to be abused” asserts Judy Henderson, NNADV Training Coordinator. Health care providers have a responsibility to proficiently screen patients for domestic violence, incorporate evidence-based interventions, make referrals to patients who reveal domestic violence, and document in a clear and concise manner (NNADV, 2016). By participating in NNADV’s “Making the Connection: The Impact of Intimate Partner Violence on Health,” healthcare providers receive education on how to enhance the skills needed to fulfill their responsibility. If you don’t think this is a problem, I implore you to look again.

As an RNA member representative on the Nevada Healthcare Leadership Team, I heard a story of a mom dropping off her two children at daycare. Her ex-boyfriend, killed her, shot the 2 children (age 3 and 4) and then killed himself. The children survived.

Ms. Henderson asserts, “Another gruesome reminder that the most dangerous time for victims is when they leave the relationship or do anything that may move toward leaving such as getting a protection order. Her ex was involved with the criminal justice system. It is so important to refer our colleagues, our patients, friends & family to get connected with a community-based advocacy program for safety planning and receive the support they need at this difficult time.”

Being the change we wish to see in the world, transforms our world.
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- M.S. in Nursing
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  - Psychiatric Mental Health Nurse Practitioner
- DNP (Doctor of Nursing Practice)
  - BSN to DNP:
    - Nurse Practitioner Tracks
  - Post-MSN DNP:
    - Advanced Practice
    - Nurse Executive

www.unr.edu/nursing
Alarmingly, our grades dropped this year! Our state’s poor report card shows that 1 in 5 of Nevada’s 2.8 million residents is a member of a vulnerable population potentially affected by poor air quality (Figure 1). Las Vegas-Henderson is ranked the 9th most polluted city for ozone in the USA! Ozone pollution prompts exacerbations of asthma & COPD.

**Tips to Protect Yourself & Your Patients from Unhealthy Air**
The American Lung Association & NNA’s Environmental Health Committee encourages everyone to get involved in the fight for cleaner, healthier air. Here are some simple, effective tips for protecting you and your patients from the dangers of air pollution:

1. Check daily air pollution forecasts in your area.
2. Avoid exercising outdoors when pollution levels are high.
3. Always avoid exercising near high-traffic areas.
4. Use less energy in your home.
5. Encourage your child’s school to reduce school bus emissions and establish “idle-free” zones. Check out Washoe County’s Idle Free Schools Program.
6. Walk, bike or carpool. Check out Washoe County’s program “Rack Em up”
7. Don’t burn wood or trash.
8. Use battery-powered or electric lawn care equipment rather than gasoline-powered.
9. Don’t allow indoor smoking and support measures to make all public places tobacco free.

**Figure 1. Nevada’s Air Quality Report Card for 2016**

<table>
<thead>
<tr>
<th>CITY</th>
<th>High Ozone</th>
<th>Particle Pollution</th>
<th>Total Population (est. 2013)</th>
<th>Pediatric Asthma</th>
<th>Adult Asthma</th>
<th>COPD</th>
<th>CVD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carson City</td>
<td>D</td>
<td>INC</td>
<td>54,522</td>
<td>758</td>
<td>3,592</td>
<td>3,439</td>
<td>4,545</td>
</tr>
<tr>
<td>Churchill</td>
<td>A</td>
<td>No data</td>
<td>23,989</td>
<td>378</td>
<td>1,515</td>
<td>1,431</td>
<td>1,886</td>
</tr>
<tr>
<td>Clark</td>
<td>F</td>
<td>D</td>
<td>2,069,681</td>
<td>33,350</td>
<td>127,038</td>
<td>107,052</td>
<td>139,435</td>
</tr>
<tr>
<td>Lyon</td>
<td>D</td>
<td>No data</td>
<td>51,789</td>
<td>784</td>
<td>3,360</td>
<td>3,290</td>
<td>4,364</td>
</tr>
<tr>
<td>Washoe</td>
<td>F</td>
<td>F</td>
<td>440,078</td>
<td>6,684</td>
<td>27,801</td>
<td>24,139</td>
<td>31,627</td>
</tr>
<tr>
<td>White Pine</td>
<td>F</td>
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<td>10,034</td>
<td>145</td>
<td>643</td>
<td>563</td>
<td>739</td>
</tr>
</tbody>
</table>

Consider – not all counties in Nevada have air quality monitors.

**Resources**
- Washoe County Air Quality Management Division: [https://www.washoecounty.us/health/programs-and-services/air-quality/index.php](https://www.washoecounty.us/health/programs-and-services/air-quality/index.php)
- Clark County Department of Air Quality: [http://www.clarkcounty nv.gov/airquality/Pages/default.aspx](http://www.clarkcounty nv.gov/airquality/Pages/default.aspx)
- State of Nevada Division of Environmental Protection – Bureau of Air Pollution Control: [http://ndep.nv.gov/bapc/index.htm](http://ndep.nv.gov/bapc/index.htm)

**Author:** Bernadette Mae Longo, Ph.D., RN, APHN-BC
ANA Clean Air Ambassador for Nevada
Associate Professor, Orvis School of Nursing at the University of Nevada Reno

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The Grey Muse: Listen Up

Val Wedler, MSN, RN

As a nursing instructor, I often hear a more experienced nurse remind a student to listen to their gut feeling when interacting with patients. Hearing this always makes me smile. I have come to understand that although we do an excellent job of listening to our patients, as nurses we often forget to listen to ourselves. We don’t always pay enough attention to that little voice in our head that tells us when something is not progressing as it should in spite of our best efforts.

I’ll never forget a situation that happened to me as new grad where listening to my intuition and dogged persistence in finding the “right answer” altered the outcome for one of my patients. The patient was admitted with a diagnosis of dementia from an assisted living facility in a nearby town and was taking two daily medications: Plavix (history of stroke) and Depakote (history of seizures). Over a period of several weeks, we noticed that the woman’s confusion seemed to be increasing. She needed more and more hands-on assistance with activities of daily living and was often combative (very unlike her). I had a bad feeling that there was something going on with this patient that I just wasn’t seeing. According to her chart, the woman had experienced some seizure activity a few months prior to being admitted. This appeared to be due to the woman’s doctor having started her on Depakote. During that same time, the patient had also been diagnosed and treated for a urinary tract infection (UTI).

I knew from experience that older adults often present with confusion and abnormal behaviors when experiencing a UTI. A urinalysis was ordered and came back negative. I requested bloodwork to be drawn. All lab results were within normal limits except for the Depakote level, which was slightly low. The woman’s doctor adjusted her Depakote dose (usual response with this med), but still nothing changed. She continued to decline, even to the point of hallucinating and not being able to hold things in her hands (loss of fine motor reflexes). After a few more weeks, another set of labs was drawn. This time her Depakote level was within normal perimeters for an adult, yet her condition continued to deteriorate.

I began doing research on my patient’s medications – Depakote and Plavix. Although not generally listed as having adverse effects when taken together, I did find several old studies indicating that Plavix acted on Depakote by increasing its effects in some geriatric patients with the toxic side effects described being very similar to the symptoms we were seeing in my patient – despite her normal lab results. Armed with this information, I was able to convince the woman’s family and doctor to discontinue the Depakote and in retrospect, I believe it may have saved the patient’s life. Within a few weeks, the woman had completely returned to her original base-line and regained full motor function. Incidentally, the woman never had another seizure during the time that I knew her, which was a period of about five years.

I encourage nurses everywhere, to listen up! Pay heed to your gut feelings and act on them. You do make a difference. Your innate ability to act critically during a situation when something is happening with a patient that just doesn’t seem right is one of the most amazing things about the men and women who make nursing their profession.

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Ensuring A Better Death For Our Loved Ones

Alberto Hazan, MD

What if you woke up tomorrow and learned that your grandmother had been kidnapped overnight by a couple of strangers, thrown in a white van and taken to a distant warehouse where she spent the subsequent forty-five minutes being tortured before finally succumbing to her death?

Where she was repeatedly beaten in the chest, where a tube was shoved down her throat, where she was tasered with high-voltage, where a metal drill was bored into her leg, where she was stabbed multiple times in the neck, arms, and groin?

As farfetched as this scenario may seem, these theatrics are played out every day in the United States and around the world. Every year a third of a million people are transported to hospitals via ambulance for cardiac arrest. Usually, the chest compressions are initiated in the field. Either an intravenous line is started by the paramedics, often in the antecubital fossa of the elbow, or if there is nowhere to insert an IV, an intraosseous line is drilled into the proximal tibia in the leg. If the patient is in ventricular fibrillation or pulseless ventricular tachycardia, they are electrically shocked at 200 joules. If the patient is transported by an experienced paramedic, they are endotracheally intubated and given oxygen via a bag valve mask.

Once the patient reaches the hospital, the physician, nurses, and technicians will take over the resuscitation. The patient will often be given a cocktail of medications (e.g. epinephrine, atropine, bicarbonate, calcium gluconate, vasopressin, lidocaine, and/or amiodarone), none of which has ever been shown to improve clinical outcomes in cardiac arrest.

Despite all the best efforts and actions performed in the field by the paramedics—or in the emergency department by technicians, nurses, and physicians—over 95% of patients presenting in cardiac arrest will die. The majority of the remaining few who survive will end up being transferred to rehab facilities or nursing homes, some of the time in a permanent vegetative state. Within a few months, most of these survivors will end up dying of horrible infections like pneumonia, urine infections, or sepsis.

Does that sound like the way your grandmother wants to live out the remaining hours of her life?

The good news is that having a very simple conversation about end-of-life care can spare your grandparents or elderly parents from this scenario. In doing so, you can find out what their expectations, goals, and wishes are—if and when they’re ever in this situation. Some elderly family members may want every drastic measure taken to revive them despite the odds. But given the low likelihood of survival, most of them would likely choose to go peacefully.

What medical practitioners should be advocating is for everyone to have this simple conversation with their family members. It should be done early, while they’re healthy, and thoroughly, giving them all options they can take prior to succumbing to cardiac arrest.

If they decide they would not like to be taken to a hospital under any circumstances or revived, then the three following actions should be taken:

1. Fill out a DNR (Do Not Resuscitate) form. They are free, quick, and serve as orders that your physician or any medical professional must follow. Under the Patient Self-Determination Act of 1991, hospitals are mandated to honor an individual’s healthcare decisions, including issues dealing with end-of-life care.
2. Make sure your family member tells all her friends, colleagues, or anyone with whom she interacts (i.e. anyone who might be in a position to call an ambulance) about her wishes.
3. In case nobody is around to make sure her wishes are fulfilled, advise her to get some kind of marker on

Protect Yourself, Your License & Your Job

“I would like to thank Mr. Perry for handling my case. I was under investigation from the Nevada State Board of Nursing, and Mr. Perry consulted with me for free, which was very helpful seeing as I was low on money, and he advised me before I even paid the retainer, he was there for me.

“After I retained him, his law office promptly send out a letter to the Nursing Board letting them know of my representation. Two weeks after the letter was mailed to the Nursing Board the investigation was closed. I couldn’t believe it. Without Mr. Perry and his staff I don’t know where I would be right now. I did not want to lose my livelihood, and Mr. Perry was willing to fight for me and go the distance. I can’t thank him and his staff enough.”

Thank You.
[Name of Client Withheld]

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Attorney Craig K. Perry
August, September, October 2016 Nevada RNformation • Page 23

her body to help medical personnel recognize and honor her wishes. There are a wide variety of options, including commercial bracelets or necklaces with the "DNR" logo.

I do not mean to denigrate end of life care or the services provided by paramedics, technicians, nurses, and physicians. Our greatest challenge in the emergency department is to make timely decisions with very little information. We never know what kind of condition the patient was in before being brought into the ER by the ambulance. Our mindset is always to do everything possible during cardiac arrest situations, but we are well aware that this may not be the best strategy for many of our patients. In the elderly, in particular, we may be doing more harm than good.

When the chest is being compressed and oxygen is being supplemented, the patient may theoretically feel every procedure being performed to her: the pounding at her chest, the sharp needles poking her body, the electrical shock delivered at her heart. This may not be the kind of care elderly parents and grandparents want. If you’d like to learn more, we refer you to arguably the best two books written on the topic: “How We Die: Reflections on Life’s Final Chapter” by Sherwin B. Nuland and “Being Mortal: Medicine and What Matters in the End” by Atul Gawande. We all need to advocate for earlier and more thorough discussions regarding options for end-of-life care. We need to be honest with elderly loved ones when educating them about the efficacy of CPR and cardiac resuscitation. Above all, we need to consider their values and honor their last wishes.

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

### A Special Message to NNA Members

**A Call to Serve**

The NNA Election will be starting on September 1, and nominations for offices will close August 15. Ballots will again be electronic. Please consider whether this is the year you would like to participate as an elected officer in NNA.

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

**At the state level** we are seeking candidates for:

- President
- Vice-President
- Treasurer
- Director at Large (1)
- Nominating Committee (3) and
- Two representatives to the annual Member Assembly.

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
- Director-At-Large (1).

We will be happy to send you a summary of the office you’re interested in. If you’d like more information, please contact Catherine Cprato@aol.com or Margaret at nna@hdiss.net.

**In Southern Nevada – District Three**

- We are seeking candidates for:
  - Secretary
  - Treasurer
  - Director-At-Large (1).

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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### Nevada Nurses Association

**Membership Options (Check One)**

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full ANNA/ANNA Membership</td>
<td>Includes ANA membership to both NNA and the American Nurses Association (ANA) for 12 months.</td>
</tr>
<tr>
<td>F-Full Membership</td>
<td>Includes ANA membership to both NNA and the American Nurses Association (ANA) for 12 months.</td>
</tr>
<tr>
<td>Reduced Membership</td>
<td>Not employed and has an Medicare (must be a RN) and new graduate from state nursing education program, within two years of graduation.</td>
</tr>
<tr>
<td>Special Membership</td>
<td>62 years of age and over and unemployed and fully retired.</td>
</tr>
</tbody>
</table>

**State Only Membership**

- Includes state membership to NNA only for 12 months. **Does not provide membership in the American Nurses Association.**

**Annual Credit Card Payment**

- Annual Credit Card Directory Payment: $232.00 / Month $22.33 Reduced NNA/ANA Annual $131.00 / Month $11.42 Special NNA/ANA Annual $165.00 / Month $15.56 NNA State Only Annual $155.00 / Month — not applicable

**To be completed by NNA/ANA**

- State
- District
- Approved by
- Date
- Approve
- Amount
- Check #

---

**SAVE THE DATE**

Saturday, September 10th, 2016, from 8:30 am to 12:30 pm - NNA District 5’s Annual Education Summit will address “Human Trafficking and “Law and Order for Nurses: Nurses & Medical Marijuana, Drug Diversion, and Hospital Ransomware.” (4CEUs)

Mark your calendar TODAY and watch for more information on the NNA website or future NNA emails.

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