ANA-Illinois successfully hosted its second annual Professional Issues Conference and 6th annual membership assembly meeting on November 3, 2018 in Lisle/Naperville at the Hilton. This year’s programs focused on nurse advocacy and included current & relevant topics for nurses at all levels. ANA-Illinois members and other nurses from across the state came together to hear about how advocacy can take many forms and why it is important to nurses and the patients we serve. Janet Haebler MSN, RN, the Senior Associate Director, ANA State Government Affairs at the American Nurses Association began the day. Ms. Haebler lead a discussion on legislative trends impacting the profession at the state and federal level and what drives the agenda. She also shared how to be an effective advocate for the profession. The next policy issue addressed was Strategies for Nursing Professionals to Advocate On Their Own Behalf to Protect and Defend Their Nursing License. Susan Wagener JD, BSN shared with the audience an overview of the licensure disciplinary process as well as the types of actions that can lead to investigation. She shared with attendees the types of actions that can lead to investigation and their legal rights and responsibilities. The presentation also provided insight into the possible outcomes from a licensure investigation, including discipline and alternative to discipline programs, with emphasis on the nurses’ role in mitigating any potential discipline to their license. The next topic focused on the lifeline for a food insecure population. Jennifer Grenier DNP, RN-BC described the mission of The Surplus Project. The Surplus Project aims to improve the nutritional health of the community through the distribution of surplus food from hospital cafeterias to food insecure families. She emphasized how hunger affects our communities and how others, especially nurses, can get involved. Mary Foote, RN, MSN, CWCN, AP, CNS, ED. DC presented a session focused on advocacy for long term care. Advocacy for the Resident: Building a Case for Protect and Defend Their Nursing License. The presentation discussed the importance of being informed and understanding the impact of abuse and neglect on residents and the increased risk of nosocomial infections. The presentation also provided an overview of the rights of residents and the roles of nurses in protecting those rights. The last session of the day was led by Karen Kelly EdD, RN, NEA-BC and was focused around human trafficking. She explored the actions, processes, means and goals related to human trafficking for nursing education and practice. The 2nd Professional Issues Conference was a great success. Nurses stated they enjoyed the opportunity to come together to discuss topics of relevance, network, share and spend time with the exhibitors. We look forward to repeating the event next year in Springfield, Illinois at the Wyndham. We hope to see you there.
Emerging Nurse Leader awardees who provide innovation, and evidence-based practice (EBP) initiatives. To support additional scholarships and grants for nurse-license plates, we will be able Illinois Nurses Save Lives year we had over 75 applicants. With the arrival of nurses in undergraduate or graduate programs. This Foundation makes for nurses in Illinois. A grateful moment to share what a difference the INF support and finance celebrating the nurse. I’d like to take

There is much to celebrate within this tireless group of dedicated individuals. Programs for fundraising each year support and finance celebrating the nurse. I’d like to take a grateful moment to share what a difference the Foundation makes for nurses in Illinois. 11 scholarships are awarded each year to advance nurses in undergraduate or graduate programs. This year we had over 75 applicants. With the arrival of Illinois Nurses Save Lives license plates, we will be able to support additional scholarships and grants for nurse-initiated research projects, patient care quality process innovation, and evidence-based practice (EBP) initiatives. On September 13th we celebrated the 40 under 40 Emerging Nurse Leader awardees who provide compassionate, patient-centered care every day. You won’t want to miss the Holiday Gala event the second Saturday of December. An Honor a Nurse nominee will be selected as “Nurse of the Year,” raffles, and the silent auction are just some of the fun-filled events. Change is always a constant. Our Board of Directors recently appointed new members to the board and elected new leadership. The outgoing leaders have accomplished great service and fortunately we will continue to have access to these great individuals as they continue to serve as board members. Our incoming Board of Directors wear roller skates on the ground and I’m hopeful I can keep up with their action-oriented creativity, and energy.

The accomplishments of the Foundation are made possible by your support. Fundraising is is our main sustainability as we strive to continue our support of the growing professional needs of nurses. Please take a few moments to reflect, be grateful to have this foundation dedicated to you, for all it can serve. Please donate today.

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Conclusions

First, I want to thank all of you who responded to Survey 5: Staffing. The response was very gratifying and made the results more powerful. The Expert Panel on Workplace Safety will convey this report with proposed recommendations to the ANA-Illinois Board of Directors at their next meeting. The panel also invites you to send your staffing related stories to the ANA-Illinois Expert Panel on Workplace Safety, as personal accounts often deliver a greater impact than numbers.

Over 700 nurses responded to Survey 5, with 75% of respondents indicating they provide direct patient care, and 80% indicating they have access to continuing education offerings, specific to patient care, provided by their employer. This group is predominantly female (91%), between 26-39 years of age (49%). Most live (54%) and work (46%) in urban and suburban areas, earn over $50,000 (83%) annually, and have a BSN or higher degree (77%). The majority work 12-hour shifts (66%) on days (55%). Most (56%) work on Medical-Surgical and higher acuity specialty units.

Only 27% of respondents reported working in a facility that has a Staffing Committee, and only 18% report that the staffing plan is being used on their unit. Most (73%) report that they are not sure (37%) or they do not have (36%) a Staffing Committee, and predominately (81%) report that the staffing plan is not used (36%) or they are not sure (45%) if their unit uses the staffing plan.

Respondents reported being responsible for an average of 10 patients per shift, with an average of 4 additional admissions, transfers, and/or discharges. Other added responsibilities included: being charge nurse or team leader (25%), preceptor/teacher (16%), part of the code or rapid response team (10%) and providing consults or procedures (5%) for other nurses. Most (75%) work through their break time and most (63%) work overtime. The majority (55%) report their workload as higher than they are comfortable with.

Respondents predominantly (79%) report having discussions about staffing at least weekly (78%) with 25% having discussions daily. Over the past month this group reported experiencing “dangerous” staffing levels 33% of the time. When asked if it was safe to report staffing concerns, almost 70% reported feeling safe (69%) to report concerns and 31% feeling unsafe. The majority (57%) reports they have enough qualified staff to handle the number of assigned patients, with 40% indicating they do not have enough qualified staff. Over 60% of nurses feel they rarely (44%) or never (18%) feel unqualified to care for patients with specialized equipment or certain conditions. Solutions during short staffing include nurses taking a heavier load (85%), pulling in agency nurses (20%), and altering routine (19%) of care.

Over 60% of nurses feel they rarely (46%) or never (25%) have enough qualified staff to handle the number of assigned patients, with 40% indicating they do not have enough qualified staff. Most (73%) report that they are not sure (37%) or they do not have (36%) a Staffing Committee, and only 18% report that the staffing plan is being used on their unit.

Implementing a Staffing Plan

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The 4th Annual 40 under 40 Emerging Nurse Leader event recognized 40 outstanding nurses in Illinois under 40 in order to celebrate and encourage exemplary dedication to the nursing profession, dedicated service within the community and the promise to grow in leadership for the advancement of nursing in Illinois.

Building on the success of previous years, the Emerging Nurse Leaders Advisory committee reconvened to review the nominations of over 100 worthy individuals for the 2018 honors. This award is designed to recognize all levels of Illinois licensed nurses, LPNs, RNs and APNs under the age of 40 years.

Nominations were received from patients, friends, family, coworkers, employers, students, etc. Award recognition recipients reflected leadership success, exemplary leadership qualities, participation in professional associations and community service.

The advisory committee was led by Eli Heicher MSN, RN, CENP who served as emcee for the event. The remaining advisory committee team members included Dan Fraczkowski MSN, RN-BC; Brandon Hauer BSN, RN; Shannon Halloway PhD, BSN, RN; Lauren Martin RN, CEN; Stephanie Mendoza RN, MSN; and Carmen Vergara RN-BSN, MPH. The committee had a difficult time as there were so many worthy candidates for this award.

One of the primary purposes of the 40 Under 40 Award is to engage, support and develop the next generation of Illinois Nurse Leaders. The committee was truly moved to have the honor of acknowledging fellow nurses who are known change agents that help shape policy statewide and beyond. Their efforts have served to expand and grow nursing practice as well as to empower our communities. Award recipients were proudly celebrated by members of their own cohort as well as Illinois nursing leaders, and of course from their family members.

The Lisle Hilton proved to be a perfect venue to host the event. The accomplishments of each award recognition recipient can be readily viewed at the IL Nurses Foundation website.

Next year, this recognition event will again take place in Lisle at the Lisle Hilton. Please watch for further details at http://www.illinoisnurses.foundation/.

Advisory Committee Consultants: Susana Gonzalez MHA, MSN, RN, CNML, Associate Dean of Nursing Instituto College; Linda B. Roberts MSN, RN, Manager, Illinois Center for Nursing; Susan Y. Swart EdD, MS, RN, CAE, Executive Director, ANA-Illinois/Illinois Nurses Foundation/ Illinois Society for Advanced Practice Nursing
Dr. Eric Williams, president, NBNA

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SPRINGFIELD — The Illinois Board of Higher Education (IBHE) and the Illinois Nursing Workforce Center (INWC) Advisory Board are proud to acknowledge the 2018 Nurse Educator Fellow recipients, each of whom is awarded $10,000 to help promote excellence in nursing education. “It is an honor to actively support the Nurse Educator Fellows program,” said Dr. Al Bowman, executive director of IBHE. “These nurse educators are highly qualified, and Illinois is fortunate to have them in teaching roles in our state as we work toward reversing our nursing shortage.”

The recipients are using the funding to conduct research, attend and/or present study findings at a conference or for continuing education. Illinois Department of Financial and Professional Regulation, Division of Professional Regulation Director Jessica Baer said, “I would like to thank and congratulate these outstanding professionals for their dedication to educating and supporting the next generation of nurses. Their qualifications are impressive, and the specialties and projects that they are pursuing are remarkable.”

Some of those projects include collaborating with a colleague in Japan on acute coronary syndrome symptoms, research into teaching strategies, evaluating federally qualified health centers, pursuing simulation education, and researching culturally sensitive care to vulnerable populations.

The awardees were given at recognition ceremonies in Chicago and Springfield. Those attending in Chicago, left to right:

Jie Chen, PhD, RN, Northern Illinois University, DeKalb
Georgine Maisch, MSN, RN, CHSE, John A. Logan College, Marion
Carol Kostovich, PhD, RN, CHSE, Loyola University of Chicago
Tisha Goad, MSN, RN, Lake Land College, Mattoon
Kelli Nickols, DNP, APRN, FNP-BC, Morningside Valley Community College, Palos Hills
Maripat King, DNP, ACNP, RN, University of Illinois at Chicago
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Not photographed:

Jennifer Smith, MSN, MBA, RN, William Rainey Harper College, Palatine

All of the recipients continue to be employed in nursing education at the institution that nominated them for this recognition. In addition, 90 percent are employed as faculty, and 10 percent have a dual administration/faculty role.

Illinois and the nation must address the healthcare demands of a growing and aging population at the same time that many experienced nurses will be reaching retirement age. This exacerbates the demand for resources necessary to train more highly-skilled nurses in Illinois by retaining qualified faculty.

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IBHE Recognizes 2018 Nurse Educator Fellows

Those recipients attending in Springfield, left to right:

Kelly Tisdale, MSN, DNP (c), RN, Joliet Junior College
Denise Caldwell, MSN, RN, Lewis & Clark Community College, Godfrey
Ann Eckhardt, PhD, RN, Illinois Wesleyan University, Bloomington
Anne Yates Hustad, MSN, RN, CNE, PEL-CSN, Illinois Eastern-Olney Central College, Olney
Amanda Hopkins, PhD, RN, Illinois Wesleyan University, Bloomington
Orin Reitz, PhD, MBA, RN, NEA-BC, Illinois State University, Normal
Jamie Nickell, MSN, RN, Millikin University, Decatur
Pam Laskowski, MSN, PhD (c), RN, CNE, Millikin University, Decatur

Not photographed:

Jennifer Smith, MSN, MBA, RN, William Rainey Harper College, Palatine

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Illinois and the nation must address the healthcare demands of a growing and aging population at the same time that many experienced nurses will be reaching retirement age. This exacerbates the demand for resources necessary to train more highly-skilled nurses in Illinois by retaining qualified faculty.
While nursing is a profession dedicated to helping others, the highly charged nature of many of the environments in which nurses work can lead to situations where emotions boil over.

Incivility, bullying, and violence in the workplace are serious issues in nursing, with incivility and bullying widespread in all settings. Incivility is “one or more rude, discourteous, or disrespectful actions that may or may not have a negative intent behind them.” ANA defines bullying as “repeated, unwanted, harmful actions intended to humiliate, offend, and cause distress in the recipient.

Such acts of aggression – be they verbal or physical – are entirely unacceptable, whether delivered by patients or colleagues. These incidents not only have a serious effect on the wellbeing of the nurse in question but also their ability to care for their patients.

ANA seeks to protect nurses from all types of workplace conflict through various methods including advocacy, policy, and resources. We want nurses, employers, and the public to jointly create and nurture a healthy, safe, and respectful work environment in which positive health outcomes are the highest priority.

Types of violence

According to The National Institute of Occupational Safety and Health (NIOSH), there are four types of violence that nurses might face in their work environment:

1. **Criminal Intent.** The perpetrator has no relationship with the victim, and the violence is carried out in conjunction with a crime.
2. **Customer/Client.** The most common health care environment-based assault, the perpetrator is a member of the public with whom the nurse is interacting during the course of their regular duties.
3. **Worker-on-worker.** Commonly perceived as bullying, in these instances the perpetrator and victim work together – though not necessarily in the same role or at the same level.
4. **Personal relationship.** In these incidents, the victim has been targeted as a result of an existing exterior relationship with the perpetrator, with the violence taking place in the workplace.

It is important to remember that none of the scenarios above are restricted to physical violence – verbal and psychological abuse can be just as damaging to both the nurse and their ability to care for patients. All such abuse comes within the scope of ANA’s anti-workplace violence agenda.

How ANA is taking action on workplace violence

Currently, there is no specific federal statute that requires workplace violence protections, but several states have enacted legislation or regulations aimed at protecting health care workers from its effects. We support these moves by individual states, and are actively advocating further, more stringent regulation.

In 2015, we convened a Professional Issues Panel on Incivility, Bullying, and Workplace Violence to develop a new ANA position statement. You can read the full position statement here, and below are some key points:

- The nursing profession will not tolerate violence of any kind from any source;
- Nurses and employers must collaborate to create a culture of respect;
- The adoption of evidence-based strategies that prevent and mitigate incivility, bullying, and workplace violence; and promote health, safety, and wellness and optimal outcomes in health care;
- The strategies employed are listed and categorized by primary, secondary, and tertiary prevention;
- The statement is relevant for all health care professionals and stakeholders, not exclusively to nurses.

How you can make a difference

Tackling workplace violence will take a united effort. To that end, we have collated a series of promotional and educational resources that can help you and your colleagues reduce incidents in your workplace, and help create safe health care environments by advocating for change.

American Nurses Association, [www.nursingworld.org](http://www.nursingworld.org)
The Illinois Society for Advanced Practice Nursing announced the election results during the association’s 2018 annual meeting at the Midwest Conference, held in Lisle, Illinois on October 20th.

The new leadership includes advanced practice registered nurse leaders from across the state and from a variety of backgrounds.

The newly elected board members are as follows:

- Secretary: Melissa Murphey DNP, APRN, NP-C
- GR/PAC Chair: Julie Darley APRN, FNP-BC
- Membership Chair: Dawn Kunz APRN, FNP-BC, AOCN, CHPN
- CNS Rep: Kathleen Fisher DNP, APRN, CNS
- CRNA Rep: Alicia Citari MSN, APRN, CRNA
- Region 4 Chair: Wamaitha Sullivan DNP, APRN, FNP
- Region 6 Chair: Julie Rimhart APRN, CNM, WHNP-BC

The new board members will join the following directors whose terms end in October 2019:

- President: Ricki Loar PhD, APRN, CNP, FNP-BC, GNP-BC
- Vice President: Brenda Madura MS, APRN, CNM-BC
- Treasurer: James Huff APRN, CNM-BC
- Marketing Chair: Betsy Gamlin MS, APRN, AGNP-BC
- Program Chair: Patricia Hess MSN, APRN, FNP-BC
- CNM Rep: Debra Lowrance DNP, APRN, CNM, WHNP, IBCLC
- CNP Rep: April Odom APRN, FNP-BC
- Region 1 Chair: Colleen Burkart APRN, FNP-BC
- Region 2 Chair: Raechel Ferry-Rooney DNP, APRN
- Region 3 Chair: Janet Collopy APRN
- Region 5 Chair: Andrea Perkins APRN, FNP-BC
- Region 7 Chair: Lauren Hedenschiou MSN, APRN, FNP-BC

About ISAPN: Formed in 2002, the Illinois Society for Advanced Practice Nursing is a powerful network of advanced practice registered nurses who are committed to advancing the profession through education and political action. ISAPN is the leading voice of the approximately 14,000 advanced practice registered nurses in Illinois. To become a member of the Illinois Society for Advanced Practice Nursing, visit www.isapn.org.
A Perspective on Senior Nurses in the Workplace

Ellen Elpern MSN, RN

In 2006, the Robert Wood Johnson Foundation issued a report entitled “Wisdom at Work: The importance of older and experienced nurses in the workplace.” in the years since the release of this report, the concerns that were raised then are more acute now. These include:

- An aging US population that places more demands on our healthcare system.
- A growing nursing shortage precipitated by loss of Baby Boomer nurses from the workforce due to aging and retirement.
- The high costs to institutions of losing older nurses, including expenses associated with turnover and replacement.
- The impact of the loss of senior nurses’ wisdom and experience on quality of care, patient satisfaction and safety, productivity, and organizational performance.

Many of us senior and retired nurses are fortunate to enjoy good health and vitality that support a significant level of continued activity in healthcare – either as employees or volunteers. I wholeheartedly agree with those who consider baby boomers to be a large untapped pool of potential contributors to the US healthcare workforce. What is often lacking is the structure to capture the contributions we would willingly make.

Before anything else, we must get the attention of institutional leaders and decision-makers and a commitment to focusing attention on senior nurses. The support of key stakeholders is essential to successful change. Once the implications of their loss from healthcare is recognized and appreciated, strategies can be explored - some to retain nurses in the workplace up to and even beyond the usual retirement age and others to capture their contributions through volunteering.

The RWF report includes detailed discussion of ways to encourage older workers to remain in the workplace. Notable among these are those that emphasize flexibility in work practices, such as different shift options, job sharing, and extended leaves. Others involve changes in human resource practices to entice older workers such as full benefits for reduced work, phased retirement, and paid sabbaticals. Workplace modifications or redesign to allow senior nurses to manage workload and physical requirements of the job such as patient mobility equipment and lift teams are also highlighted.

Often, senior nurses wish to maintain some degree of professional involvement after retirement through volunteering. These retirees seek to continue to contribute in meaningful ways to the mission and goals of the organization through volunteer roles that capitalize on their interests and experience. Specific volunteer activities that meet these criteria are diverse as the institutions that integrate volunteers. In a hospital setting, nurse volunteer functions could include mentoring new clinicians or managers, serving on ethics committees, assisting with the gathering and writing of front line scenarios for Magnet applications, participating on clinical research teams, and monitoring for such quality indicators as handwashing and other protective precautions. In all instances, nurse volunteers are meant to complement, not replace, paid staff.

Issues raised by the Wisdom at Work document are as relevant today as when the report was released. It is my hope that nurses of all ages will consider the wisdom of integrating and maintaining senior nurses in our ranks. The stakes for not attending to this crisis are ominous.

The time to act is now.

President: Dan Fraczkowski MSN, RN
Secretary: Kathryn Serbin DNP, MS, BSN, CCM
Director: Colleen Morley MSN, RN, CMCN, ACM
Director: Kathryn A. Weigel MS, RN, GCNS

The newly elected board members are as follows:

Vice President: Karen Eggen EdD, MSN, MA, RN
Treasurer: Pam Brown PhD, RN, ANEF
Director: Stephanie Yohannan DNP, MBA, RN, NE-BC
Director: Crystal Vasquez DNP, MS, MBA, RN, NE-BC
Director: Lauren Martin RN, CEN

The new board members will join the following directors whose terms continue through October of 2019:

President: Michelle Diament MSN, RN
Secretary: Lisa Waterman RN, BSN
Director: Crystal Vasquez DNP, MS, MBA, RN, NE-BC
Director: Colleen Morley MSN, RN, CMCN, ACM
Director: Kathryn A. Weigel MS, RN, GCNS

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Openly discussing the contributions we would willingly make. Before anything else, we must get the attention of institutional leaders and decision-makers and a commitment to focusing attention on senior nurses. The support of key stakeholders is essential to successful change. Once the implications of their loss from healthcare is recognized and appreciated, strategies can be explored - some to retain nurses in the workplace up to and even beyond the usual retirement age and others to capture their contributions through volunteering.

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Pay attention to your environment—it can affect your body, mind, and spirit.

This is the ninth installment in a series of articles on wellness. You can read the earlier articles at amercianrnursetoday.com/category/wellness/101.

Environmental wellness

“Environment” doesn’t mean only the great outdoors. It may be time to review your work environment and consider the many aspects of the environment in which you work. It may be time to review or new strategies to reduce stress. You may even find opportunities to make your environment healthier, from recycling to creating a more positive work culture.

The evidence is in

Research has demonstrated that green space, such as parks, forests, and river corridors, are good for our physical and mental health. In a study by Blumenthal and colleagues, 71% of people found a reduction in depression after going for a walk outdoors, versus a 45% reduction in those who took an indoor walk. In a 2013 study, nurses and colleagues, gardening demonstrated a significant reduction in subjects’ levels of the stress hormone cortisol. And in 2016, the World Health Organization conducted a systematic review of 60 studies from the United States, Canada, Australia, New Zealand, and Europe and concluded that green space is associated with reduced obesity.

More than nature

“Environment” doesn’t mean only the great outdoors. Your environment is everything that surrounds your home, your car, your workplace, the food you eat, and the people you interact with. Nurses’ work environments contain many hazards, so we need to pay extra attention to this component of our wellness. The U.S. Department of Labor rates hospitals as one of the most dangerous places to work. In 2017, the Bureau of Labor Statistics reported that private hospital industry workers face a higher incidence of injury and illness—six cases per 100 full-time workers—than employees working in other industries traditionally considered dangerous, such as manufacturing and construction. In 2015, the most common event leading to injuries in hospitals was overexertion and bodily reaction, including injuries from moving or lifting objects. In other hospitals, those of us working with patients outside of a hospital setting are more vulnerable, too.

Improve your workplace environment

The good news is that many injuries can be prevented with proper equipment and training. For instance, almost 50% of reported injuries and illnesses among nurses and other hospital workers were musculoskeletal, many (25%) of all workers’ compensation claims for the healthcare industry in 2011), caused by overexertion from lifting, transferring, and repositioning patients. Learning safe ways to handle patients can safeguard your well-being as well as your patients’.

When we take care of our environment, we take care of ourselves. Get started with these ideas:

• Reuse it. Drink from reusable water bottles and shop with reusable bags. Glass or stainless steel water bottles are the best options, but a plastic water bottle works well, too—as long as you reuse it. Reusable shopping bags cut down on plastic bag waste. According to The Wall Street Journal, the United States goes through 100 billion plastic shopping bags annually. Evidence shows that they slowly release toxic chemicals once they get in the soil. If you use plastic bags, recycle them at your local grocery store.

• Eat local. Take advantage of farmers’ markets, community-supported agriculture, and restaurants that serve local foods. Most local foods are packed with more nutrients because they don’t have to travel long distances to reach your plate. Locally grown food also means less energy (fuel) is used to transport it to your kitchen or grocery store.

• Turn it off. Whether it’s a faucet you leave running while you brush your teeth or the TV’s that’s on when you’re not in the room, if you’re not using it, turn it off. You’ll save energy and, as a bonus, you may save money in cheaper utility bills.

• Travel light. If you can, find environmentally friendly ways to travel—walk, ride your bike, or take public transportation.

• Clean green. Using natural or homemade cleaning products is better for you, your home, your pets, and the environment. Some items to keep on hand include white vinegar, natural salt, baking soda, and lemons.

• Recycle. Most communities recycle, whether by a city-sponsored program or a local recycling location. Learn more about what you can recycle from your local solid waste authority.

Nurse.org offers these suggestions when dealing with a difficult patient:

• Avoid defensive thoughts. Remember, it’s not about you; it’s about the patient. Don’t blow up at him or her because you’re frustrated.

• Set boundaries. If someone behaves inappropriately toward you by swearing or yelling, set limits by saying, “There are certain things we allow here, and this behavior is not one of them. I’ll step out of the room to give you time to calm down.”

• Let them tell their story. Letting a patient tell you how he or she got to this point can help reduce distress and might even give you insight into the behavior. Even if you don’t agree with what the patient says, he or she will feel listened to, which can be calming.

• Realign your body language. Taking a few measured breaths to refocus your thoughts can help you calm down. Tension can create defensive body language that patients may react to negatively.

Choosing to thrive

Studies show that we thrive when surrounded by people who support our goals and want to help us succeed. We can’t always choose the people we work with, but we can consciously choose to spend more time with those friends and family members who support and uplift us.

And we can all contribute to making our physical surroundings healthier, from recycling to creating a culture of respect and gratitude. (See 6 ways you can improve your environment.) Start with a small step today—at work, at home, at school, with your family, or by volunteering in the community–to improve your environmental wellness.

The authors work at The Ohio State University in Columbus, Ohio. Megan Amaya is director of health promotion and wellness and assistant professor of clinical nursing practice at the College of Nursing and president of the National Consortium for Building Healthy Academic Communities. Bernadette Mazurek Melnyk is the vice president for health promotion, university chief wellness officer, dean and professor in the College of Nursing, professor of pediatrics and psychiatry in the College of Medicine, and executive director of the Helene Fuld Health Trust National Institute for Evidence-based Practice in Nursing and Healthcare. Susan Neale is senior writer/editor of marketing and communications in the College of Nursing.

Selected references


Implementing and Sustaining Successful Public Health Nursing Academic-Practice Partnerships

For the second year, the Illinois Healthcare Action Coalition (IHAC) Public Health Nurse (PHN) Academic-Practice Partnership Workgroup provided a day of interactive workshops. These workshops were designed to provide tangible tools to both develop and sustain academic-practice partnerships in the public health and community health settings. This annual conference was held on September 4 at Illinois Wesleyan University School of Nursing, Bloomington, Illinois, the day prior to the Illinois Public Health Association (IPHA) 77th Annual Conference. All participants received 4.0 hours of continuing education credits, which was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

The afternoon workshops were based on feedback from those who attended the October PHNL 2017 conference, which focused on building new public health and community health settings. This annual conference was held on September 4 at Illinois Wesleyan University School of Nursing, Bloomington, Illinois, the day prior to the Illinois Public Health Association 77th Annual Conference. All participants received 4.0 hours of continuing education credits, which was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

The day began with a panel discussion showcasing the academic-practice partnerships that were funded by the Illinois Nurses Foundation (INF). All projects funded pre-licensure RN students in baccalaureate or MSN-entry programs. Projects included:

- Southern Illinois University Edwardsville and the Madison County Health Department: Wellness Promotion and Screening Across the Lifespan in Madison County
- St. Xavier School of Nursing and Cook County Department of Public Health Oak Forest: Increasing Intimate Partner Violence (IPV) Awareness Among Culturally Diverse Populations in Suburban Cook County
- St. Xavier School of Nursing and St. John Fisher School: Saving Lives Through Training School Staff on Epi-Pen Administration
- Lewis University and Will Grundy Medical Clinic, Will County: Salsacie Plus

After a brief introduction of partners and project description(s), panelists provided partnership facilitators and challenges as well as lessons learned. The question and answer session was moderated by Dr. Krista Jones, University of Illinois at Chicago.

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What Do We Know About Illinois APRNs as We Move Towards Independent Practice?

Theresa Towle, DNP, FNP-BC, CNRN, Illinois Nursing Workforce Center
Board member, poster presentation at the Illinois Society of Advanced Practice Nurses annual conference, October 2018.

The Advanced Practice Registered Nurse Workforce Survey 2016 contains 2016 data on the characteristics, supply, and distribution of Illinois’ Advanced Practice Registered Nurses (APRNs). The results include data on the type of APRNs, the relative numbers of APRNs in each age group, their cultural diversity and education preparation. The data also quantifies the services APRNs provide, billing for services, and collaborative agreements with the Illinois physician(s). Survey results and reports are on the Illinois Nursing Workforce Center (INWC) website, tab: Data/Reports: http://nursing.illinois.gov/ResearchData.asp

The survey was developed by the INWC Board of Directors and is consistent with the 63 question Health Resources and Services (HRSA) National Sample Survey of Nurse Practitioners (NSSNP). The survey was conducted during the 2016 Illinois APRN license renewal period (3/14/16-5/31/16) and two additional email requests (7/29/16, 8/11/16) for participation post license renewal. Voluntary participation 26% Illinois APRNs.

**Demographics:**
- Racial and ethnic diversity has increased in younger cohorts
- Hispanic/Latino APRNs = 44% are younger than 45 years
- Black or African American APRNs = 39% are younger than 45 years
- Younger than 44 years: 29% CRNAs, 31% CNMs, 42% NPs
- Older than 55 years: 67% CNSs

**Age:**
- Younger than 44 years: 60%
- Over 55 years of age: 42%

**Gender:**
- Approximately 90% are female

**Aging Workforce:**
- 17% of respondents intend to retire in the next 10 years

**Discussions:**
- Illinois APRN workforce grew by approximately 26% since 2014. The majority of this increase can be attributed to the Certified Nurse Practitioner (NP) specialty group which increased by 30%.
- In 2008 there were 6,164 Illinois APRNs, as of January 23, 2018 there are 13,819 APRNs; a 44% increase in the total number of active APRN licenses including all APRN specialties.
- Density of Illinois NPs remain at approximately 60 per 100,000 population. APRN population over 55 years of age is 42%. The availability of APRNs to address the needs of Illinois citizens, particularly within Illinois’ 229 Health Professional Shortage Areas is a concern (Kaiser Family Foundation, 2017). Specialty areas of increased concern: Psychiatric Mental Health (PMH) NPs; Geriatric and Long Term Care NPs.
- APRNs provide direct care (82%) in a variety of ambulatory and inpatient services. Primary care, diagnosis/treatment/management, physical exams and prescribing medications and care coordination is provided.
- Most APRNs providing direct care see more than 50 patients per week and are also providers to Medicare (35%) and Medicaid (23%) recipients. In high quality and less intensive use of costly health services (DeRoche et al., 2017).
- APRN collaboration and billing practices are anticipated to change with the impact of increased practice authority in the Illinois APRN practice laws. Only 43% of APRNs bill under their own NP provider number even though most APRNs have an NPI number (92%).
- The Illinois APRN Survey 2016 results indicate low numbers of APRNs and primary care providers in the state.
- It is important to continue to recruit and train a diverse APRN workforce to address the human health care capital that will be needed in Illinois. This will be critical to low income and low access areas of the state.
- Continued data collection and focused workforce planning are vital to assure access to healthcare for all Illinois residents.

The survey report is on the Illinois Nursing Workforce Center website http://nursing.illinois.gov/ResearchData.asp

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**Figure 9: Summary of Advanced Practice Nurse (APRN) Practice Focus Specialty**

**Job Characteristics**
- Services Provided (top four)
  - Counsel and educate patients and families
  - Conduct physical exams and obtain medical histories
  - Order, perform and interpret tests, diagnostic studies
  - Prescribe drugs for acute and chronic illnesses
- Employment Setting
  - Majority (79%) of APRNs work one FT job, 31-40 hours per week, paid an annual salary
  - 30% work in a hospital setting
  - 23% work in an ambulatory setting
  - 19% work in private practice
- Prescriptive Authority
  - 77% do have prescriptive authority
  - 65% of these APRNs have a controlled substance license
  - 60% also have a DEA number
- Professional Collaboration
  - 53% responded that physicians are present 75-100% of the time
- Billing, Reimbursement
  - 92% have a NPI number (up from 73.5% in 2015)
  - 44% bill under own provider number
  - 25% receive reimbursement from Medicare,
  - 24% Medicaid 31-42% private insurance
- Earnings
  - Median income, full-time, $90,950, range. The lowest 10% earned less than $74,300, highest 10% earned more than $175,170
  - Nearly 70% receive an annual salary rather than hourly rate or percent of billing

**Limitations**
- Data were self-reported
- A total of 3 requests were sent to accrue sufficient participants
- Survey data were compared to the Illinois Department of Financial and Professional Regulation (IDFPR) licensure database for validity

**Report References**
1. Deckers, S. L. (2012). In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. Health Affairs, 31(8), 1673-1679.
Nurse-patient assignments help coordinate daily unit activities, matching nurses with patients to meet unit and patient needs for a specific length of time. If you are new to this challenge, try these eight tips as a guide for making nurse-patient assignments.

### Find a mentor
Most nurses learn to make nurse-patient assignments from a colleague. Consider asking if you can observe your charge nurse make assignments. Ask questions about what factors are taken into consideration for each assignment. Nurses who make assignments are aware of their importance and are serious in their efforts. Often, you will begin making assignments by asking questions. By asking questions, you’ll better understand how priorities are set and the thought that’s given to each assignment. This knowledge is the last piece of information you need before you can make assignments. The names of the nurses assigned to the shift can be found on the unit layout with your patient flow. Nurses typically use one of three processes—area, direct, or group—to make assignments.

### Gather your supplies (knowledge)
Before completing any nursing task, you need to gather your supplies. In this case, that means knowledge. You’ll need information about the unit, the nurses, and the patients. (See the previous step.) You may already be familiar with your unit’s layout and patient flow, but do you know the average LOS or nurse-to-patient ratios? Do you know what time of day most admissions and discharges occur or the time of certain frequently scheduled nurses? Do you know how other duties need to be covered (rapid response, on call to another unit)?

Review your unit’s policy and procedures manual for unit-specific information. (See the American Nurses Association’s ANA’s Principles for Nurse Staffing 2nd edition also an excellent resource.) The emergency department (ED) and intensive care unit (ICU) are the most common examples of units that use policies or whiteboard information. It is helpful for the framework of the assignment-making process, including staff constraints, additional duties that may interfere, and other factors. Important factors include your unit layout, unit size, and RN staff strengths.

As the charge nurse, you must communicate with other nurses and have worked with them, you’ll be able to determine who has the most and least experience, who’s been on the floor the longest, and who has specialty certifications. You’ll also want to keep in mind who the newest nurses are and who’s still on orientation.

### Decide on the process
Now that you’ve gathered the information you need, you’re ready to develop your plan for assigning nurses. This step usually combines the environment (unit physical layout, other goals will compete for consideration and priority. This is where making assignments gets difficult. You’ll need to consider continuity of care, new nurse orientation requests, and staff limitations. This includes being, fairness, equal distribution of the workload, nurse development, and workload completion.

### Make the assignments
Grab your writing instrument and pencil in that first nurse’s name. This first match should satisfy your highest priority. For example, if nurse and any other returning nurses are reassigned to the patients they had on their previous shift. If, however, you have a complex patient with a higher-than-average acuity, you just assigned your best nurse to this patient, and you’ve satisfied your highest priority, move to your next highest priority and match nurses with unassigned patients and areas.

Sounds easier than it is, though, you’ll be faced with competing priorities that aren’t easy to rate, and completing the assignments may take a few tries. You want to assign patients as you can so that you’ll be delivering safe, quality nursing care to patients. You’ll shuffle, move, and change assignments many times before you’re satisfied that you’ve maximized your priorities and the potential for positive outcomes. Congratulate yourself—the nurse-patient assignments are finally made.

### Adjust the assignments
You just made the assignments, so why do you need to adjust them? The nurse-patient assignment list is a living, breathing document. It involves people who are constantly changing—their conditions improve and deteriorate, they’re admitted and discharged, and their nursing needs can change in an instant. The assignment process requires constant evaluation and reevaluation of information and priorities. And that’s why the assignments are usually written in pencil on paper or in marker on a dry-erase board. As the charge nurse, you must communicate with patients and staff throughout the shift and react to changing needs by updating assignments. Your goal is to ensure patients receive the best care possible; how that’s accomplished can change from minute to minute.

### Evaluate success
What’s the best way to evaluate the success of your nurse-patient assignments? Think back to your priorities and goals. Did all the patients receive safe, quality care? Did you maintain continuity of care? Did the new nurse get the best orientation experience? Were the assignments fair? Measure success based on patient and nurse outcomes.

### What you need to know
Before you make decisions about nurse-patient assignments, you need as much information as possible about your unit, nurses, and patients. Common patient decision factors include:

- Admissions, discharges, transfers
- Blood products
- Chemotherapy
- Drains
- Dressing changes
- End-of-life care
- I.V. therapy
- Lines
- Medications
- Phototherapy
- Physical therapy
- Treatments
- Activities of daily living
- Bowel incontinence
- Feeding
- Total care
- Safety measures
- Airway
- Contact precautions
- Dental precautions
- Fall precautions
- Restraints
- Surveillance
- Psychosocial support
- Emotional needs
- Familial support
- Intellectual needs
- Ethnicity
- Language
- Race
- Age
- Gender
- Culture/race
- Generation/age
- Personality
- Competence
- Certification
- Experience
- Knowledge
- Knowledge/education
- Licensure
- Peers
- Orienting
- Skills
- Status
- Float (travel)

### Set priorities for the shift
The purpose of nurse-patient assignments is to provide the best and safest care to patients, but other goals will compete for consideration and priority. These goals include being, fairness, equal distribution of the workload, nurse development, and workload completion.

### Choose your process
Your nurse-patient assignment process may be dictated by unit layout, patient census, or nurse-to-patient ratio. Most nurses use one of three assignment processes.

#### Group assignment
This process involves assigning nurses and patients to areas. If you work in the emergency department (ED) or postanesthesia care unit (PACU), you likely make nurse-patient assignments this way. A nurse is assigned to an area, such as triage in the ED or beds 2 and 3 in the PACU, and then patients are assigned to each area throughout the shift.

#### Direct assignment
The second option is to assign each nurse directly to a patient. This process works best on units with a low patient census and nurse-to-patient ratio. For example, on a more acute or intensive care unit, the nurse is matched with one or two patients, so a direct assignment is made.

#### Group assignment
With the third option, you assign patients to groups and then assign the nurse to a group. Bigger units have higher nurse-to-patient ratios, and you may need to assign a group to one patient. The nurse-patient assignment process is the same, but the group is matched with the patient, and then the patient is matched with the nurse. You can also combine processes. For example, in a labor and delivery unit, you can assign one nurse to the triage area (area process) while another nurse is assigned to one or two specific patients (direct process). Unit characteristics will vary, but you can maintain the same level of nurse-patient care.
The Nursing Voice December 2018

Illinois Board of Nursing

The Illinois Department of Financial and Professional Regulation (IDFPR) Advisory Board of Nursing met on November 2, 2018. The Board of Nursing meets by IDFPR videoconference, Chicago and Springfield, six times per year, meetings are open to the public. The FY 2019 Chairperson is Catherine Miller, EdD, MS, RN, and the Vice-chairperson is Charity Cooper, MSN, CNM.

Aging of the LPN Workforce
66.7% of the LPN workforce in upper age ranges
31% between the ages of 55-64 years
21% plan to retire in one to five years

Diversity
26% Black/African American
9% Male
60% of Hispanic/Latino are less than 44 years of age.

Illinois Nursing Workforce Center
Licensed Practical Nurse Survey 2017

4,951 LPNs
17.7% of 29,541 LPNs licensed in Illinois

Decreased educational opportunities to replace retiring LPNs outside metropolitan areas
Full report is available on the IL Nursing Workforce Center website: http://nursing.illinois.gov/ResearchData.asp

Summary
Aging LPN workforce, one fifth planning to retire within 5 years
Increase diversity of LPN workforce to mirror state population
LPN distribution is lowest in rural counties

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(Please Include a Voided Check with Form)

I wish to make my monthly Nurses-PAC contribution via credit card. By signing this form, I authorize the charge of the specified contribution to Nurses-PAC on or after the 15th of each month.

I wish to make my annual lump sum Nurses-PAC contribution via credit card. By signing this form, I authorize ANA-Illinois to charge the specified contribution to Nurses-PAC via a ONE TIME credit/debit card charge.

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Signature: ____________________________________________
Date: ______________________________________________
Printed Name: _______________________________________
E-Mail: ______________________________________________
Address: _____________________________________________
City, State, Zip Code: _________________________________
Preferred Phone Number: ______________________________

Please mail completed form & check to:
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Attn: Nurses-PAC
PO Box 636
Manteno, Illinois 60950

LPN Workplace Settings
47.6% Nursing homes/extended care/assisted living environments
11% practice in home health settings
35% practicing in the nursing homes/extended care/assisted living environment plan on retiring in one to ten years

LPN Distribution
36% located in Cook County

LPN Workplace Settings
66.7% of the LPN workforce in upper age ranges
31% between the ages of 55-64 years
21% plan to retire in one to five years

Diversity
26% Black/African American
9% Male
60% of Hispanic/Latino are less than 44 years of age.

Race or Ethnicity

American 49.9%
Black or African American 26.2%
Hispanic or Latino 5.1%
Native American 0.6%
White 2.4%
Multiracial 2.3%
Other 65.1%
Patient violence: It’s not all in a day’s work

Strategies for reducing patient violence and creating a safe workplace

By Lori Locke, MSN, RN, NE-BC; Gail Bromley, PhD, RN; Karen A. Feder Sergio, DNP, MS, RN-BC, GCNS-BC

Reprinted from American Nurse Today, Volume 13, Number 5

Robert, a 78-year-old patient, requests help getting to the bathroom. When the nurse, Ellen, enters the room, Robert’s lying in bed, but when she introduces herself, he lunges at her, shoves her to the wall, punches her, and hits her with a footstool. Ellen gets up from the floor and leaves the patient’s room. She tells her colleagues what happened and asks for help to get the patient to the bathroom. At the end of the shift, Ellen has a swollen calf and her shoulder aches. One of her colleagues asks if she’s submitted an incident report. Ellen responds, “It’s all in a day’s work. The patient has so many medical problems and a history of alcoholism. He didn’t intend to hurt me. What difference would it make if I filed a report?”

These kinds of nurse-patient interactions occur in healthcare settings across the United States, and nurses all too frequently minimize their seriousness. However, according to the National Institute for Occupational Safety and Health, “...the spectrum [of violence], ranges from offensive language to homicide, and a reasonable working definition of workplace violence is as follows: violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty.” In other words, patient violence falls along a continuum, from verbal (harassing, threatening, yelling, bullying, and hostile sarcastic comments) to physical (slapping, punching, biting, throwing objects). As nurses, we must change our thinking: It’s not all in a day’s work.

This article focuses on physical violence and offers strategies you can implement to minimize the risk of being victimized.

Consequences of patient violence

In many cases, patients’ physical violence is life-changing to the nurses assaulted and those who witness it. As a result, some nurses leave the profession rather than be victimized—a major problem in this era of nursing shortages.

Too frequently, nurses consider physical violence a symptom of the patient’s illness—even if they sustain injuries—they don’t submit incident reports, and their injuries aren’t treated. Ultimately, physical and psychological insults result in distraction, which contributes to a higher incidence of medication errors and negative patient outcomes. Other damaging consequences include moral distress, burnout, and job dissatisfaction, which can lead to increased turnover. However, when organizations encourage nurses to report violence and provide education about de-escalation and prevention, they’re able to alleviate stress.

Workplace violence prevention

Therapeutic communication and assessment of a patient’s increased agitation are among the early clinical interventions you can use to prevent workplace violence. Use what you were taught in nursing school to recognize behavioral changes, such as anxiety, confusion, agitation, and escalation of verbal and nonverbal signs. Individually or together, these behaviors require thoughtful responses. Your calm, supportive, and responsive communication can de-escalate patients who are known to be potentially violent or those who are annoyed, angry, belligerent, demeaning, or are beginning to threaten staff. (See Communication strategies.)

Other strategies to prevent workplace violence include applying trauma-informed care, assessing for environmental risks, and recognizing patient triggers.

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Alarming statistics

The statistics around patient violence against nurses are alarming.

67% of all nonfatal workplace violence injuries occur in healthcare, but healthcare represents only 11.5% of the U.S. workforce.

Emergency department (ED) and psychiatric nurses are at highest risk for patient violence.

Hitting, kicking, beating, and shoving incidents are most reported.

25% of psychiatric nurses experience disabling injuries from patient assaults.

At one regional medical center, 70% of 125 ED nurses were physically assaulted in 2014.

Sources: Emergency Nurses Association (ENA) Emergency department violence surveillance study 2011; ENA Workplace violence toolkit 2010; Bates 2011; Li 2012.

Effective communication is the first line of defense against patient violence. These tips can help:

• To build trust, establish rapport and set the tone as you respond to patients.
• Meet patients’ expectations by listening, validating their feelings, and responding to their needs in a timely manner.
• Show your patients respect by introducing yourself by name and addressing them formally (Mr., Ms., Mrs.) unless they state another preference.
• Explain care before you provide it, and ask patients if they have questions.
• Be attentive to your body language, gestures, facial expressions, and tone of voice. Patients’ behavior may escalate if they perceive a loss of control, and they may not hear what you say.
• Control your emotions and maintain neutral, nonthreatening body language.
• Strive for communication that gives the patient control, when possible. Example: “Which of your home morning routines would you like to follow while you’re in the hospital? Would you like to wash your hands and face first, eat your breakfast, and then brush your teeth?”
• Offer a positive choice before offering less desirable ones. Example: “Would you prefer to talk with a nurse about why you’re upset, or do you feel as though you will be so angry that you need to have time away from others?”
• Only state consequences if you plan to follow through.
• Listen to what patients say or ask, and then validate their requests.
• Discuss patients’ major concerns and how they can be addressed to their satisfaction.

Despite these strategies, patients may still become upset. If that occurs, try these strategies to de-escalate the situation before it turns violent.

• Nonverbal communication. “I see from your facial expression that you may have something you want to say to me. It’s okay to speak directly to me.”
• Challenging verbal exchange. “My goal is to be helpful to you. If you have questions or see things differently, I’m willing to talk to you more so that we can understand each other better, even if we can’t agree with one another.”
• Perceptions of an incident or situation. “We haven’t discussed all aspects of this situation. Would you like to talk about your perceptions?”

Trauma-informed care

Trauma-informed care considers the effects of past traumas patients experienced and encourages strategies that promote healing.

The Substance Abuse and Mental Health Services Administration says that a trauma-informed organization:

• realizes patient trauma experiences are widespread
• recognizes trauma signs and symptoms
• responds by integrating knowledge and clinical competencies about patients’ trauma
• resists retraumatization by being sensitive to interventions that may exacerbate staff-patient interactions.

This approach comprises six principles: safety; trustworthiness and peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. Applying these principles will enhance your competencies so that you can verbally intervene to avoid conflict and minimize patient retraumatization. For more about trauma-informed care, visit samhsa.gov/ntic/trauma-interventions.

Communication strategies

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• Perceptions of an incident or situation. “We haven’t discussed all aspects of this situation. Would you like to talk about your perceptions?”
Advocate for the workplace you deserve

Physically violent patients create a workplace that’s not conducive to compassionate care, creating chaos and distractions. Nurses must advocate for a culture of safety by encouraging their organization to establish violence-prevention policies and to provide support when an incident occurs.

You can access violence-prevention resources through the American Nurses Association, Emergency Nurses Association, Centers for Disease Control and Prevention, and the National Institute for Occupational Safety and Health. Most of these organizations have interactive online workplace violence-prevention modules. (See Resources.) When you advocate for safe work environments, you protect yourself and can provide the care your patients deserve.

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Selected references
Occupational Safety and Health Administration. Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. 2016. osha.gov/Publications/osha 3148.pdf
Substance Abuse and Mental Health Services Administration. Trauma-informed approach and trauma-specific interventions. Updated 2015. samhsa.gov/nctic/trauma-interventions

Patient triggers

Recognizing and understanding patient triggers may help you de-escalate volatile interactions and prevent physical violence.

Common triggers:
• Expectations aren’t met
• Perceived loss of independence or control
• Upsetting diagnosis, prognosis, or disposition
• History of abuse that causes an event or interaction to retraumatize a patient

Predisposing factors:
• Alcohol and substance withdrawal
• Psychiatric diagnoses
• Trauma
• Stressors (financial, relational, situational)
• History of verbal or physical violence

Environmental risks

To ensure a safe environment, identify objects in patient rooms and nursing units that might be used to injure someone. Chairs, footstools, I.V. poles, housekeeping supplies, and glass from lights or mirrors can all be used by patients to hurt themselves or others. Remove these objects from all areas where violent patients may have access to them.

What should you do?

You owe it to yourself and your fellow nurses to take these steps to ensure that your physical and psychological needs and concerns are addressed:
• Know the definition of workplace violence.
• Take care of yourself if you’re assaulted by a patient or witness violence.
• Discuss and debrief the incident with your nurse manager, clinical supervisor, and colleagues.
• Use the healthcare setting’s incident reporting to report and document violent incidents and injuries.
• File charges based on your state’s laws.

Your organization should provide adequate support to ensure that when a nurse returns to work after a violent incident, he or she is able to care for patients. After any violent episode, staff and nurse leaders should participate in a thorough discussion of the incident to understand the dynamics and root cause and to be better prepared to minimize future risks. Effective communication about violent patient incidents includes handoffs that identify known risks with specific patients and a care plan that includes identified triggers and clinical interventions.

Influence organizational safety

You and your nurse colleagues are well positioned to influence your organization’s culture and advocate for a safe environment for staff and patients. Share these best practices with your organization to build a comprehensive safety infrastructure.
• Establish incident-reporting systems to capture all violent incidents.
• Create interprofessional workplace violence steering committees.
• Develop organizational policies and procedures related to safety and workplace violence, as well as human resources support.
• Provide workplace violence-prevention and safety education using evidence-based curriculum.
• Design administrative, director, and manager guidelines and responsibilities regarding communication and staff support for victims of patient violence and those who witness it.
• Use rapid response teams (including police, security, and protective services) to respond to violent behaviors.
• Delineate violence risk indicators to proactively identify patients with these behaviors.
• Create scorecards to benchmark quality indicators and outcomes.
• Post accessible resources on the organization’s intranet.
• Share human resources contacts.

Resources
• American Nurses Association (ANA) (goo.gl/1kBsPW): Learn more about different levels of violence and laws and regulations, and access the ANA position statement on incivility, bullying, and workplace violence.
• Centers for Disease Control and Prevention (cdc.gov/niosh/topics/vio-lence/training_nurses.html): This online course ("Workplace violence prevention for nurses") is designed to help nurses better understand workplace violence and how to prevent it.
• Emergency Nurses Association (ENA) toolkit (goo.gl/loU75b): This toolkit offers a five-step plan for creating a violence-prevention program.
• The Joint Commission Sentinel Event Alert: Physical and verbal violence against health care workers (bit.ly/2vRbFw): The alert, released April 17, 2018, provides an overview of the issue along with suggested strategies.
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