President’s Message

What does culture of safety mean to you?

Roberta Young MSN, RN, President NDNA

It is interesting to think about how many times a day a person thinks of safety. My daughter was raiding my pantry the other day and took a jar of my ‘Fall 2015 Salsa.’ She texted me wondering if it was still safe to eat. Apparently she had second thoughts! My son and husband got home from our farm quite late last week and my son was complaining of a headache. He was standing in front of our medicine cabinet trying to decide if it was safe for him to take ibuprofen since he hadn’t eaten all that much yet. I made him toast and soup just to be sure (be safe that is).

Questions and pondering about safety enter our daily lives all the time, in an unintentional manner. We are generally curious and do not want to cause harm. In professional nursing practice we are called to not only be intentional in our safety practices, but curious and passionate enough to continually improve a safe practice environment. I love visiting with nurses who stay curious in their practice. They are creative and have chosen to test their assumptions. They are interested enough to want to know “why” and “how come” and “what if?” I do believe it is a choice that contributes to a culture of safety.

One of Florence Nightingale’s quotes is a basic curiosity question: “Let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?” Notes on Nursing: What It Is, and What It Is Not (first published in 1859).

The question, “How can I provide for the right thing to be always done,” leads us to the concept of highly reliable organizations (HRO) that many of us are reading about, working on, and assessing. Below are four trademarks of a system of high reliability:

- Errors and near-misses provide valuable lessons. For example, the organization uses near-misses to reflect on the fact that there are effective safeguards in place.
- The system has a just response to human error and differentiates the unintentional actions from the intentional ones.
- The system provides for easy, de-identified reporting of unexpected events or errors so that individuals are not discouraged from reporting them. In turn, they can receive feedback and learn from the experience.
- Leaders use learnings to redesign the operations and challenge the assumptions underlying the system, with the goal of creating a safer system.

In other words, these systems are curious and relentless in studying errors and near misses in an effort to find ways to help prevent them. There is a culture of justness in the response to error with the structure to look differently on unintentional actions versus intentional disregard of a safety behavior. These systems provide for an easy way for all employees and patients to report events and near events so all can learn. This encourages active participation in making care safe. Lastly lessons are not wasted but used by leaders to design and resource novel workflows to deliver care. Leaders in these organizations do not let their underlying assumptions get in the way of implementing and testing new and innovative care that is safer.

Curiosity is honored, encouraged and expected in these safe practice environments. Today as you read this consider all the times you are curious about safety in your practice environment. Write the questions down, share with your colleagues and see what improvement plans come out of that. Congratulations! You are creating a culture of Safety.

Please consider joining the North Dakota Nurses Association. Together we can make care safer for the citizens of ND. Visit www.ndna.org.

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Vol. 85 • Number 3

August, September, October 2016

The North Dakota Nurse

The Official Publication of the North Dakota Nurses Association

Sent to all North Dakota Nurses courtesy of the North Dakota Nurses Association (NDNA). Receiving this newsletter does not mean that you are a member of NDNA. To join please go to www.ndna.org and click on “Join.”

Quarterly publication direct mailed to approximately 16,000 RNs and LPNs in North Dakota

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Official Call for Nominations for the NDNA Board of Directors 2017-2018 Term

This is the official call for nominations for the North Dakota Nurses Association Board of Directors. The 4 open positions on the board for the 2017-2018 term are President; Vice President of Finance; Vice President of Practice, Education, Administration & Research and Director at Large- New Graduate. According to the current NDNA bylaws, the description of open positions are as follows:

The President shall:
1. Serve as the official representative of the association and its spokesperson on matters of association policy and position.
2. Chair the annual meeting and the NDNA Board of Directors.
3. Serve as an ex-officio member of all task forces and ad hoc committees except the nominating committee.
4. Serve as representative to the ANA membership assembly, provided that the ballot reflects that the president will also serve in that capacity.
5. Shall serve as a representative of NDNA at ANA meetings as appropriate.
6. Serve on the Board of the North Dakota Center for Nursing.

The Vice President of Finance shall:
1. Monitor NDNA fiscal affairs.
2. Oversee NDNA’s financial policies and procedures. When appropriate, and as the position requires.
3. Oversee the implementation and interpretations of NDNA's financial policy, as required by the Annual Meeting of the membership and the NDNA Board of Directors, coordinate an annual audit or financial review.

The Vice President of Practice, Education, Administration, & Research shall:
1. Coordinate with the Vice President of Membership to develop recruitment strategies for NDNA.
2. With the President, serve as a joint liaison with the Nursing Student Association of North Dakota Board of Directors.
3. The Director at Large: Recent Graduate shall be defined as one who has graduated from their first Registered Nurse educational program within five years of being elected into office.

Your current nominating committee members are: Jami Falk RN, CNML, MS, Karla Haug MS, RN

Please contact info@ndna.org if you are interested in serving in any of the above positions or have names of nurses you would like to suggest for these leadership roles. All of the positions are 2 year terms. Each nominee will need to complete a “Consent to Serve” form.

The slate of candidates shall be solidified by August 15th, 2016. Elections will occur electronically in September. Installation of new members will take place at the NDNA Annual Meeting & Conference on October 7 & 8th in Bismarck.

Thank you for your consideration to serve!

Welcome New Members

Shawna Stowman
Lori Hodek
Kimberly Strankowski
Shari Lawrence
Margaret Miller
Christina Nicolas
Robin Hayes
Kris Kjelshus
Melissa Wagner
Jan Lynch
Biye Tambang
Connie Kadri
Bernesia Radcliffe
Natalie Tuff

Writing for Publication in The North Dakota Nurse

The North Dakota Nurse accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and submitted electronically in MS Word to director@ndna.org. Please write North Dakota Nurse in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. Deadlines for submission of material for the North Dakota Nurse are 3/17/16, 6/16/16, 9/15/16 and 12/15/16.

Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don’t know how or where to start, contact one of the NDNA Board Members.

The North Dakota Nurse is one communication vehicle for nurses in North Dakota. Raise your voice.

The Vision and Mission of the North Dakota Nurses Association

Vision: North Dakota Nurses Association, a professional organization for Nurses, is the voice of Nursing in North Dakota.

Mission: The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.
The opioid epidemic is being called the worst public health crisis in this nation’s history. One American dies every 20 minutes from an opioid overdose (Volkow, 2016). Legislators, law enforcement officers, clinicians, educators, families, and those who struggle with addiction, as well as many others struggle to find ways to manage this crisis that has already cost us so many lives. Few have a real understanding of what it means to struggle with addiction.

According to the American Society of Addiction Medicine, “Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biochemical, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or by reliance on substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death” (American Society of Addiction Medicine, 1980).

Despite our knowledge of the disease concept of addiction, in many cases, we continue to treat addiction as a crime. Treating addiction as a crime is ineffective and inhumane. President Barack Obama spoke at the National Prescription Drug Abuse and Heroin Summit in March 2016 at which time he took a stance that more resources are needed to focus on saving lives. Naloxone is a lifesaving medication that a person can administer at the time of an opioid overdose.

Many states have passed laws to expand access to Naloxone. In North Dakota, a prescription is required to obtain Naloxone. North Dakota Century Code § 23-01-42 states:

> A health care professional acting in good faith directly or by standing order prescribe, distribute, or dispense an opioid antagonist, if the health care professional provides training to:
> a. An individual at risk of experiencing an opioid-related overdose;
> b. A family member, friend, or another individual in a position to assist an individual at risk of experiencing an opioid-related overdose.

An individual who acts in good faith may receive or possess an opioid antagonist if that individual is:

- An individual at risk of experiencing an opioid-related overdose;
- A family member, friend, or another individual in a position to assist an individual at risk of experiencing an opioid-related overdose.

The Opioid Epidemic continued on page 4
Since the state convention this past winter, the Nursing Student Association of North Dakota board has been busy transitioning into their new roles and getting to know one another! Two meetings have been held and lots of changes have been made already. The first meeting took place on a beautiful February Saturday in Bismarck, where the old board members were able to attend and assist the new board in taking over the necessary duties. In March, NSAND had a few members attend the national conference in Orlando. This experience was an awesome opportunity to learn about the profession of nursing while also getting a break from the cold North Dakota weather. Another meeting was held in April via Google Hangouts, as it was a very busy time for many of the nursing students and meeting in person was not feasible. The board spent time revising the bylaws and already preparing for the upcoming state convention. We hope to organize a time during the busy summer months where we can get together and continue updating the association and preparing for the state convention. We have a very enthusiastic and passionate group that makes up the 2016 NSAND Board and are excited to make an impact on the Nurses of North Dakota!
Prone Position in Patients with ARDS

Clinical Question: In patients with Acute Respiratory Distress Syndrome (ARDS), does placing them in the prone position decrease mortality rates?

Articles: Gattinoni, L., Tognoni, G., Pesenti, A., Taccone, F., Fernandez, R., Trenchs, X., Klamburg, J., Castedo, G., Guerin, C., Reignier, J., Richard, J., Beuret, P., Guerin, C., Reignier, J., Richard, J., Beuret, P., Vagginelli, F., Miatto, C.,... Gattinoni, L. (2009) conducted a randomized control trial. Prone positioning in patients with moderate and severe acute respiratory distress syndrome or ARDS. The control-group of 1,042 patients suffering from severe acute respiratory distress syndrome or ARDS. The control group of 1,042 patients were placed in prone position while control group included twenty one patients positioned in prone position while control group included twenty one patients. The patients that were turned prone demonstrated an apparent increase oxygenation within six hours, and this increase reached statistical significance on day 3. Also, discovered was a 15% reduction in mortality in the prone group compared with supine (38% vs. 53%). Although this difference fits the projected survival advantage, it did not reach statistical significance due to the small sample size.

In addition, Taccone et al. (2009) conducted a randomized control trial at 25 different Intensive Care Unit facilities in Paris and Spain over a period of 60 days to identify if prone position while control group included nineteen patients positioned in supine position. Patients turned prone demonstrated an apparent increase oxygenation within six hours, and this increase reached statistical significance on day 3. Also, discovered was a 15% reduction in mortality in the prone group compared with supine (38% vs. 53%). Although this difference fits the projected survival advantage, it did not reach statistical significance due to the small sample size.

The included trials were somewhat diverse with variable in the severity of ARDS, the duration of the prone position, ventilation strategies, and associated treatment. Secondly, all relevant evidence may not have been included considering all the articles searched were limited to English. Lastly, the small number of trials available may have led to underestimation of the heterogeneity and less precise estimates of the pool-effect. Prone positioning is a relatively safe procedure if equipment and position change is handled with great care. Prone positioning demonstrated a reduction in mortality rates in patients with ARDS in conjunction with lung-protective strategies and longer duration of the position (>12hrs). This procedure should be prioritized, although additional large RCT’s are required to continue researching this intervention.

Fernandez et al. (2008) conducted a randomized control trial in 17 Spanish medical surgical ICUs for period of 60 days to identify if prone position with patients with ARDS decreases the mortality rate. Participants in the study were forty mechanically ventilated adult patients with ARDS with the average age 54-55. The intervention group included twenty two patients positioned in prone position while control group included nineteen patients positioned in supine position. Patients turned prone demonstrated an apparent increase oxygenation within six hours, and this increase reached statistical significance on day 3. Also, discovered was a 15% reduction in mortality in the prone group compared with supine (38% vs. 53%). Although this difference fits the projected survival advantage, it did not reach statistical significance due to the small sample size.

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Prone Position in Patients with ARDS continued on page 6

Synthesis of Evidence:
A total of five research articles were evaluated to answer the PICO question. Four article studies were randomized control trials, and one article was a meta-analysis. One of these studies included a 10 day randomized control trial done by Gattinoni et. al. (2001) involving 28 intensive care units in Italy and 2 intensive care units in Switzerland. The study focused on 304 patients; 192 patients were randomly assigned to the prone group and the other 192 patients were assigned to the supine control group. The patients that were assigned to the prone group were placed in prone position for an average of 7 hours per day. Patients in the supine group were not repositioned to their stomachs at all during their stay. Every morning each patient was assessed for respiratory and biochemical variables used to monitor patients for system failure; which was criteria determined by Acute Respiratory Distress Syndrome Network Trail of the National Heart, Lung, and Blood Institute. Data was collected by having hospital staff members assess patients every morning and fill out the set criteria. The findings of this study indicated there was no significant decrease in mortality rates. However, they did determine that placing the patient in the prone position improved oxygenation status by 70% after the first hour and may be beneficial to patients who are unable to maintain oxygenation saturation. There are not specific limitations to this study, however, they do recommend more experiments be conducted in order to provide more accurate data.

Park et al. (2015) conducted a meta-analysis of 8 randomized control trials that took place in an adult intensive care unit. A total of 2,168 patients were included in this study. The intervention group of 1,099 was placed in prone position for an average of 7 hours per day. Patients in the supine group were not repositioned to their stomachs at all during their stay. Every morning each patient was assessed for respiratory and biochemical variables used to monitor patients for system failure; which was criteria determined by Acute Respiratory Distress Syndrome Network Trail of the National Heart, Lung, and Blood Institute. Data was collected by having hospital staff members assess patients every morning and fill out the set criteria. The findings of this study indicated there was no significant decrease in mortality rates. However, they did determine that placing the patient in the prone position improved oxygenation status by 70% after the first hour and may be beneficial to patients who are unable to maintain oxygenation saturation. There are not specific limitations to this study, however, they do recommend more experiments be conducted in order to provide more accurate data.

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Lastly, a prospective multicenter randomized controlled trial conducted by Guerin (2013) over a 5 year period. Patients were recruited from 26 ICU in France and 1 in Spain. The purpose of this research was to identify if prone positioning would decrease the mortality rate in patients with ARDS versus supine positioning. The study included two groups. First group consisted of 229 patients assigned to supine positioning who remained in a semi-recumbent position during mechanical ventilation for 4 hours. The study included 237 patients assigned to the prone position who were turned to the prone position within the first hour after randomization. They were placed in a completely prone position for at least 16 consecutive hours with mechanical ventilation. In supine group, measurements were performed every 6 hours. In the prone group, measurements were taken just before the patient was turned back to the supine position, after 1 hour of prone positioning, just before the patient was turned back to the supine position, and 4 hours after the patient was returned to the supine position. A total of 31 cardiac arrest occurred in the supine group versus 16 in the prone group (P=0.02). Mortality rate at day 28 was significantly lower in the prone group than in the supine group and persisted at day 90. In conclusion, this trial showed that patients with ARDS and severe hypoxia could benefit from prone treatment when it is used early and relatively in long sessions.

Bottom Line:
Three out of the five studies concluded that there was no significant difference in regards to prone position and decreased mortality rates. The two other studies indicated a decreased mortality rate if patients with ARDS were placed in the prone position. Considering that half of the studies indicate no significant difference and the other half of the studies indicate that placing patients in the prone position does decrease the chances of mortality rates more studies need to be conducted. In conclusion, placing ARDS patients in the prone position is not going to harm them so we would recommend this intervention if our patient is not maintaining their oxygen saturation.

Implications for Nursing Practice:
Evidence suggests that we should place patients in the prone position if they are unable to maintain their oxygenation status. This may not decrease likelihood of mortality but evidence states that it will improve their oxygenation saturation. This occurs because the prone position allows the patients lungs with ARDS and severe hypoxia to be at maximum expansion. This therapy should be assessed and reassessed often, as airway and breathing are included as our top nursing priorities.
IV Catheterization Pain Analgesia

**Clinical Question:**
In adults, is bacteriostatic normal saline as effective as buffered lidocaine in decreasing pain during peripheral IV catheterization?

**Articles:**

**Synthesis of Evidence:**
Four experimental studies were analyzed as evidence regarding the PICO question, each study was examined for its credibility and validity. The studies included fit within the inclusion and exclusion criteria set by the appraisers.

The first study was a randomized, double-blind, parallel-design quasi-experiment conducted by Burke, Vercler, Bye, Desmond, and Rees (2011). It compared the patients pain rating during the IV peripheral catheterization and the type of pain analgesic used. The population studied was adults (18-80 years old) who went through the same-day surgery unit from February to May in 2008; 150 patients were enrolled in the study. The patients were split up into two groups, one group received a bacteriostatic normal saline injection prior to intravenous catheterization as a means of an analgesic; the other group received buffered lidocaine before intravenous catheterization as the other means of analgesic. Findings of the study showed that the patients who received the buffered lidocaine as the analgesic reported a lower perceived pain level. The second study appraised was a randomized control trial performed by Winfield et al (2013) in a 23-bed surgical unit. Data was collected from 94 individuals who were given either lidocaine, bacteriostatic normal saline, or topical spray analgesic prior to peripheral IV insertion. After being given one of the pain relief measures and upon IV insertion, the patients rated their pain on the Pain Analog Scale. There was no statistical difference in pain when anesthetizing the site using the above three methods. However, there was a difference in pain when the IV was inserted. The use of 1% lidocaine resulted in the least pain IV insertion when compared to topical spray. Research shows, the use of bacteriostatic normal saline (BNS) and/or lidocaine provides more effective options in controlling pain felt when starting IVs.

The third study analyzed was by Gaunter-Ritz, Speroni, and Atherton (2012) and a double blind randomized control. They tested which intradermal anesthetic was the most effective for pain relief during IV insertion using a technique. Two hundred fifty six surgical patients met the inclusion criteria and were randomly put into one of the three groups (1% lidocaine, 1% buffered lidocaine, and bacteriostatic normal saline with a benzyl alcohol preservative). The subjects were given one of the pain relief measures; the other group received buffered lidocaine. Group participants received a bacteriostatic normal saline injection in one hand and 1% buffered lidocaine in the opposite hand. Once the IV was put in place the participants were asked to rate the pain level they felt using a modified verbal descriptor scale and they were asked to select the preferred arm for future IV insertions. Research showed that inserting IV’s 1% buffered lidocaine was more effective in reducing pain compared to bacteriostatic normal saline; but bacteriostatic normal saline was effective in reducing pain and should not be ruled out.

**Bottom Line:**
After reviewing all of the studies, the findings were consistent. All studies looked at the pain control of buffered lidocaine and bacteriostatic normal saline in adults receiving peripheral IV’s. All four studies concluded that lidocaine was more effective in pain control compared to bacteriostatic normal saline; It also showed that bacteriostatic normal saline was effective in reducing pain as well.

**Implications for Nursing Practice:**
A common deterrent to providing pre-insertion analgesia is difficulty obtaining resources on the floor, the cost of lidocaine, and having to subject the patient to at least two injections. The need for the project is to improve patient I.V. satisfaction by decreasing pain ratings while using the most effective analgesic in lidocaine or bacteriostatic normal saline (BNS) while maintaining effectiveness and efficiency for nursing staff.

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**Family Nurse Practitioner**
Presentation Medical Center in Rolla, ND, is seeking a Family Nurse Practitioner to staff our clinic. A provider can expect compensation for this position to be approximately $105,000 annually. There is also the opportunity to provide additional income by working in our clinic for additional compensation. Benefits include medical, dental and vision insurance, along with malpractice insurance and reimbursement for CME. Excellent student loan repayment options are available at PNC is a NHSC facility and with a HPSP score of 30. Relocation assistance is available. Providers who apply should be ATLS, ACLS and PALS certified.

For more information about this position, contact Chris Albertson, Human Resources, at 701-477-1949 (chris.albertson@presentationmedical.com).

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Music Therapy Postoperatively for Pain Control


Synthesis of Evidence:
A prospective clinical study with two parallel groups was conducted by Vaajoki, Pietilä, Kankkunen, and Vehviläinen-Julkunen (2011). One hundred and sixty-eight men and women were randomized to an experimental group and a control group. The relaxation scores also improved. There were no major barriers in this study.

Our mission is to "enrich lives with love and compassion" and our vision is to become a care center of learning and innovation, a great place to grow in your Nursing career and utilize professional skills in bringing a daily difference in the lives of people. MSLC offers excellent benefits, shift and weekend differentials and numerous incentives, including sign-on bonuses and tuition reimbursement program. To view our current openings and details of what we have to offer, please visit our website at www.mslcc.com or contact us at 2425 Hilkhaven Ave., Bismarck, ND 58501 (701)233-9407.

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I AM ALTRU
"A small act of kindness can have a huge impact on a person’s day!"
- Bethany I Registered Nurse

What is it about Altru?

Four simple words guide the actions of our employees.
Improving Health, Enriching Life

Achieve your goal of helping others when you start your career with Altru Health System in Grand Forks, ND. Altru, a progressive, non-profit, integrated health system offers a comprehensive benefits package to all of its full and part-time employees. Altru has great nursing opportunities for experienced nurses and new graduates!

Admission Standards

- Ability to speak English
- High School Diploma or equivalent

Clinical Requirements

- Current RN license
- BLS or equivalent
- CNA preferred

- Background Check

If you are interested in a position with Altru Health System, please apply online.

Contact Information

For more information about Altru Health System, call 701.780.5107 or hr@altru.org. Altru Health System is an Equal Opportunity Employer.

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"A small act of kindness can have a huge impact on a person’s day!"
- Bethany I Registered Nurse

What is it about Altru?

Four simple words guide the actions of our employees.
Improving Health, Enriching Life

Achieve your goal of helping others when you start your career with Altru Health System in Grand Forks, ND. Altru, a progressive, non-profit, integrated health system offers a comprehensive benefits package to all of its full and part-time employees. Altru has great nursing opportunities for experienced nurses and new graduates!

Admission Standards

- Ability to speak English
- High School Diploma or equivalent

Clinical Requirements

- Current RN license
- BLS or equivalent
- CNA preferred

- Background Check

If you are interested in a position with Altru Health System, please apply online.

Contact Information

For more information about Altru Health System, call 701.780.5107 or hr@altru.org. Altru Health System is an Equal Opportunity Employer.

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Cholesterol Lowering Medication, Lifestyle Changes and their Effects on Coronary Artery Disease

Clinical question:
In adults with coronary artery disease (CAD), without a history of myocardial infarction (MI), does the risk of having an MI decrease more with the use of cholesterol lowering medications compared to lifestyle changes, alone, such as diet and exercise?

Articles:

Synthesis of evidence:
Prevention of cardiac events for adults with CAD can be facilitated by encouraging exercise and a healthy diet but sometimes lifestyle modifications aren't enough. Cholesterol-lowering medications are commonly used to decrease the amount of LDL (low-density lipoproteins, or bad cholesterol) from remaining in the blood which can help prevent MI for those with CAD. According to a survey from the *Journal of Evaluation in Clinical Practice* from 2011, 89.5% of physicians prescribe a statin medication to a patient without a history of CAD, but with risk factors.1 Additionally, 93% would prescribe a statin to those patients with a current cardiac history.1 These statistics speak loudly about the importance of cholesterol-lowering medications and their utilization in primary and secondary prevention of cardiac events. In addition to lowering LDL levels, our group found further information, through extensive research surrounding this clinical question, showing that statin medications can also help prevent clot formation and reduce inflammation in the patient's vascular system, adding to their potential cardiac benefits.2 Also, there is potential that the addition of a statin medication could add an additional three, or more, years to the life expectancy of those on statin therapy.1

Bottom line:
Often diet and exercise alone are not an effective strategy to reduce the risk of MI in patients with CAD. The gold standard is the addition of statin medications to reduce cholesterol and lipid levels in the blood. “While medication should not be viewed as a substitution for a healthy diet and exercise, statins continue to be the cornerstone of LDL-cholesterol-lowering in CAD patients.” (Karalis, Victor, Ahedor, & Lin, 2012, p. 6)

Implications for nursing practice:
It is important for nurses to recognize the risk factors and symptoms for CAD and MI, as well as the potential benefits of adding statin therapy (or other lipid-lowering medications) to the plan of care for adults with CAD. Nurses should also reiterate and further educate their patients on the importance of making effective lifestyle changes, as these measures have overall health benefits that cannot be achieved by medication therapy alone.
McDougall Retires After 51 Years in the Medical Field

Submitted by Chris Albertson

In less than a week, Peggy McDougall will leave the only profession she’s ever known. After 47 years at Rolla Hospital and 51 years in the medical field, McDougall still wasn’t sure if she would make it to the exit of April 30th, her last official day.

“I think I’ll have to take a walk to walk away out of here,” said McDougall from her office on the second floor of Presentation Medical Center, where she currently serves as the Vice President of Patient Care. McDougall’s career in health care began in 1969 as a 20-year-old Nursing Assistant at St. Andrew’s Hospital in Bottineau, where she grew up. She attended a training program at the facility and received a nursing diploma and Bachelor of Science in Nursing.

McDougall did her pediatric rotation at the Presentation Medical Center, where she currently serves as the Vice President of Patient Care. McDougall’s career in health care began in 1969 as a 20-year-old Nursing Assistant at St. Andrew’s Hospital in Bottineau, where she grew up. She attended a training program at the facility and received a nursing diploma and Bachelor of Science in Nursing.

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ANA Membership Application

For dues rates and other information, contact ANA Membership Billing Department at (800) 989-7889 or e-mail us at memberservices@ana.org

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*By signing the Monthly Electronic Payment Authorization Authorization, you authorize ANA to debit your checking account or your credit card account for the amount agreed to by you and the ANA. If you do not authorize ANA to debit your checking account or credit card account, you must provide other payment methods. ANA will charge a $1 fee for any returned checks or charges declined. If the ANA declines to charge a $1 fee for any returned checks or charges declined, the individual must agree to an account in good standing for 12 months from the date of the return. For more information, please visit www.nursing.org/finance/|

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Go to joinana.org to become a member and use the code: NDNA10

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American Nurses Association
Re-Elects President

SILVER SPRING, MD – The American Nurses Association (ANA) announced that Pamela P. Cipriano, PhD, RN, NEA-BC, FAAN has been re-elected as President of the professional association that represents the interests of the nation’s 3.6 million registered nurses (RN). The voting representatives of ANA’s Membership Assembly also elected five members to the nine-member board of directors. Terms of service begin January 1, 2017.

“For the past two years, it has been with great pride that I have led ANA, a trusted voice that represents nurses in the halls of government, protects and promotes nursing practice, and influences healthcare policy,” said Cipriano, a member of the Virginia Nurses Association.

Registered nurses are on the frontlines of providing lifesaving health care to millions of people each day and it is an honor to advocate for nurses and to lead an association committed to improving health care for all.”

The following ANA board members were re-elected: Secretary Patricia Travis, PhD, RN, CCRP, Maryland Nurses Association; Faith Marie Jones, MSN, RN, NEA-BC, Wyoming Nurses Association (two year term); and Director-at-Large, Staff Nurse Gayle M. Peterson, RN-BC, ANA Massachusetts. The newly elected board members are: Director-at-Large (one year term) Elizabeth Fildes, EdD, RN, CNE, CAHN-AP, APhN-BC, Nevada Nurses Association and Director-at-Large (two year term) Tonisha J. Melvin, MS, CRRN, NP-C, Georgia Nurses Association.

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For more information or to apply online go to: https://www.governmentjobs.com/careers/wyoming/jobs/1381747/hsdp10-04222-lead-health-facility-surveyor-cheyenne

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For info: 858.3101 or 1.800.777.0750

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