The North Dakota Nurse

NDNA
NORTH DAKOTA NURSES ASSOCIATION

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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 18,000 RNs and LPNs in North Dakota

Vol. 88 • Number 1 **January, February, March 2019**

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Message from the President

Falling in Love with Nursing

Tessa Johnson

Greetings nurses of North Dakota!! As we have moved into a new year and soon a new month of hearts and love, let's talk about falling in love with the nursing profession. I feel that in order to continue to be successful in our nursing careers, it is important to remember why we felt the passion for nursing to begin with. Although you can't expect to love every aspect of your job, you should expect to get fulfillment from your career. If you're not, maybe your job isn't the problem. Maybe you just need a little career resuscitation to turn things around. (Borgatti, 2007). If you have had this happen or you feel as though you want to regain your love, let's talk about some ways to do so.

First, it is important to determine where the love lost started. Is it your workplace? If it is, then be an advocate and work to make it better. If it is the area in nursing in which you work, you can change that!! Be sure to look within and LOVE yourself.

Going further, start with refocusing on the big picture. We must understand that (in ways you can't see or even imagine) you've forever touched and changed the lives of the patients you've cared for. According to Borgatti (2007), "The ability to touch and heal another person is a gift that's available to few people in other professions, who struggle to find meaning in what they do." Another thing to consider and always remember: we must communicate clearly and ask for what we need. We tend to immediately have dissatisfaction instead of communicating our needs and feelings. Your colleagues and supervisors can't read your mind. To get more of what you want and less of what you don't want, learn to communicate in a clean, neutral way. Let's say you consistently wind up with the more difficult patient assignments. Could you assume your boss does that because you're the most clinically experienced nurse on the unit—not because she's the devil incarnate? Consider looking at things differently and in a more positive light.

Lastly, I encourage you to always remember to find your true north. This will almost always help you find and redefine your love for your career. A large part of how we judge ourselves, our worth, our success, and our happiness hinges on how other people see us. But true success, true happiness, and true job satisfaction are determined from within, by your inner compass (Borgatti, 2007).

You own your life, your choices and your career you must follow a true north, because it never changes (much like your core values). According to Borgatti (2007), "We must know the difference between true north and compass north. Unlike true north, compass north is affected by the earth's magnetic pull. In life, compass north is the magnetic pull of "you should do this" and "you ought to do that" messages." In conclusion, if we can learn to follow our own inner loves and passions and carry that through to our work, we are bound to regain or continue to find the love in our nursing careers.

Be well, we need all of you!!!

Borgatti, J. (2007). Learning to love your job. *American Nurse Today, 2*(2). Retrieved November 28, 2018, from https://www.americannursetoday.com/learning-to-love-your-job/.

Member Spotlight

This issue's member spotlight is Halley Maas, BSN, RN who is a member and also VP of Government Relations for NDNA.

Kayla Kaizer, BSN, RN, VP of Communications

Please tell us about your nursing career?

I graduated from the University of North Dakota with my RN, BSN. I worked as a Nurse Intern on the Cardiac and Intermediate Care Unit at Essentia Health for one year before I was hired full-time as Registered Nurse back in July. I am starting a new venture and will be working as a Medical Spa Nurse at Hair Success in Fargo, ND while still working PRN at the hospital. This spring, I will be going back to school to obtain my MSN and become a Family Nurse Practitioner. My passion lies within dermatology and aesthetics. I enjoy helping people achieve their optimal wellness inside and out, which is why I have decided to pursue my graduate studies.

Member Spotlight of Halley Maas continued on page 7

Nurses on Boards Open Spots Available!!

The Nurses on Boards Coalition (NOBC) represents national nursing and other organizations working to build healthier communities in America by increasing nurses' presence on corporate, health-related, and other boards, panels, and commissions. The coalition's goal is to help ensure that nurses are at the table filling at least 10,000 board seats by 2020, as well as raise awareness that all boards would benefit from the unique perspective of nurses to achieve the goals of improved health, and efficient and effective health care systems at the local, state, and national levels.

North Dakota is doing well and we want to keep the momentum going! We are seeking nurses to join our state group. Be a part of all nurses being counted and making a difference in improving health for all.

https://www.nursesonboardscoalition.org/

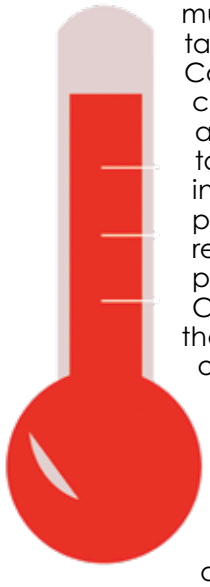
*If you are interested in joining our state coalition, please email Sherri Miller at director@ndna.org

*If you are nurse and want to serve on a board, https://www.nursesonboardscoalition.org/i-want-to-serve/

NURSES BE COUNTED

Nurses have been the nation's most trusted profession for the past 16 years - let's bring their voices to the boardroom.

Every day, nurses work to help make the communities they live in a better place. Together, they are working to educate and motivate those around them towards a healthier lifestyle.



Their perspective and influence must be at decision-making tables. The Nurses on Boards Coalition represents the collaboration of national nursing and other organizations working to build healthier communities in America by increasing nurses' presence on corporate, health-related, and other boards, panels, and commissions. The Coalition's intent is to ensure that at least 10,000 nurses are on boards by 2020, as well as raise awareness that all boards would benefit from the unique perspective of nurses to achieve the goals of improved health and efficient and effective health care systems at the local, state, and national levels.

Visit our website and learn more about our mission and log your board service today!

www.nursesonboardscoalition.org

Welcome New Members

Jaci Reep
Stanley

Amalia Brandenburger
Williston

Kathy Schaefer
Minot

Halley Maas
Fargo

Michelle Censoplano
Wahpeton

Alicia Meidinger
West Fargo

Quinn Parisien
Bismarck

Breanna Kompelien
Valley City

Sheila Netz
Grand Forks

Julie Klein
Bismarck

Jessica Hinkel
Bismarck

Quantia Johnson
Fargo

Maureen Bentz
Bismarck

Meghan Asleson
Fargo

Courtney Urness
Cooperstown

Lauren Wheeler
Fargo

Linda Volness
Fargo

Claudia Wehri
Hebron

Lori Kertz
Fargo

Jennifer Henderson
Bismarck

Rachel Baumgart
Fargo

The North Dakota Nurse

Official Publication of:
North Dakota Nurses Association

NDNA
NORTH DAKOTA NURSES ASSOCIATION

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Published quarterly: January, April, July, and October for the North Dakota Nurses Association, a constituent member of the American Nurses Association, 1515 Burnt Boat Dr. Suite C #325, Bismarck, ND 58503. Copy due four weeks prior to month of publication. **For advertising rates and information,** please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@aldpub.com. NDNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

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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 article*** in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. **Deadlines for submission of material for upcoming North Dakota Nurse are 3/6/19 and 6/5/19.**

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.

2018-2019 Advocacy Platform

The North Dakota Nurses Association (NDNA) is the only professional organization representing all registered nurses (RNs) in North Dakota. NDNA is involved in the shaping of public policy about health care in line with the goals of nurses, nursing, and public health. NDNA promotes legislation, policies, and strategies that help meet North Dakota's most pressing needs.

Workforce Development:

- Support efforts to attract and retain more nurses to the profession and to the state (Workforce Development).
  - o Support efforts to improve Workforce Development including improved Loan Reimbursement, Faculty Loan Forgiveness, and growth of Educational programs.

Population Health:

- Support Population Health focused legislation and activities including, but not limited to, Obesity Prevention & Treatment, Substance Abuse Prevention & Treatment – including drugs, alcohol and tobacco, Access to Behavioral Health Services, and Access to Early Childhood Preventative Interventions – including increased access to School Nursing
  - o Address the Opioid Crisis
    - ♦ "Dealing with opioid addiction is one of the most significant issues the US health system faces today, and nurses are playing a key role in our nation's efforts to deal with the crisis." (ANA, 2018)
    - ♦ Support expanded access to Medication-Assisted Treatment (MAT), allowing APRNs to prescribe MAT to patients.
    - ♦ Support provider education and training and continued utilization of Prescription Drug Monitoring Programs and increasing access to Naloxone and prescription drug disposal in our communities.
  - o Advocating for increased access to School Nursing.
    - ♦ Students' health and health needs must be addressed in schools to achieve optimum learning. Supports the assignment and daily availability of a registered school nurse for the central management and implementation of school health services at the recommended ratio of one nurse for every 750 students, with an ultimate goal of at least one nurse in every school (ANA, 2007).
    - ♦ On any given weekday, as much as 20% of the combined US population of children and adults can be found in schools (AHA, 2004). To best serve the health needs of students and staff in educational settings, ANA supports a collaborative school health model which requires the cooperation and participation of the school nurse, students, families, teachers, school administrators and staff, other health care professionals, and the community.

Nursing Education, Practice and Licensure:

- Continue to advocate for increased access to professional nursing education and Nurses working in the full authority of their practice.
  - o Support higher education for nurses. We need fundamental wide-range planning for changes in the education and deployment of the nursing workforce.
  - o Reduce regulatory barriers, enabling Registered Nurses (RNs) to practice to the full extent of their education and training. Support compact licensure for Registered Nurses and Advanced Practice Registered Nurses (APRNs)
  - o Revise scope-of-practice laws that discourage full use of advanced practice nurses, pharmacists, and other allied health professionals (collaborative practice agreements, supervisory requirements, prescribing limitations).

Care Delivery:

- Promote programs that support improved Care Delivery across the state of North Dakota.
  - o Continue support of technologies, including Telehealth to support expanded access to services.
  - o Support new and evolving roles as long as there is role clarity, appropriate education and training, appropriate oversight and that nurses are recognized for their role as care coordinators, which may necessitate removal of the delegation rules in the Nurse Practice Act that limit nurse's ability to exercise their judgment.

Funding:

- Ensure adequate funding for vital health care related services, including direct care, illness prevention, and health outcomes
  - o Shortfalls in funding for health and behavioral health services will increase costs in other areas of the budget, and will lead to negative consequences for individuals, families, and communities.

Leadership Summit

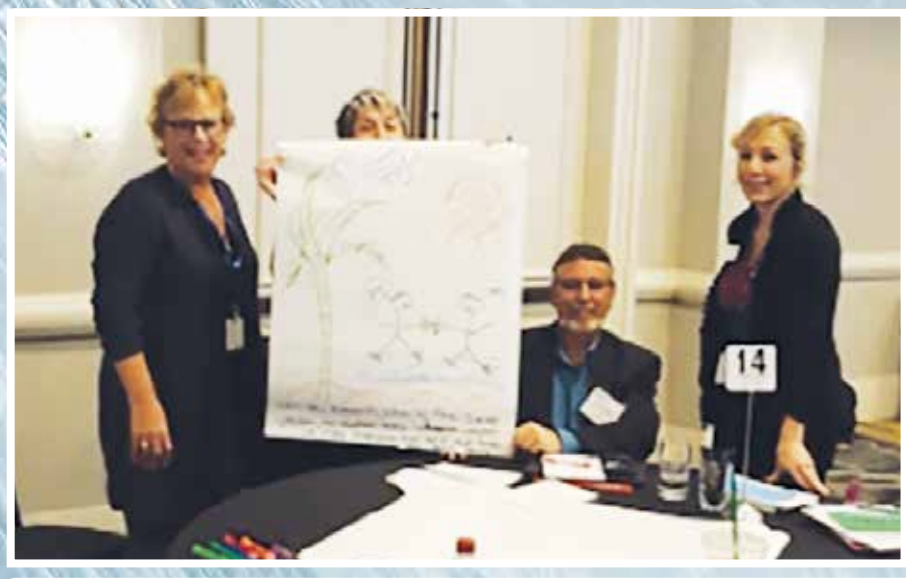
NDNA President Tessa Johnson and Executive Director Sherri Miller had the opportunity to attend the 2018 ANA Leadership Summit in Alexandria, Virginia on November 26-29, 2018.

Topics touched upon at the summit included workplace violence, opioids, staffing, universal healthcare, full practice authority for APRN's, labor unions, and registered veterinary nurses. A definite theme was present and that was to keep strong communication between the states and ANA. Communication avenues will be Pres-ED quarterly calls, bi-monthly GOVA calls, ANA volunteers, ANA open sessions, and conferences such as the summit itself.

NDNA and the other state leaders worked in small groups to identify their own top priorities and the methods that will be used to work on them. The groups shared ideas amongst the larger group. Ideas included making the priorities actionable, communicating achievements, and taking advantage of resources offered from ANA – actually scheduling time to seek out the resources!

This meeting offered networking and team building. It underlined the importance of seeing what other states are experiencing in regards to nursing and health issues and how NDNA can learn from them.

Ernest Grant, Incoming ANA President speaking to States' Leaders



Kansas, Nevada, North Dakota - small group happenings!

NDNA Executive Director, Sherri Miller, and NDNA President, Tessa Johnson attending an awesome appreciation dinner sponsored by Mercer and Omnisure. To learn more about liability insurance and risk management content - both benefits available to NDNA members - contact: Sherri Miller director@ndna.org.

How to submit an article for *The North Dakota Nurse*!

The North Dakota Nurses Association accepts articles on topics related to nursing. We also accept student articles & evidence based practice articles. All articles are peer reviewed and edited by NDNA volunteers. Nurses are strongly encouraged to contribute to the profession by publishing evidence-based articles; however, anyone is welcome to submit content to the North Dakota Nurse. We review and may publish anything we think is interesting, relevant, scientifically sound, and, of course, well-written. The editors staff look at all promising submissions.

Deadline for submission for the next issue is ***3/6/2019***.
Send your submissions to director@ndna.org or info@ndna.org.

Chocolate Chip Comfort

While we all seem to be on a "new year – healthy focus," the new year and winter can (on occasion) also be comfort food time!

Nurses - take some time to enjoy being cozy at home when you have a day off. Bake up a batch of these yummy cookies.

Chocolate Chip Cookies

2 cups unsalted butter melted and cooled 10 minutes
3 cups packed light brown sugar
1 cup sugar
4 eggs – sit out to become room temperature
2 1/2 teaspoons vanilla
2/3 cup maple syrup
6 3/4 cups all-purpose flour
4 teaspoons cornstarch
2 teaspoons baking powder
2 teaspoons baking soda
2 teaspoons salt
4 cups semi-sweet chocolate chips (if you prefer milk chocolate chips, they work well too)

Blend butter and sugars, add eggs stir until well blended
Add vanilla and maple syrup
Set aside

In separate bowl mix flour, cornstarch, baking soda, baking powder, salt

Add dry mixture 1 cup at a time to wet mixture
Add chocolate chips

Cover bowl and refrigerate for an hour
Preheat oven to 350 F
Form 2-3 tablespoon dough balls- place them on a cool cookie sheet
Bake 13 minutes, let them cool on the cookie sheet before removing them

Yields 5 dozen cookies

Recipe is courtesy of NDNA's VP of Membership, Kami Lehn

ANA
AMERICAN NURSES ASSOCIATION

Why should nurses advocate?

For the past 16 years, the public has voted nursing the most trusted profession in Gallup's annual honesty and ethics survey, and this is a testament to the dedication that nurses show every day. Nurses provide essential services, are knowledgeable about client needs, and interact closely with health care consumers across a variety of care settings and social groups. This gives nurses a broad appreciation of health needs and an understanding of the factors that affect health care delivery.

The Effect of Nurse to Patient Ratios on Patient Safety and Mortality in the Hospital Setting

Dominique Bruso, Holly Gaugler, Leana Kastern, Jessica Kurtz, University of Mary BSN Students; Kathy Roth, MSN, RN, Assistant Professor of Nursing

Clinical Question

Are lower nurse to patient ratio standards more effective and safer for patients in the hospital setting when compared to nurses who have unrestricted patient ratios policies in place?

Summary of Evidence

The first study reviewed, written by Cho, Mark, and Knafl (2017), explored the "relationships between nursing staffing, patient experiences, and the effects of missed nursing care" (p. 347). The findings of the study showed "lower patient perceived staffing adequacy was associated with more missed care and adverse events, and a lower likelihood of experiencing good communication with nurses and of giving a high overall rating to the hospital" (Cho et al., 2017, p. 347). The conclusion is when there were less patients assigned to one nurse, both the nurses and patients are more likely to be satisfied with the level of care provided.

A study done by Choi and Miller (2018) examined the relationship between registered nurse working conditions and specific outcomes based on perceptions of patient assignments. The surveys found RNs who rated their patient assignments to be appropriate were significantly more likely to report higher quality of care than those who rated their patient assignments to be too much (Choi & Miller, 2018). The conclusion of the study proposes optimal nurse to patient ratios creates better patient outcomes. Another study by Hill and Dewitt (2018) came to a similar conclusion. The data strongly correlates how nurses in neurocritical care units are typically given more work than can be completed in a 12-hour shift (Hill & DeWitt, 2018). Finally, the study highlights how proper patient assignments are crucial to effective and safe patient care.

A fourth study by Neuraz et al. (2015) studied the impact of the staffing to patient ratio and workload on ICU mortality. Results from the study show how the risk of death in the ICU increased when the number of patients was above 2.5 per nurse (Neuraz et al., 2015). Based on this study, The Society of Critical Care Medicine agrees safe care requires a decrease in current nurse to patient ratios (Neuraz et al., 2015). Similarly, a study by Sakr et al. (2015) examined the relationship between ICU nurse to patient ratios and patient outcomes. The study by Sakr et al. (2015) "found lower nurse to patient ratios were associated with a lower risk of in-hospital death" (p. 520). This study used an international large cohort of ICU patients to prove ICU patient mortality is decreased with adequate nurse to patient ratios.

A study by Unruh and Zhang (2012) found "changes in registered nurse (RN) full-time equivalents (FTEs) had a significantly positive effect on RN per adjusted patient day (APD), indicating an increase in RN FTEs over time was related to an increase in RN/APD over time and that decrease in RN FTEs over time was related to a decrease in RN/APD over time" (p. 10). One positive finding from Unruh and Zhang (2012) was "hospitals with higher RN FTEs and RN/ADP have a greater ability to catch and report infections before the patient is discharged" (Unruh & Zhang, p. 10). Their overall conclusion showed hospitals who have an adequate number of nurses for their patient census were better equipped for all patients' needs.

Bottom Line

Research has shown smaller nurse to patient ratios not only improve staffing satisfaction but increase the level of patient care nurses are able to bestow. Healthcare has become a business industry, focusing more on revenue than patient satisfaction. This has caused facilities to rely on using less resources in order to have a larger income generation. Nurses who have higher patient ratios often need to rush through their cares in order to get everything completed during their shift, leaving less time for their patients. Maya Angelou wrote, "they may forget your name, but they will never forget how you made them feel." Nurses leave a lifelong impression on their patients, no matter how short the hospital stay is. Although there may be changes needed to increase unit budgets in order to provide smaller nurse-to-patient care ratios, in this situation, the benefits of more satisfied patients outweigh the costs of increased staffing.

Nursing Implications

Helping the healthcare industry understand the magnitude and consequences of inadequate staffing and the effect it has on patient care is the first step in recommending a plan for change regarding nurse ratios and patient safety. The goal will be to implement lower nurse to patient ratios in the hospital setting. This initiative will decrease the nurse workload and increase their capabilities to complete their tasks and cares to the best of their knowledge. With this change, nurses are able to ensure patients' needs are being met completely and cares are not being rushed. The prime barrier against the new staffing policy would be administration allowing an increase in unit budgets, since there may be a need to possibly hire more nurses in order to make smaller ratios effective. Most facilities try to lower staffing costs by increasing nurse to patient ratios. One way the group could motivate staff to improve patient care would be to provide a monetary bonus to the nurses after six months of a steadily declining adverse event percentage. Another way the group could motivate staff would be to apply money saved from the hospital not having to pay patient's adverse event cares to purchase new equipment for units. If nurses can see the money that they are saving the hospital is being used to improve the unit, they are going to be more motivated to continue giving patients high quality care. This will allow hospital administration to see the connection and effectiveness lower nurse to patient ratios can have, not only on staff morale, but on the hospital's budget as well. It is the group's goal, as evidenced by the research data, to eventually implement this policy to lower nurse to patient ratios across the country.

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Member Spotlight of Halley Maas continued from page 1

What made you want to become a nurse?

Both my grandmother and mom are nurses. My grandma is no longer with us, but she inspired me in so many ways. My grandma, Audrey, was diagnosed with cancer and while undergoing treatment she continued to go to nursing school and obtain her RN license. I truly believe their compassion for others was instilled in me. I always knew I wanted to go into nursing, but it wasn't until I started the nursing curriculum that I knew this was the perfect fit. I enjoy challenging myself and being able to help those in need. There is nothing more rewarding than helping people when they need it the most.

How did you decide to run (or accept an appointment) for the NDNA board?

I decided to accept the position of Vice President of Government Relations because I wanted to become more involved with my nursing community. Government relations and legislation is something I was always interested in, but never really knew how to dive in and become involved. This position has allowed me to network with so many amazing people and continuously learn new things every day.

As a new board member, what goals do you have for your position?

The major goal I have for my position is to bridge the communication gap between my fellow board members and what is going on the legislative world of nursing. I hope to attend as many government events that I can and represent NDNA to my best capacity.

What do you like to do in your free time?

In my free time I enjoy traveling, going to the gym and spending time with loved ones. Any spare time I can get, I love doing just about anything with my fiancé! We have recently built our first home together, so our free time lately has been spent at Home Goods or Target trying to decorate for the holidays.

What goals do you still have for yourself (Professionally or personally)?

The major goal I have for myself is to obtain my FNP and impact as many people as I can. I held the title of Miss North Dakota USA 2016 and with that title I met so many incredible people who truly showed me how to feel confident and beautiful in my own skin. This was a big reason why I have decided I wanted to work in dermatology and aesthetics. I love helping people feel confident and comfortable in their own skin. Doing that as a Nurse Practitioner would be a dream come true!

Is there anything else you want to tell us about you?

I am really excited about this new position and I can't wait to see where it takes me!

...So How Do We Address Incivility?

Jessica Vos, BSN, RN, Director at Large, Recent Graduate

Incivility is a term being spotlighted lately, and for good reason. We have generally accepted our fate as new nurses who have been thrown to the sharks to either teach us to swim or let us down. I'm sure everyone has heard the phrase, "Nurses eat their young." If you haven't heard this phrase it refers to senior nurses not being very welcoming or particularly helpful to new nurses on the unit.

We can no longer accept this way of life. We need to change the culture of precepting and teaching. Even though most of us survived our orientations, I'm sure some of us have scars from that one Nurse Ratchet who let us figure things out for ourselves and did not give us any answers or help, but was only really trying to teach us a lesson (the hard way.) As new nurses on a unit it is overwhelming and scary, and feeling like you cannot ask questions without eye rolling or a condescending tone can make for a very long and torturous orientation. This way of teaching is not beneficial for new nurses to learn and does not make for a very professional environment. This is just one scenario of incivility. I can think of a hundred scenarios off the top of my head that can happen, whether it be a doctor yelling at you for calling them in the middle of the night to clarify orders, making you reluctant to call when other instances arise, or whether a nurse manager is condescending to you and makes you feel small and insignificant. Incivility comes in many forms and I'm sure we have all witnessed or been a part of some sort of incivility at some point in our careers. The difference now is, we should no longer stand for incivility. We need to demand a safe and professional work environment. When we allow incivility to happen we are saying it's OK to treat each other with disrespect.

Incivility violates professional behaviors and expectations in the workplace. Incivility is described as inconsiderate behavior that can be psychologically damaging even if the intent to harm is not clearly defined. Incivility and its disruptive behaviors can impact victims psychologically, resulting in decreased patient safety and organizational commitment, while increasing stress, absenteeism, turnover and turnover intentions. Ignoring incivility leads to adverse outcomes in employees, patients and the organization (Felblinger, D. 2009).

Acts of incivility can include: using nonverbal behaviors (eye rolling, making faces, deep sighing), using demeaning comments, putdowns or sarcastic remarks, using the silent treatment or withholding information, using anger, humiliation and intimidation, spreading rumors or gossiping, making fun of another's appearance, demeanor or personal trait, and taking credit for others' work (Griffin, M. and Clark, C., 2014). As you can see, uncivil actions can range from ambiguous, meaning the intent is not clear regarding the offender's actions, to straight bullying. How people perceive the uncivil action affects the level of intensity of the impact from those actions according to (Griffin and Clark 2014). Incivility can be kind of tricky because there are always two sides to every story so what may be offensive to one person may not be to the next. Incivility is an unprofessional action, but the intent to harm is not black and white. So, someone may have done something that may have offended you, but that was not necessarily their intention. Regardless, uncivil actions violate a positive workplace environment and should not be tolerated.

So how do we address incivility? What do we do to make our workplace a more cohesive, professional one? Griffin and Clark (2014) suggest each nurse making a commitment to take responsibility for their own actions, to address their co-workers when they notice uncivil actions occurring, refrain from bickering and gossiping and endorsing an environment of trust. This cannot happen if the organization does not fully support and adhere to the same commitment. Everyone must be on board with the same shared goal. We as employees also need to feel safe when addressing uncivil actions without repercussions. We need to feel heard and our complaints taken seriously. If everyone commits to a professional environment, the transition from the uncivil culture we are allowing now, should be a smooth one.

I'm sure everyone has done some of these things at one point or another whether it was intentional or not. There should be two parts to the way we look at incivility. The first one being looking within ourselves to understand why we are reacting the way that we do to someone else's actions. The second part is being able to converse with the person who has offended you and being able to have a respectful conversation about why you viewed their actions as uncivil. This will help you and the person committing the uncivil acts to form a mutual respect by being able to address incivility and change future actions. Through education and awareness, and being able to address incivility without repercussions, we can start to change the culture of incivility in the workplace.

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Griffin, M., & Clark, C. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *The Journal of Continuing Education in Nursing, 45*(12), 535-542

NDNA – A Bit of History

Karen Macdonald

With the recent events in mind, I wanted to include something in *The North Dakota Nurse* regarding history that might be of interest to the nurse readers. The first is the WWI centennial. This was celebrated November 11, 2018 with a variety of events. I attended the one at the Heritage Center and heard Barbara Handy Marchello's work on the Gold Star Mothers. Included in her presentation was information about nurses who had served in WWI from North Dakota (approximately 700).

NDNA members will probably recall Sarah Sand Stevens as a past NDNA President who served with Dr. Quain in a local hospital unit that went to France in September of 1918. There were nurse fatalities in the war, but most of them were from influenza rather than injuries. Several nurses were honored by the American Legion (also formed after WWI) with posts named after them. Post #7 in Lisbon, ND was named after Miss Florence Kimball who died in 1918 and is buried in the American Cemetery in Bordeaux, France. If you have the opportunity, ask a member of your local American Legion chapter about their post name. Most likely it will be in honor of a WWI soldier who died in service. Information about nurses who served in WWI is available at the Heritage Center as well as in a recent publication by Grace E.F. Holmes, M.D *North Dakota Nurses Over There 1917-1919*, North Dakota American Legion Auxiliary, 2017. Authors Jacqueline Winspear and Charles Todd have fictionalized nurses serving in WWI I recommend their books if you are interested in reading works that seem to be pretty factual.

December 7 of last year was the 77th anniversary of the attack on Pearl Harbor Naval Air Base. Two ND nurses were stationed at Pearl Harbor and were there to take care of the wounded. Irma Block and Agnes Shurr were both members of the Army Nurse Corps. Agnes later taught at University of North Dakota and Irma worked in the ND State Department of Health. Of interest too might be the fact that there were only 42,000 nurses in the United States in 1942, and only 1000 were in the Army Nurse Corp at the time of Pearl Harbor. At that time, the US government predicted a need for an additional 125,000 nurses within the next two years. The United States Cadet Nurse Corp. was formed by P.L. 74 on July 1, 1943 to accelerate nurses training with an emphasis on public health. Sixty-five million dollars was earmarked for the first year, and funding provided stipend and costs for nursing students as well as improvement in nursing schools. Seventeen thousand nurses entered Federal Service between 1943 and 1945 and nursing programs were shortened from 36 months to 30 months followed by a six month residency. You may know a Cadet Nurse. I worked with several, notably Betty Maher and Clarice Weber, both now deceased. Most graduates served in public health or federal or governmental institutions after graduation and were valuable assets as many graduate nurses had enlisted in the armed services. I tend to read obituaries and quite often there will be records of a nurse passing who was in the Cadet Nurse Corps. Or ask at your local nursing home about retired nurses who might be interested in visiting about their experiences. Several years ago, I interviewed two nurses at the Veterans Home in Lisbon who had served in WWII. Information for this segment was from the United States Cadet Nurse Corps, Public Health Service publication, no. 38.

There is pending legislation to provide graduates of the Cadet Nurse Corp veteran status to enable them to be buried in veterans' cemeteries. HR 1168, introduced by Nita Lowry, NY and S3729 introduced the U.S. Cadet Nurse Corp. Equity Act and as of December 10, 2018 it has not received a hearing. A similar bill has been introduced in 2005, 2007, 2011, 2013, 2015, and 2017. Sounds like we need to mount a campaign!

Support the North Dakota Center for Nursing's Recruitment and Scholarship Efforts on Giving Hearts Day

The North Dakota Center for Nursing is excited to once again participate in Giving Hearts Day, held February 14th, 2019. Giving Hearts Day is a 24-hour fundraising effort hosted by the Impact Foundation and the Alex Stern Family Foundation for organizations in North Dakota and Western Minnesota. Each year the campaign raises millions of dollars for non-profits across the region.

All proceeds given to the North Dakota Center for Nursing on Giving Hearts Day will fund scholarship opportunities, as well as recruitment efforts. The North Dakota Center for Nursing's goal, through your Giving Hearts Day Donations, is to provide student nurses with financial resources in addition to marketing the nursing profession to meet the healthcare demands of tomorrow. Your donations will help support the next generation of nurses.

There are two easy ways to give towards our Giving Hearts Day Campaign:

1. Mail a check to our office – your check must be dated for February 14th, 2019 and made out to the North Dakota Center for Nursing. Please put "Giving Hearts Day" in the memo line. You may mail your check to the following address:

North Dakota Center for Nursing
3523 45th St S, Suite 152
Fargo, ND 58104

2. Make a donation online on Giving Hearts Day, February 14th, 2019 at www.givingheartsday.org

The Dakota Medical Foundation is partnering with the center to provide matching dollars. If the North Dakota Center for Nursing is able to raise $3,500, the Dakota Medical Foundation will provide an additional $3,500 in matching dollars.

In addition, the North Dakota Center for Nursing will be participating in the Giving Hearts Day/Vision Bank video contest. As Giving Hearts Day approaches, the North Dakota Center for Nursing will email out a link allowing nurses to vote for its video. This year's video winner will receive $500. Everyone is encouraged to vote and share the voting link with their friends, family and co-workers. More details about this contest will be announced in early 2019.

Help support our future nurses by making a donation on Giving Hearts Day!

The Effect of Travel and Float Nurses on Patient Safety Within Hospitals

Erika Berg, Zachary Fischer, Cassidy Freeman, Shelby Nelson, Jadon Thomas, University of Mary BSN Students; Kathy Roth, MSN, RN, Assistant Professor of Nursing

Clinical Question:

In hospital nursing staff, what is the effect of travel nurses and float nurses when compared to core nursing staff on patient safety?

Synthesis of Evidence:

Priority in all areas of healthcare is patient safety. With the nursing shortage, hospitals are trying to make use of flexible resources like travel and float nurses. As a result of the increasing need to utilize these resources to fill staffing shortages, temporary nurses make up about 30% of the nursing workforce in the United States (Faller, 2017). The main concern with having travel and float nurses is their effect on patient safety.

A review of literature was performed regarding the effect of travel and float nurses on patient safety. A total of six research articles were carefully critiqued. Of the six studies reviewed, three of the studies states there is no evidence that suggests there is decreased patient safety among travel nurses and float nurses (Aiken, Freund, Noyes, & Xue, 2012; Faller, 2017; Larson et al., 2012). In another clinical study the conclusion was that less than 15% of travel nurses should be used to safely deliver patient care (Bae, 2010). The fifth reviewed study was a qualitative study that looked at how nurses felt about floating. It was found that while nurses do not like to float, they will as long as there are measures put into place that will make floating comfortable (Lafontant, 2016). The sixth clinical study that was reviewed looked at burnout and quality of care in regard to travel nurses. It was found that if the travel nurse had a higher patient assignment, the risk of burnout was higher than those who had fewer patients in their care (Connelly, 2011).

Bottom Line:

The amount of studies regarding travel nurses and float nurses and their effect on patient safety is minimal. Recommendations made were to conduct more research and have a pilot study in multiple hospitals. The use of flexible resources, like travel nurses or float pool nurses, is beneficial when dealing with a staffing shortage of nurses within the hospital setting. However, making sure that the travel nurses are not getting burnt out, which can cause unsafe patient care, is the top priority that needs to be focused on.

Implications for Nursing Practice:

Further research needs to be done in order to get a more conclusive result. One recommendation would be to have a pilot study conducted in multiple hospitals and further research regarding different specified patient safety clinical indicators, such as increased infection rates, when travel or float nurses are utilized. Data could be collected on patient safety outcomes with the use of travel nurses who are contracted for shorter or longer periods of time. Another recommendation that can be looked at is a travel nurse's work satisfaction in order to see if it contributes to the hospital's patient safety outcomes.

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Obesity and Diabetes - Looking at Risks in Ages 10-19

Kelly Hanson RN, Amanda Horner RN, Hattie Idalski RN, (Mayville State University RN-to-BSN students)

Clinical Question:

Are obese individual's ages 10 to 19 compared to non-obese individual's ages 10-19 more at risk of developing Type II Diabetes Mellitus in their lifetime?

Articles:

Albow, B., & Alenezy, A. (2016). Risk factors of type 2 diabetes and cardiovascular diseases among Saudi Arabian adolescents. *Pakistan Journal of Nutrition, 2016, 15*(9), 883-888.

Amuta, A. O., Barry, A. E., & McKyer, E. J. (2015). Risk perceptions for developing type 2 diabetes among overweight and obese adolescents with and without a family history of type 2 diabetes. *American Journal of Health Behavior, 39*(6), 786-793.

Ehehalt, S., Wiegans, S., Korner, A., Schweizer, R., Liesenkotter, K.-P., Partsch, C.-J., Kiess, W. (2017). Diabetes screening in overweight and obese children and adolescents: Choosing the right test. *European Journal of Pediatrics. 176* (1), 89-97.

Mahlouz, R. A., Alzaiat, A., & Yousry, A. (2015). Relationship of epicardial fat thickness with endothelial and cardiac function in children with family history of type 2 diabetes mellitus. *Echocardiography, 32*(1), 28-33.

Soltero, E., Konopken, Y., Olson, M., Keller, C., Castro, F., Williams. A.,....Shaibi, G. (2017). Preventing diabetes in obese Latino youth with prediabetes: A study protocol for a randomized controlled trial. *BioMed Central,* 1-12.

Synthesis of Evidence:

Our team reviewed 12 articles and chose the following five studies to further evaluate if obese individuals ages 10 to 19 compared with non-obese individuals ages 10-19 are more at risk of developing Type II Diabetes Mellitus (T2D) in their lifetime.

The first study conducted by Albow & Alenezy (2016) included a descriptive epidemiological cross-sectional study with 200 participants with participants ranging from 14-19 years old randomly selected to assess the risk factors of T2D and CVDs such as overweight and obesity, along with family history of overweight and poor diet intake. They utilized both normal and overweight adolescents for this study. From their study there was a significant positive correlation between BMI and HbA1c. From their study, the authors noted that positive family history of diabetes tended to have higher BMI measurements and total serum cholesterol level when compared to those of negative ones. The type of diet, extent of physical activity and climatic conditions, all play a role in influencing overweight and obesity prevalence. Genetic contribution is considerable, since obesity is a multifactorial complex genetic disorder. This information is important as obesity is an adverse biomarker for not only T2D but also, CVD. Limitations for this study may be that they find it hard to measure adequate physical activity and imbalance in dietary patterns along with the social restrictions of their culture.

The second study conducted by Amuta et al. (2015), examined the risk perceptions for developing T2D among overweight and obese adolescents compared to their peers, in adulthood and in their lifetime. To study for these perceptions, they used three variable behavioral causes, genetic causes, and ageing. From their study, findings suggest that overweight and obese adolescents base their T2D risk assessment primarily on non-modifiable risk factors. They also found an association between T2D family history and T2D risk perception. The relationship between family history and perceived risk may be attributed to the fact that most people who have a family member with a disease have at least some important beliefs and knowledge about their disease risk. Family history with or without obesity plays an important role in determining ones risks of developing T2D.

The third study conducted by Ehehalt et al. (2017) elaborates on the fact that obesity is increasing at a young age and this increases those young peoples' chance of developing T2D. T2D can occur without any obvious signs or symptoms at a young age. The screening test that is most accurate is still being studied. They tested obese adolescents age 7 to 17 that had never been previously diagnosed with diabetes type 2. They used the Hemoglobin A1c (HbA1c) test and the Oral Glucose Tolerance Test (OGTT) to test these individuals. Their studies pointed to the possibility that HbA1c may be more reliable than the OGTT. This article is important to our specific question because it discusses what may be the best test for diagnosing T2D.

The fourth study conducted by Mahlouz et al. (2015) was designed to show if there was correlation in increasing risk factors for T2D in a child born to a mother with T2D. The study was used to compare and contrast if there were any other significant risk factors for T2D other than obesity in our youth. The outcome of the study did not conclude that a child born to a parent with T2D increased their risk factors for the disease, however, it did identify that children born to a mother with T2D are at greater risk for a cardiac conditioning where the endo cardio lining is thickened. This information helped to eliminate genetic risk factors for T2D from a child born to a parent with T2D. It did, however, help to straighten the fact that a child born into a family with T2D are at great risk for similar beliefs and knowledge that is being displayed within their family ties.

The last study conducted by Soltero et al. (2017) had a focus regarding what role genetics plays in T2D. It shows how obese Latino youth are at a higher risk for their bodies resisting insulin than those of other ethnicities. They report that this population is underserved and there are not enough studies being done to prevent the advancement of T2D. They also report that in order for prevention programs to be optimally effective, there needed to be lifestyle adaptations while involving family and working with their cultural needs. The authors want to help with establishing a model lifestyle that Latinos can follow and can be carried over to help other at-risk populations with lifestyle changes to prevent or decrease the effects of T2D. This article is important because it points out the fact that not only obesity, but other factors such as genetics contribute to the development of T2D. We need to take this into consideration that just because a young person is obese does not mean that that is the absolute reason they may develop T2D.

Bottom Line:

In conclusion, according to the research found, age (10-19) does not seem to be a pertinent factor when it comes to T2D, but obesity is a factor. Genetics also seem to play a role and this may partially relate to lifestyle habits learned as a young person. There does not seem to be enough research available and continued research is necessary to study the relationship between T2D and early onset obesity. More research is also needed to determine which screening method is best used for T2D in obese adolescents. Screening of obese young people appeared to be more reliable using the HbA1c test than screening of obese young using OGTT method.

Implications for Nursing Practice:

T2D is a disease that can lead to serious health issues. Nearly all nurses will treat or help plan care for a patient with diabetes at some point in their career. We need to be aware of risk factors for T2D and use our nursing education to educate others. Hopefully, we can decrease the number of patients with T2D along with minimizing or preventing the lifelong effects by promoting preventative T2D education.

Disinfecting Caps to Prevent Central Line Associated Bloodstream Infections

Nicole R.P. Everitt, Hannah L. Grebner, Taryn A. Small, & Sarah A. Wentz, University of Mary BSN Students; Kathy Roth, MSN, RN, Assistant Professor of Nursing

Clinical Question:

In hospitalized patients with central lines, what is the effect of disinfecting caps when compared with scrubbing the hub with an alcohol wipe on central line associated bloodstream infections?

Synthesis of Evidence:

The literature examined demonstrated that there was significant reduction in central line associated bloodstream infections (CLABSI) with the use of an antiseptic barrier cap. It was determined that the application of the implementation of a disinfection cap resulted in a significant reduction in *S. aureus* than the standard cleaning practice (Casey et al., 2018). Fewer instances of bacterial contamination were observed with the implementation of disinfecting caps than with standard cleaning processes (Wright et al., 2013). Cameron-Watson (2016) researched the reduction in catheter-related bloodstream infections (CRBSIs) with the implantation of the antimicrobial cap. They noted CRBSI incidence rates dropped significantly after the implementation of the disinfection caps, along with a dramatic increase in staff compliance and cost saving considerations. The data concluded from Sweet et al (2012) showed the incidence of CLABSI and contaminated blood cultures dropped from 2.3 per 1000 central-line days to 0.3 per 1000 central-line days after the new standard of disinfectant caps were used, in comparison to a traditional cleaning method of central lines. Another study examined includes a survey that was sent out via email to 57 different hospitals, which canvased the CLABSI prevention strategies and interventions each facility uses to reduce the incidence of infections. The survey concluded that multiple interventions were implemented to prevent CLABSI occurrences, such as disinfectant caps, chlorhexidine baths, and scrubbing needless connections with chlorhexidine products (Klieger et al., 2013). The final literature examined was a four phase study that sought to determine the effectiveness of disinfecting caps for central line hub decontamination in hematology-oncology patients. The occurrence of decreased CLABSI rates was demonstrated and an estimated annual net savings to be $3,268,990 with the cost of implementation (Kamboj et al., 2015).

Bottom Line:

One of the main benefits of implementing disinfectant caps is to decrease the staggering rates of central line infections versus the standard practice of scrubbing the access port with an alcohol wipe. The research studies examined have demonstrated a significant decrease in the incidence of central line infections when utilizing these passive disinfection caps in comparison to the standard scrub the hub. In addition to improved infection rates, several studies also displayed cost-saving principles through the preventative nature of the caps. Therefore, disinfection caps should be integrated into the standard nursing clinical practice.

Implications for Nursing Practice:

In order to change clinical practice to align with best practice approaches, awareness must first be created about the increasing effect of CLABSI on patients and what can be done to reduce these infection rates. To establish this, managers should be consulted to spark change and journal articles that support disinfection caps should be provided to persuade staff into compliance. Once awareness is established, a committee or task force should be formed to spearhead implementation into clinical practice and a communication plan should be developed to keep people interested in decreasing CLABSI rates. Once a committee is formed and people are engaged, a plan for integrating the use of disinfecting caps into practice needs to be created. Afterwards, meetings, emails, in-services, online-teaching modules, newsletters, and posters should be created to spread awareness of the practice change. Even more importantly, nurse leaders need to lead by example and encourage their staff to be open minded about the change. Staff needs to be empowered to accept the change by having barriers removed. This can be done by making disinfecting caps convenient and feasible to implement into nursing practice. Feedback should also be elicited to evaluate how disinfecting caps are being perceived by the staff; it will also be important to keep the lines of communication open and reinforce the vision of reducing CLABSI rates for the facility. These short-term successes should then be implemented throughout entire organizations, while continuing to receive feedback and make changes as necessary. Finally, disinfecting caps positive effects on the CLABSI rates should continue to be monitored and evaluated to ensure continued success.

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Healthy Recipes

Banana Smoothie

Ingredients

1 banana, peeled
1/4 cup strawberries, washed and sliced
1/3 cup non-fat milk
8 ounces plain yogurt, non-fat

Directions

1. Combine all ingredients in a blender.
2. Blend until smooth.

Early Morning Parfait

Ingredients

3 medium kiwifruits
2 medium red grapefruit, sectioned
1 cup honey
1 cup oat granola
2 containers 6 oz. custard style yogurt
mint sprigs, for garnish

Directions

- Peel the kiwifruit, cut lengthwise into quarters, then thinly slice.
- Reserve 8 slices for garnish.
- To assemble the parfaits, divide the grapefruit sections among parfait glasses.
- Spoon about 1 tablespoon yogurt over the grapefruit.
- Sprinkle with about 2 tablespoons granola then top with another layer of yogurt and one-fourth of the kiwifruit.
- Continue layering with the remaining yogurt, granola, and grapefruit.
- Top with the reserved kiwifruit and garnish with the mint.

French Toast

Ingredients

1 1/2 cups Granny Smith apples, cored and diced with skin on
3 teaspoons Splenda® No Calorie Sweetener
1/4 teaspoon cinnamon
1 1/2 tablespoons skim milk
2 eggs
2 egg whites
3 seconds butter-flavored cooking oil spray
6 slices whole wheat bread
6 tablespoons reduced-calorie syrup

Directions

- In a microwave safe medium sized bowl, combine diced apples, Splenda® No Calorie Sweetener, and cinnamon.
- Mix well.
- Microwave mixture for 1 minute.
- Beat milk, eggs, and egg whites together in a wide, shallow bowl.
- Spray cooking pan with cooking oil.
- Place on burner over MEDIUM-HIGH heat.
- Dip bread into egg batter coating lightly but completely on both sides.
- Place in pan.
- Cook turning often until golden brown on both sides.
- Place two slices of french toast on a plate.
- Cut each slice of bread in half.
- Top each serving with diced apple mix and 2 tablespoons of syrup.

Eight Hour Versus Twelve Hour Nursing Shifts

Beth Kubish, Elizabeth Bruss, Emma Hanley, & Bernadette Newport, University of Mary BSN Students; Kathy Roth, MSN, RN, Assistant Professor of Nursing

Clinical Question:

In nurses, what is the effect of 12-hour shifts as compared to 8-hour shifts regarding quality of nursing cares, nursing fatigue, patient safety, and the employer's perspective?

Synthesis of Evidence:

Quality of care and patient safety are the top priorities in the nursing practice. Shift length has been shown to affect quality care outcomes based on its impact on nurses and the patient population. A review of literature was performed on seven articles observing the impact of 8 and 12-hour shifts. The following highlights were identified throughout these articles:

- Nurses perceive 12-hour shifts as more preferable for time off and better life balance (Cheng et al., 2015).
- Nurses preferred 12-hour shifts because it allowed for more time to complete tasks (Cheng et al., 2015; Haller et al., 2018).
- Nurses report higher job satisfaction working 12-hour shifts (Parkinson et al., 2018).
- One reason in which nurses prefer 12-hour shifts is because of their lack of desire to work five days a week (Martin, 2015).
- After working 12-hour shifts nurses did admit to more fatigue and less vigilance (Griffiths et al., 2014).
- Alternating between day and night shifts alters the body's circadian rhythms thus inducing poor health and increased risk for developing chronic diseases (Rhéaume & Mullen, 2018).
- Studies found that more mistakes were made and more cares were missed due to fatigue from longer working hours (Stimpfel & Aiken, 2013).
- Hospitals preferred 12-hour shifts due to decreased need for nursing employment and fewer shift changes (Griffiths et al., 2014).

Bottom Line:

While some nurses preferred 12-hour shifts because of work-life balance, and hospitals preferred them due to lower staffing needs and lower costs, 12-hour shifts were linked with inconsistencies in care, increased fatigue, and decreased patient safety. Nurses miss more cares and get poorer sleep with longer shifts, and this means that patients receive poorer quality of care. This leads to more stress on the nurses, contributing to burnout.

Implications for Nursing Practice:

Facilities should consider offering both 8- and 12-hour shifts to nurses as some preferred working 12-hour shifts because of the added free time they had. Nurse managers should begin a discussion with their coworkers and research evidence-based practice articles to come to a conclusion on this issue as a unit. After this discussion takes place and a plan is implemented, managers should welcome staff feedback and communication to enhance staff teamwork. By using this method of feedback and communication, managers can develop a schedule for their nurses that enables them to have decreased fatigue and patients to experience the best care during their hospitalization.

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The Effect of Family Presence During Resuscitation of Pediatric Patients

Jeni Baustad, Shania Brooks, Kaitlyn Gulick, Karlee Kautzmann, University of Mary BSN Students; Kathy Roth, MSN, RN, Assistant Professor of Nursing

Clinical Question:

Does family presence during pediatric resuscitation attempts versus those whose family members are not present provide better patient and family satisfaction?

Synthesis of Evidence:

The advantages and disadvantages of parental presence during pediatric resuscitation have been discussed since 1982. In that year, a hospital in Michigan began allowing family members to be present at the bedside during resuscitation (O'Connell et al., 2017). It is pertinent to keep families together during critical care of children and in fact, family-centered care is endorsed by the top pediatric hospitals in the United States (Smith McAlvin & Carew-Lyons, 2014). Numerous national nursing and medical organizations endorse the option for families to be present for resuscitation attempts including: Institute of Medicine, American Academy of Pediatrics, and the American Heart Association among others (O'Connell et al., 2017). Parents can cope better and understand what has happened to their child if they are present. Some challenges of allowing family members to be present are a lack of both education and a designated support person for the parents. The following key points were highlighted in the review of literature:

- The majority of family members held the belief that it was their right to be present and it decreased the anxiety experienced by the patient (O'Connell et al., 2017).
- Data concluded that families being present during resuscitation did not negatively affect the workflow of the healthcare team (Pasek & Licata, 2016).
- Family members reported that they felt their presence was important in being able to comfort, protect, and support the patient (Leske et al., 2013).
- It was found that the best outcome was to give parents the option to witness resuscitation attempts and to support parents throughout the process (Perry, 2009).
- If given the choice, 100% of parents who had witnessed previous resuscitation attempts on their child responded that they would choose to be present again (Smith McAlvin & Carew-Lyons, 2014).

Bottom Line:

Family presence during cardiopulmonary resuscitation reduces parent and child anxiety, helps children better cope with pain and fear, allows parents to witness that everything possible was done for their child, and facilitates the grieving process if death occurs (O'Connell et al., 2017). Upon review of five articles, overwhelming evidence proves that parents want to be there as a support person for their child during this stressful time. Therefore, healthcare providers should do their best to accommodate the child and their family. Parental presence promotes the best outcomes for the child and the parents by facilitating family-centered care.

Nursing Implications:

According to evidence-based practice, parents should be allowed the choice to be present during resuscitation of their child. Implementation of a new policy would have to be presented to and approved by the hospital board. The next step to implement this as a new policy would be to conduct educational seminars for pertinent staff. The hospital would need to educate staff that could each act as the designated support person for the parents who are present during resuscitation. This support person, or facilitator, could be a variety of people, from nurses to social workers to physicians. Whoever is supporting the family needs education to serve as a resource for parents during a resuscitation event (Smith McAlvin & Carew-Lyons, 2014). This facilitator is the parents' greatest resource during a critical time in their child's care. The facilitator should update the family on the status of their child, inform them of expectations during the event, and explain interventions being performed (Smith McAlvin & Carew-Lyons, 2014). Supporting parents during this process is beneficial to everyone involved.

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Wound Cleansing: Tap Water Versus Normal Saline

Kallie Anderson, Gwendolyn Davis, Brandi Oerter, and Amber Weber, University of Mary BSN Students; Kathy Roth, MSN, RN, Assistant Professor of Nursing

Clinical Question:

In patients with open wounds, what is the effect of cleansing the area with tap water when compared with normal saline on patient infection rates, satisfaction and cost effectiveness?

Synthesis of Evidence:

Four articles were reviewed to evaluate the effectiveness of cleansing wounds with normal saline versus tap water. Cleansing wounds has been a topic of discussion in the nursing profession regarding infection rates, patient satisfaction, and cost effectiveness. Over the years, debates have gone over the use of normal saline (sterile or non-sterile) versus tap water. Although using normal saline has been best practice in hospitals and home settings for many years, tap water is becoming increasingly popular due to its immediate availability. Which cleaning method is more cost effective? Which cleansing method is best at lowering infection rates?

The first article conducted by Stanford University Medical Center's emergency department determined if there is a difference in infection rates in traumatic wounds when they are cleansed initially with tap water versus when they are cleansed with normal saline (Weiss, Oldham, Lin, Foster, & Quinn, 2013). There were a total of 631 patients in the randomized controlled study, of which 318 were randomly placed into the tap water group and 313 of them were in the normal saline group. Non-caregiving staff utilized a randomized control system to prepare basins with either tap water or normal saline to cleanse the patients who presented to the emergency department with traumatic wounds. The patients, the attending emergency department physicians who initially treated the wounds, and the physicians who were providing the patients with follow-up care to check for infection were all blind to which solution was used to cleanse the wounds before suture closure. The results revealed that there were twenty infections in the normal saline control group and eleven in the tap water control group; the research conducted showed no significant difference in the type of solution used to treat wounds (Weiss et al., 2013).

The second article review was on wound infection, however, placed an emphasis on cost effectiveness and patient autonomy. The study was conducted in Switzerland at the Lucerne Cantonal Hospital and contained one control (sterile technique) group and an intervention group (Ruhle et al., 2017). According to Ruhle et al. (2017), the variable group was to follow a protocol of non-sterile irrigation, which included taking a shower in room temperature water with gentle pressure for 1-2 minutes and dressing the wound with non-sterile gauze and tape. Patient satisfaction for wound cleansing done by sterile technique was decreased due to the wound dressing process completed by home health nurses that lasted for twenty minutes two times daily, which lead to loss of employment income. Using non-sterile technique for wound cleansing would add up to savings of approximately $300,000 in hospital costs per year (Ruhle et al., 2017). The researchers concluded that non-sterile wound care had comparable results to sterile methods in terms of reinfection/reintervention rates, while health care costs to the patient decreased dramatically and independence increased considerably post-surgery leading to an increased patient satisfaction.

The focus of the third article was on wound infection and conducted in Hong Kong by Mun Che Chan, Kin Cheung and Polly Leung (2016). The wounds were assessed according to size (as compared to the beginning state), location, color and frequency of dressing changes (Chan et al., 2016). Two wounds from the experimental group were found to have developed infection with inflamed skin surrounding the area, while there was no development of infection in the control group. In the experimental group, there were ten wounds that decreased in size with three wounds that developed epithelialization and granulation, and in the control group nine wounds decreased in size with no signs of developing epithelialization or granulation. The limitations that are noted for this experiment include the fact that the group size was relatively small as compared to the population and that hospital tap water was used instead of tap water at a patient's home. There was no significant difference found between the use of tap water and sterile normal saline and further research with larger groups needs to be conducted to determine the accuracy of the findings in this study (Chan et al., 2016).

The final article reviewed by Ritin Fernandez and Rhonda Griffiths (2013) reviewed randomized and quasi randomized controlled trials that compared the use of normal saline, tap water, and other solutions for wound cleansing. Research has found that normal saline is a better cleaning solution due to its isotonic properties and it does not interfere with healing process. As the further research was conducted, it was found that there was no more or no less of an infection rate with wounds cleansed with normal saline or tap water. When using tap water, supply must be taken into consideration, as in some areas constant drinking water is not available. The patient's overall health condition, comorbidities, and the characteristics of wounds should be taken into consideration when it comes to choosing a method to cleanse wounds. "The updated trial demonstrates no reduction in the infection rates in wounds that were cleansed using tap water compared to those cleansed with normal saline" (Fernandez & Griffiths, 2013, p. 9).

Bottom Line:

There have been many studies conducted on the difference in the use of normal saline versus tap water for wound cleansing, and no significant difference was noted in rate of infection. However, the cost to the patient and facility for the wound care treatment was less with the use of tap water than that of normal saline. Some shifts have been made regarding the discussion of wound cleansing from the topic of infection to cost to the facility and patient. The decision to use tap water or normal saline for treatment is made based on the patient's needs and preferences.

Implications for Nursing Practice:

Research has shown there is a more significant difference in the cost of the wound care than there is in infection rate. It would be imperative that researchers speak with local health care facilities to implement the change to tap water for wound cleansing, after more definitive studies have been conducted, in order to decrease the costs to both the facility and the patient. Researchers could share their findings with local health care staff to discuss policy changes regarding the protocol in their facility and create outreach programs. Creation of a wound care committee, composed of nurses, physicians, aids, and community members could be beneficial to continue research, education, and to implement finding. Throughout the individual facilities, patient satisfaction should be included in the evaluation of the newly implemented wound care protocols, this could be completed through surveys, interviews and debriefs following their treatment. After reviewing these articles, it is recommended that additional research be conducted to build on the foundation set by these studies to continue improvements of best clinical practice.

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17th Annual Northwest Region North Dakota Collaborative Educational Nursing Conference

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Lisa Dooley, BCJ, MCJ, EdD
Terry Eckmann, PhD., ACSM-EP-C, ACE-GFI, RYT-200
Melissa Fettig, MSN, RN
Nicola Roed, DNP, RN, CNE
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7:30am – 8:00am	**Registration**
8:00am – 8:15am	**Welcome**
8:15am – 9:15am	**"Let Your Voice Be Heard"** Lisa Dooley BCJ, MCJ, EdD
9:15am – 10:15am	**"Let's Break the Bullying Cycle"** Dr. Nicola Roed DNP, RN, CNE
10:15am – 10:30am	**Break**
10:30am – 12:00pm	**"Life Hacks for Living Well"** Dr. Terry Eckmann PhD., ACSM-EP-C, ACE-GFI, RYT-200
12:00pm – 1:00pm	**Lunch (Provided)**
1:00pm – 2:00pm	**"It Happened to Me, It Could Happen to You"** Jackie Binstock BSN, RN
2:00pm – 3:30pm	**Breakout Sessions**

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3:30pm – 3:45pm **Evaluations and Wrap up**

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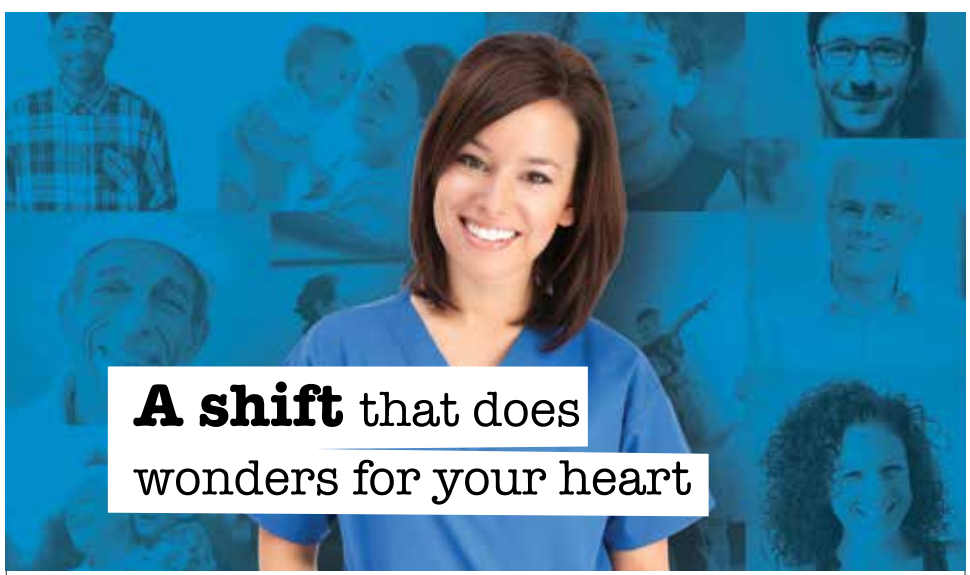

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