The North Dakota Nurse

NDNA
NORTH DAKOTA NURSES ASSOCIATION

NORTH DAKOTA NURSES ASSOCIATION

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 4 **October, November, December 2019**

INDEX

Congratulations President Johnson!

Our NDNA President, Tessa Johnson, was honored by her employer, Agemark/Dickinson CountryHouse at their annual corporate awards banquet on October 8 in Omaha, Nebraska with the 2019 Agemark Director of the Year! The North Dakota Nurses Association congratulates her for her hard work and accomplishments with memory care. In addition, CountryHouse Dickinson won the Rising Star award as well as the LifeCylces award.

Message from the President

Thankful and Grateful

Tessa Johnson MSN, BSN, RN, CDP

Greetings North Dakota Nurses! This is the time of year that we get to reflect. We get to reflect on why we are grateful, why we are thankful and how we remain humble. When considering our careers, our business and the demands on us as nurses, it can sometimes be a challenge, but we must be intentional about it. As we look onward to a new year, it is normal to reflect and be thankful for those people who are most important to us including family, friends, and coworkers and to acknowledge the areas that make our lives meaningful and bring us joy. As nurses, we should be aware that the act of being grateful is more powerful than we may realize (Haryanto, 2018). When we remember to be grateful, our attitude in general can change things positively around us. Being grateful also can have significant positive effects on our health.

Being grateful and having a positive attitude as a nurse at times can be more difficult than we would like to admit. Considering the daily strains that face nurses, it is comprehensible that negativity in the work environment can result in a toxic culture and ungrateful teams. According to Mickey, "A recent survey conducted by http://nursing.org asked nurses who were in the profession for less than one year what they wished they had known before starting their first positions. The top five items were understanding and acceptance that no one has all the answers, realization of the independent nature of the work, recognition that slow deliberate action is better than rushing, the need to keep the best interests of the patient in the forefront, and the insight that small degrees of gratitude can make a considerable difference" (Haryanto, 2018).

When reflecting on those survey results, it very much implicates on not only just nurse leaders to set good examples, but all nurses. Every single nurse plays an important role in making sure they do their part. The act of all nurses practicing gratitude is a factor of emotional intelligence and is essential for effective nursing practice for all of us. Gratitude affects the way nurses are perceived by others and is necessary for good teamwork. When people feel valued, they have higher job satisfaction, engage

Message from the President continued on page 2

How to submit an article for The North Dakota Nurse!

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 look at all promising submissions.

Deadline for submission for the next issue is ***12/4/2019***. Send your submissions to director@ndna.org or info@ndna.org.

Welcome New Members

Jayme Meier *Fargo*	Kara Leopold *Horace*	Taryn Small *Bismarck*	Lynn Paulson *Williston*
Michelle Pratt *Bismarck*	Jill Wiese *Washburn*	Melinda Balderas *Halliday*	Karissa O'Daniel *Fargo*
Stephanie Hauge *Dickinson*	Julia Lemke *Fargo*	Brenda Amundson *Bismarck*	Tiffany Sommerer *Zap*
Richelle Johnson *Minot*	Dallas Hepper *Fargo*	Carmin Erickson *Dickinson*	Miriam Anderson *West Fargo*
Caitlin Stockert *Bismarck*	Jessica Neibauer *Bismarck*	Kelsey Henderson *Gwinner*	Lacey Bergh *Kindred*
Jennifer Minion *Fargo*	Erin Wolters *West Fargo*	Donna Lagois *Garrison*	Denise Beaver-Eslinger *Hannaford*
Courtney Naastad *Grand Forks*	Gail Pederson *Valley City*	Tania Brost *Gladstone*	

Message from the President continued from page 1

positively with coworkers, and are more eager to work toward organizational goals. Even if we must make it very intentional in our workplaces to be a grateful, humble and thankful nurse the good news is, it is contagious. Everybody likes to feel good and to be in a positive environment. Be well, we need all of you!

Haryanto, M. (2018). Nursing and the Attitude of Gratitude: Keep the Spark Burning. Orthopedic Nursing, 37(6), 335–336. Retrieved from https://www.nursingcenter.com/journalarticle?ArticleID=4843654&Journal_ID=403341&Issue_ID=4843653

NDNA
NORTH DAKOTA NURSES ASSOCIATION

ALL Nurses!

NDNA is so proud of what we are experiencing – growth!

We would love our members and potential members to assist us in our efforts for furthering the organization's mission which is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.

We are looking for nursing students, retired nurses, part time nurses, full time nurse, staff nurses, nursing leaders, clinic nurses, hospital nurses, nursing home nurses, (read: ALL NURSES) and healthcare facilities to join us in activities in the advancement of nursing.

There is much to do – help with conferences, meeting representation, attendance at educational offerings, public speaking, and more. We are seeing growth in the association and want to make sure you are a part of it.

Please contact director@ndna.org to see what YOU can do.

The North Dakota Nurse

Official Publication of:
North Dakota Nurses Association

NDNA
NORTH DAKOTA NURSES ASSOCIATION

General Contact Information:
701-335-6376 (NDRN)
director@ndna.org

Officers

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.

Acceptance of advertising does not imply endorsement or approval by the North Dakota Nurses Association of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. NDNA and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser's product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the staff, board, or membership of NDNA or those of the national or local associations.

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 12/4/19.**

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.

Medical Cannabis Update and a Bit of Education for Nurses

By Gail Pederson, SPRN, HN-BC

The citizens of North Dakota overwhelmingly voted for Measure #5, legalizing Medical Marijuana in 2016 by over 65%. Implementation of the Medical Marijuana Program (MMP) in North Dakota has been on a slow roll out with the first dispensary opening in February, 2019. I would like to update nursing colleagues, who can be an integral part of care and offer support for medical cannabis patients.

Developed in 2016, the ANA statement, The Therapeutic Use of Marijuana and Related Cannabinoids, calls for the rescheduling of cannabis and articulates a national response to the current individual state's laws and differences. It is sourced below.

The history of the word "marijuana" is racially charged and I encourage the use of "cannabis" as proper terminology. It has a history of inequality, both racially and economically and I feel strongly the "reefer madness" mentality that goes with the word must be dispelled. Ancient history of cannabis and hemp has been evident. More recent history, when cannabis was removed from the US pharmacopoeia in 1937, there were over 200 preparations that contained cannabis on the list.

My history with medical cannabis started in 1995 when my mother was diagnosed with pancreatic cancer. She was in pain, anxious and having trouble eating. Attending one of my holistic programs, I approached a Naturopath who had spoken to us and asked his opinion. He immediately said "Find her some marijuana." My mom? Something illegal? I never brought it up, learning just a short while ago she had asked my brother about it.

Fast forward to Measure 5 in 2016. I did not participate in that movement until I was asked to work with Measure 5 representatives in the rewrite to Senate Bill 2344. I have to admit, I am a life long North Dakotan and I had never been to the capitol while in session. I spoke before the House and Senate Health and Human Services subcommittees. I spoke for basic patient protections and reducing the criminality of this now legal product. HIPAA certainly came in to play in the discussion.

That began my quest for continued knowledge. I found the American Cannabis Nurses Association (ACNA), took their recommended program and have a Certificate of Completion from The Medical Cannabis Institute. I have incorporated the ACNA's scope and standards of practice into my Specialty Practice RN scope of practice, focusing on education and consultation. I want to bring credible information to this new frontier of medicine. There are many other significant organizations that have provided me with a network of support including Cannabis Nurses Network and Green Nurses Group.

One of the most significant publications to come out is The National Council for State Boards of Nursing National Guidelines for Medical Marijuana, which was published in July, 2018. This is a comprehensive supplement that's purpose is "To provide nurses with principles of safe and knowledgable practice to promote patient safety when caring for patients using medical marijuana." It is designed for Nursing and APRN students, nurses and certifying practitioners.

The 5 Principles of Essential Knowledge as outlined in the guidelines are a strong starting point and I would like to briefly touch on each one.

1. The nurse shall have a working knowledge of the current state of legalization of medical and recreational cannabis use.

North Dakota has legal medical cannabis. Recreational cannabis is not legal but look for several opportunities to vote on this issue in the 2020 election. I support it for many reasons. Safety of products purchased on the black market is of major concern among others.

2. The nurse shall have a working knowledge of the jurisdiction's Medical Marijuana Program (MMP). North Dakota's program is managed by the Department of Health and Information can be found at https://www.ndhealth.gov/mm/. There are patient and provider portals with tutorials available.

3. The nurse shall have an understanding of the endocannabinoid system, cannabinoid receptors, cannabinoids, and the interactions between them. This subject is a whole other article! Please think about this…would you not learn about your respiratory system? It is time to recognize the importance of the endocannabinoid system. It is referred to as the 11th body system, and consists of endocannabinoids, the receptors and the enzymes responsible for degradation and synthesis of the cannabinoids. The endocannabinoid system was discovered in 1973. It is seen as the great balancer in the body and maintains homeostasis for many other body systems. Phytocannabinoids are external sources and include THC, CBD and CBN among many others. These are most well known. THC acts as agonist and CBD an antagonist on a receptor site. A tip if someone overindulges using a THC product, CBD can be used to dampen the side effects. Another important thing to know, there are no receptors in the respiratory center in the brain. A person will not stop breathing with over intoxication of cannabis.

4. The nurse shall have an understanding of cannabis pharmacology and the research associated with the medical use of cannabis.

Legislation has outpaced research in this situation. Reliable studies are coming from states where they are able to do research. Adverse effects are often due to the patient's current condition and medication the person is already taken. A general rule of dosing is for the patient to "start low and go slow" with dosing. Dosing is very individual and patient directed for efficacy. Cannabis is not without drug interactions. It metabolizes through the liver and uses the P-450 pathway. Warfarin is one of the most recognized as having changes in therapeutic levels. It is not without some concerning side effects, though they pale compared to opioids and other traditional therapies.

5. The nurse shall be aware of the facility or agency policies regarding administration of medical marijuana.

Nurses, by jurisdictional law are not permitted to give cannabis unless it is under the guidance of facility policy. What are your policies for patients who come in to your facility who are using cannabis? How can we ethically restrict our patients use? Another controversial aspect is the allowance of employees to use medical cannabis and are drug tested. They have a card. It is legal. It is a grey area and policy should be developed. It is a myth that cannabis patients want to "get high." They want to be able to function with their condition, with the least side effects.

North Dakota's MMP has had some immediate implementation problems. Many providers do not wish to or are unable to certify patients, building great frustration among patients. The slow rollout of our dispensaries and only one of two grow facilities currently providing product has proven to be a major barrier. Selection is limited and prices are high. Can you imagine a pharmacy that provided a medicine that works well for you one month, but does not have a consistent supply or the same medicine the next month? This is happening!

Another reality? The cost makes it an impossible option for many, especially the disabled. I was disheartened to hear another cannabis activist tell me "I can go bankrupt (buying cannabis), be in pain or go back to the 'legal heroin' I can get almost free at the pharmacy." The issue of growing your own cannabis is also very controversial. Be assured, it's not that easy to grow, but it would solve the cost problem for many patients (including people like this young man) who are priced out of purchasing. A full monthly allotment of cannabis could be about $1500. A cancer patient may have costs up to $2500. Dispensaries had to lay out a compassion program to help those of limited resources, but it is not providing much relief. The exorbitant price continues to make the black market viable. Unfortunately, we are not the only state with this problem.

The final problem that has become evident, I see as a human rights issue and has become personal. The article I wrote for the last newsletter was about serving on the board of directors where my cognitively disabled son is a client. Another board member and guardian for his disabled son approached me. Their son's neurologist and psychiatrist have both recommended they try cannabis. He sleeps very little and his anxiety is through the roof. This young man is denied the ability to trying this maybe life changing medicine, until we can amend the law in 2021.

Our program states a caregiver can have 5 MMP card holders under their caregivers license. The MMP patient can have just one caregiver. That caregiver is the only person that can purchase and handle the cannabis and the only one that can dose that person, if they are unable to do it themselves. Only one person…covering the daily dosing for an individual, 365 days a year. It is not very realistic. I live in the same town as my son. I could not do this every day. The law needs to allow supplemental caregivers to provide routine dosing. It is something that until implementation was not identified as a needed change.

While there are problems, I am reassured by other cannabis nurses across the country. Every state has had problems. High prices and shortages are not unheard of. We have an admirable list of approved conditions and our legislators are receptive to listening to our cannabis advocates. I leave you with this final statement from the NCSBN guidelines, which has been a hallmark of my holistic philosophy.

"In addition to ethical responsibilities under the nurse's jurisdictional law, the nurse shall approach the patient without judgment regarding the patient's choice of treatment or preferences in managing pain and other distressing symptoms.

Awareness of one's own beliefs and attitudes about any therapeutic intervention is vital, as nurses are expected to provide patient care without personal judgment of patients."

GUIDELINES FOR THE NURSING CARE OF PATIENT WHO USE CANNABIS

Resources
ANA position statement on Cannabis:
https://www.nursingworld.org/~4ad4a8/globalassets/docs/ana/therapeutic-use-of-marijuana-and-related-cannabinoids.pdf
https://ncsbn.org/The_NCSBN_National_Nursing_Guidelines_for_Medical_Marijuana_JNR_July_2018.pdf
Healer.com
American Cannabis Nurses Association.
https://cannabisnurses.org/State-Medical-Marijuana-Laws
ProjectCBD.org
TMCI Education https://themedicalcannabisinstitute.org/product-category/nursing/

Gail Pederson, SPRN, HN-BC is a board certified holistic nurse and in 2014 was recognized by the North Dakota Board of Nursing as a Specialty Practice RN in Holistic Nursing. Gail opened her private holistic nursing practice-Be Well Healing Arts, pllc in November 2014, providing health education and complimentary therapies. She also coordinates care for aging religious sisters in their home, Maryvale convent, north of Valley City. She has recently been recognized as a 2019 Legendary ND Nurse for Advocacy by the ND Center for Nursing.

Maintenance

By Kami Lehn, BSN RN

As fall fades into winter, are you planning your final lawn clean up? The leaves have changed and fallen, and we all are getting the lawn mowed one last time before winter sets in. Can you picture forgetting to mow the lawn for a week? A month? And maybe you just choose to avoid the lawn care for years, you don't have the time, or just simply forget to do it.

Eventually at some point one of two things will happen; that lawn will be maintained by someone else or will be become an overgrown mess. We are going to think of our body's as our lawn, we water it, we want it to be healthy and well kept, and that often takes maintenance. We need to be the person responsible for maintaining our bodies year round, not just at annual check up time.

Now let's think about our health maintenance. I, as a nurse, know that breast self-exams are important. I could make 100 excuses of why I didn't do my monthly breast exams. I was a busy mom, I was in school, and so on. None of those excuses were valid, and five years ago those excuses disappeared. I wish that I could tell you that I finally decided that my health was important enough to make time to do monthly breast exams, but that is a lie. It took my sister's breast cancer diagnosis to scare me into monthly breast exams.

I got the call from my sister that the lump she found on self-exam, was very likely malignant. I got to the hospital and they took her back for a biopsy. As soon as she was out of sight, I fell apart sobbing in the waiting area. She was 37 years old, and we had no strong familial history of breast cancer so this could not be real. We spent the last afternoon before her diagnosis watching her kids' softball game. She is now in remission and I am thankful everyday that she 'found' her lump and had the courage to seek treatment.

Take the time to get to know your body, we will need to both feel and look for changes in our breasts. Things to watch for are: lumps, bumps, redness, rashes, bloody discharge, dimpling, new nipple inversion. Look in the mirror and examine your breasts with your hand on your hips, shrug your shoulders, and raise your hands above your head. (Mayo Clinic, 2019)

You can do the breast exam standing or lying down. Using the pads of your fingers make a pattern that includes the area under the armpit, also including the area up to your collar bone. Try and relax and take your time and be sure to cover the entire breast. (Mayo Clinic,2019)

If this is difficult, or you are unable to perform please ask your care provider for guidance. Breast self-exams are not the only tool in your breast maintenance, mammogram and other screening tools should be reviewed with your healthcare provider.

References

Mayo Clinic (2019). *Breast self-exam for breast awareness.* Retrieved from: https://www.mayoclinic.org/tests-procedures/breast-exam/about/pac-20393237

Nurses on Boards Coalition

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, click here: https://www.nursesonboardscoalition.org/i-want-to-serve/

NDNA 2019 Elections - Newly Elected Nurses to Serve

NDNA Election 2019 took place August 12-21, 2019. These nurses were re-elected or elected to serve:

KAMI LEHN, BSN, RN
VP OF MEMBERSHIP

Employer - Sanford Health

I have really enjoyed serving in the role VP of Membership since last year. It's an honor to represent and support ND nurses. I have been a nurse for 10 years and have experience in clinic, psych, ICU and Utilization Management.

I feel that having a collaborative voice on important nursing/patient related issues is essential in the legislature. By supporting each other and growing together we are giving our best to one another, just as we give our best to our patients. I feel strongly that we need voices from many different nursing roles to get a solid understanding of what nursing in North Dakota means to our members.

DEEANNA OPSTEDAHL, MSN, RN , CNOR
VP OF FINANCE

Employer
CHI St Alexius Dickinson

I previously belonged to the SDNA and SDHA. I did not hold an office, but attended most of the meetings. I was the Acute Care director in Spearfish, SD and then took a director position in the OR I Sturgis. I was the chair of a board that made decisions on products purchased and contracts signed by Rapid City Regional Health. I was recruited by Dickinson for the Director of Surgery position and then CHI asked if I would be the regional OR director for the western side of ND. I was then recruited to be the VP of Patient Care in Dickinson. I am responsible for many budgets within the hospital. I work very well with others and have had opportunities to get the best price of products in the surgery departments.

MELANIE ANNE SCHOCK, MS, RN, CNE
VP OF COMMUNICATIONS

Employer
BSC/Dakota Nursing Program

I have been a registered nurse for 23 years and have practice experience in a variety of settings and roles (inpatient, ambulatory care, management, informatics, occupational health, and most recently, nursing education). I am also currently seeking my Doctor of Nursing Practice. As part of the DNP Essentials, I think it is important to serve in leadership positions and perfect one's professional nursing potential. In this role, I feel I would serve the NDNA well. Over the course of my nursing career, I have had the opportunity to lead ad-hoc groups as well as serve in the Secretary/Recordkeeping role. For example, currently, I serve as the Secretary for my Doctor of Nursing Practice Association (DNPA) Board at Western University of Health Sciences.

DONNA LAGOIS, BSN, RN
VP OF GOVERNMENT RELATIONS

Most of my career has been travel nursing. I also have a strong background in alternative healing. I'm a Core Synchronism Practitioner since 2003. I went to school for massage therapy in 2011. I'm at a point in my life where I feel I can assist making a difference on a higher level for nursing. I'm a strong advocate for nurse to patient ratios, and have experience in Med/surg, peds, OB, critical access hospital, ER, long term care, home health, hospice, and clinic.

JAMI FALK, RN, MSSL, CNML
NOMINATING COMMITTEE MEMBER

As a servant leader, I have a desire to serve the nursing community to ensure health care and public policy aligns with the knowledge and expertise of the nursing community. I want to serve as an advocate for the work force and provide unification across professional nurses in the state of ND by promoting excellent professional practice.

Jami is the Veteran Health Administration's West Region Community Based Outpatient Clinic Nurse Manager. She works out of the VA Clinic located in Bismarck, ND and oversees the Primary Care clinical and administrative functions within four rural clinics in North Dakota. Over the past 15 years Jami has served as a front line Labor and Delivery RN, ICU nurse, ICU and Dialysis Nurse Manager, Inpatient Mental Health Nurse Manager, Acting Associate Chief Nurse of Primary Care and currently as the West Region CBOC Clinic Manager. Through these positions she has been involved in ensuring that front line staff has the education, training and knowledge they need to successfully take care of patients while working on ensuring quality nursing care is provided. She completed her undergraduate through the University of Jamestown in 2002, and completed her graduate studies through the University of Mary in 2015. She certified as a Contracting Officer Representative, and also holds a Certification in Nurse Manager Leadership through AONE Association of Nurse Executives.

SUSAN INDVICK, BSN, RN
NOMINATING COMMITTEE MEMBER

My name is Susan Indvik, and I am a BSN, RN and Student Health Nurse, Instructor, and Athletic Nurse for DCB. I'm a graduate of the DCB nursing program and a BSN graduate of Capella University. Currently, I am working on completing my MSN in nursing education by the years' end. I have worked in the medical field most of my adult life in different capacities. I was born and raised in Minot, but have lived in the community for the past 25 years. In my spare time, I continue to work for the Mayo Health System in Minnesota. I am married and have three grown children and five grandkids with a sixth on the way. I love to cook, bake, and have fun with my three dogs and one cat. My husband and I also have a farm and ranch where I occasionally help, when I am able. I am licensed in the states of ND and MN.

SHEILA NETZ, BSN, RN
NOMINATING COMMITTEE MEMBER

I have been a nurse in ND since 1994 as an LPN. Over the years I have advanced my education for which I am currently in school for my masters as a nurse educator. I have found over the past year that I need to stretch in the area of being more of a representative of who and what nurses are.

DONELLE RICHMOND, BSN, CHPN
MEMBERSHIP ASSEMBLY REPRESENTATIVE

I have 40 plus years of acute care experience and am currently working in inpatient Palliative Care. I have been active in NDNA for the past 25 years, and had the opportunity to attend the general Membership Assembly filling in for the Executive Director. Many of the decisions that affect how we can provide our bedside care are made at the national level, and I feel it is important we have a strong voice in those decisions.

Handwashing and MRSA

Appraised by:
Caleigh Differding, RN, Danielle Evans, RN, and Toyin Aderemi-Ata, RN Mayville State University RN to BSN Program

Clinical question:
What is the effect of handwashing alone vs contact precautions in reducing the transmission of MRSA in adults in healthcare facilities?

Chowers, M., Carmeli, Y., Shitrit, P., Elhayany, A., & Geffen, K. (2015). Cost Analysis of an Intervention to Prevent Methicillin-Resistant Staphylococcus Aureus (MRSA) Transmission. *PLoS ONE, 10*(9), 1–9. https://doi.org/10.1371/journal.pone.0138999

Labrague, L. J., McEnroe, P. D. M., van de Mortel, T., & Nasirudeen, A. M. A. (2018). A systematic review on hand hygiene knowledge and compliance in student nurses. *International Nursing Review, 65*(3), 336–348. https://doi.org/10.1111/inr.12410

Marimuthu, K., Pittet, D., & Harbarth, S. (2014). The effect of improved hand hygiene on nosocomial MRSA control. *Antimicrobial resistance and infection control, 3*, 34. doi:10.1186/2047-2994-3-34

Verbeek, J. H., Ijaz, S., Mischke, C., Ruotsalainen, J. H., Makela, E., Neuvonen, K., Edmond, M.B., Sauni, R., Balci, F. K., & Mihalache, R. C. (2016). Personal protective equipment for preventing highly infectious diseases due to exposure to contaminated body fluids in healthcare staff. *Cochrane Database of Systematic Reviews*. Retrieved from https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011621.pub2/full

Synthesis of evidence:
Methicillin-resistant Staphylococcus aureus (MRSA) is usually spread by direct contact with an infected wound or from contaminated hands. People who carry MRSA might not have signs of infection immediately and can spread the bacteria to someone else without knowing that they are spreading it. There are many ways of hand hygiene after a contact with a patient with MRSA in healthcare facilities but evidence from our research has shown that an effective hand washing with soap and water for at least 20 seconds is the most effective especially if the caregiver's hand is visibly soiled. Contact precautions such as the use of PPE can equally prevent the transmission of MRSA, but it is not as effective as hand washing because it can get wet from breathing through the mask or a spill. Effective handwashing after contact with patient with MRSA has proven to be the best way to reduce the transmission of MRSA compared to just putting on glove and gown (Labrague, McEnroe, van de Mortel, & Nasirudeen, 2018).

Based on our research from the Cochrane database, it was clear that effective handwashing alone can prevent the transmission of MRSA compare to contact precautions. In this systematic review, two pairs of gloves led to less contamination than only one pair of gloves. The outer gloves were immediately removed after the task was finished and apron or gown removal led to less contamination. It was also shown that if the nurse or the provider wore gloves there was a greater chance that the nurse or provider forgets to wash their hands. This increases the risk for infection to spread to another patient or the provider. In general, there was evidence that contact precaution alone was a low quality, and not totally safe without the use of hand washing as a backup to reduce contamination. It was concluded in Cochrane database that contact precautions equipment can be expensive, uncomfortable for both patients and caregivers, and not totally safe without the use of handwashing method as a backup. (Verbeek, Ijaz, Mischke, Ruotsalainen, Makela, Neuvonen, Edmond, Sauni, Balci, & Mihalache, 2016).

Bottom line:
Research from international nursing review and Cochrane database create an awareness that handwashing vs. contact precautions were to evaluate the appropriate personal protective equipment (PPE), removal methods with the least risk of self-contamination or infection for Health Care Workers, and the most effective training method that increase compliance with PPE protocols. It was discovered during the study that use of PPE can help in reducing MRSA and other infections. However, there were also evidence that this method was low quality, and not totally safe without the use of hand washing method as a backup. More research should be conducted to specify the standards and appropriate materials that should be used for all kinds of PPE, including gowns, goggles, face shields, short-sleeved and long-sleeved gloves.

Implications for nursing practice:
There are many implications for nursing practice when it comes to MRSA prevention. Patients at high risk for MRSA carriage, such as patients that have been hospitalized in the last month, are on long-term hemodialysis, or if they have a history of MRSA, were screened by nasal swab upon admission. If the patients were found to be MRSA carriers, they were placed in contact isolation (Chowers, Carmeli, Shitrit, Elhayany, & Geffen, 2015). This is important information for nursing because there are nurses caring for and being exposed to these patients before we know if their swabs come back negative or positive so it's important that we take the proper precautions when caring for them to not only protect ourselves but to protect the other patients that are in our care. There is also something called a vertical MRSA prevention program. This was a prevention program targeted at high-risk patients which turned out to be very effective in preventing bacteremia. It also has been very cost effective (Chowers, Carmeli, Shitrit, Elhayany, & Geffen, 2015). Proper handwashing and the use of alcohol-based hand rubs decrease the spread of MRSA. (Marimuthu, Pittet, & Harbarth, 2014). This goes to show that foaming when going into a patient's room and foaming when leaving is so important and can help prevent the spread of infections such as MRSA. Hand washing is so important any time in healthcare however, it's especially important if the person that you're in care of, has an infection that can be transmitted so easily to other people.

-Narcotics/Anesthesia Treatments on Treating Phantom Limb Pain-

Appraised by:
Emily Kari, RN, Danielle Bilden, RN & Aminata Swaray, RN, Mayville State University RN-to-BSN students

Clinical question:
What is the effect of narcotics/anesthesia treatments on treating phantom limb pain in patients who have had an amputation of a limb compared to those patients who do not use narcotics/anesthesia treatments?

Articles References:

Batsford, S., Ryan, C. G., & Martin, D. J. (2017). Non-pharmacological conservative therapy for phantom limb pain: A systematic review of randomized controlled trials. *Physiotherapy Theory & Practice, 33*(3), 173–183. https://doi.org/10.1080/09593985.2017.1288283

Kollewe, K., Jin, L., Krampfl, K., Dengler, R., & Mohammadi, B. (2009). Treatment of Phantom Limb Pain with Botulinum Toxin Type A. *Pain Medicine, 10*(2), 300–303. https://doi.org/10.1111/j.1526-4637.2008.00554.x

Niskakangas, M., Dahlbacka, S., Liisanantti, J., Vakkala, M., & Kaakinen, T. (2018). Spinal or General anaesthesia for lower-limb amputation in peripheral artery disease - a retrospective cohort study. *Acta Anaesthesiologica Scandinavica, 62*(2), 226-233. https://doi.org/10.1111/aas.13019

Rothgangel, A., Braun, S., Witte, L., Beurskens, A., & Smeets, R. (2016). Development of a Clinical Framework for Mirror Therapy in Patients with Phantom Limb Pain: An Evidence-based Practice Approach. *Pain Practice, 16*(4), 422–434. https://doi.org/10.1111/papr.12301

Synthesis of evidence:
Phantom limb pain occurs after one has a limb amputation and feels pain where the removed limb once existed. The leading intervention for pain management of this condition is narcotic pain medication. There was an abundance of evidence pertaining to intervention options for treatment of phantom limb pain; however, it was difficult finding evidence that compared interventions. Some that we did find were:

- Researchers used the Cochrane handbook for systematic reviews of interventions to guide the development. The following interventions were studied: Transcutaneous electrical nerve stimulation therapy or TENS therapy; mirror therapy; electromagnetically shielding limb liners; electromagnetic-own-signal-treatment or EMOST; phantom exercises; transcranial magnetic stimulation; and sensory motor discrimination training. The results were inconclusive except that it is important to be monitored by trained medical professionals during intervention decisions (Batsford, Ryan, & Martin, 2017).
- Another study showed that mirror therapy was effective and improved phantom limb pain in conjunction with other interventions (Rothgangel, Braun, Witte, Beurskens, & Smeets, 2016).
- We reviewed a study that contained three patients who had undergone amputation from accidents and were being treated with Botulinum toxin Type A. Findings of the study showed these patients stated relief of pain and needed less of their previously prescribed narcotic medications. There were also no side effects reported by these patients (Kollewe, Jin, Krampfl, Dengler & Mohammadi, 2009).
- Patients who have had spinal anesthesia may need less narcotics or analgesic to manage their pain levels postoperatively. Pain management in patients with spinal anesthesia may require a minimum dosing compared to patients who had general anesthesia (Niskakangas, Dahlbacka, Liisanantti, Vakkala, & Kaakinen, (2018).

Bottom line:
Through our research, we came to the conclusion that, for any type of phantom limb pain, one must work with a licensed health care professional to create a treatment plan that constitutes both conservative and pharmacological modalities (for example, using oral morphine and mirror therapy together). Each patient is different and it may take some time before a proper treatment plan is formulated that fits their needs. As always, further ongoing research is needed to study the mechanism of phantom pain and, hopefully one day, there will be better answers providers can give their patients.

Implications for nursing practice:

- In treatment of patients with phantom limb pain, the nursing team may have to look at what type of anesthesia was used during surgery as this may be a very important aspect of how pain can be managed in the future.
- Patients who have had spinal anesthesia may need less narcotics or analgesic to manage their pain levels postoperatively.
- When using treatments, like narcotics, does not efficiently manage a patient's pain, another option is more conservative modalities such as mirror therapy or even hypnosis.

Diabetes: How do Acupuncture and Spinal Cord Stimulation Compare

Appraised By:
Kristina Phillips, RN; Nicole Myklebust, RN; Queen Elizabeth Fugah, RN

Clinical Question:
In adults diagnosed with diabetes, how do acupuncture and spinal cord stimulation compare to help manage pain in patients with neuropathy?

Articles:

Bailey, A., Wingard, D., Allison, M., Summers, P., & Calac, D. (2017). Acupuncture treatment of diabetic peripheral neuropathy in an American Indian community. *Journal of Acupuncture and Meridian Studies, 10*(2), 90–95. doi.org/10.1016/j.jams.2016.10.004

Duarte, R., Andronis, L., Lenders, M., Vos, C., Duarte, R. V., Lenders, M. W. P. M., & de Vos, C. C. (2016). Quality of life increases in patients with painful diabetic neuropathy following treatment with spinal cord stimulation. *Quality of Life Research, 25*(7), 1771–1777. doi.org/10.1007.s11136-015-1211-4

Meyer-Hamme, G., Friedmann, T., Greten, H. J., Plaetke, R., Gerloff, C. & Schroeder, S. (2018). ACUDIN-Acupuncture and laser acupuncture for treatment of diabetic peripheral neuropathy: A randomized, placebo controlled, partially double-blinded trial. *BMC Neurology, 18*(40). doi.org/10.1186/s12883-018-1037-0

Slangen, R., Schaper, N. C., Faber, C. G., Joosten, E. A., Dirksen, C. D., van Dongen, R. T., van Kleef, M. (2014). Spinal cord stimulation and pain relief in painful diabetic peripheral neuropathy: A prospective two-center randomized controlled trial. *Diabetes Care, 37*(11), 3016–3024. doi.org/10.2337/dc14-0684

Synthesis of Evidence:
The purpose of this review was to examine acupuncture and spinal cord stimulation. A study conducted in 2016 showed that with the use of spinal cord stimulation, study participants had a substantial improvement of pain and an overall increase in quality of life (Duarte, Andronis, Lenders, Vos, Duarte, Lenders, & de Vos, 2016). Each study in this review had limitations that affected the outcome, the most being in the article from Slangen et al. (2016). One limitation included the pain levels of the participants, as the study included individuals who had higher pain levels that failed treatment of pharmacological therapy alone. Another limitation was that the study included only individuals who suffered from diabetic neuropathy in the lower limbs (Slangen, et al., 2014).

Acupuncture treatments also proved to help lower pain from diabetic neuropathy, as in the article from Meyer-Hamme, Friedmann, Greten, Plaetke, Gerloff, & Schroeder (2018). With the addition of acupuncture to modern therapies, diabetic peripheral neuropathy pain was alleviated over the ten-week study (Meyer-Hamme et al., 2018). Much like the previous article, another study showed that over a ten-week period, diabetic neuropathic pain was decreased in all nineteen participants who finished the study (Bailey, Wingard, Allison, Summers, & Calac, 2017). Overall, when comparing acupuncture and spinal cord stimulation to lessen pain in adults with diabetes, research shows that both interventions lessen pain and improve quality of life. However, when used alone and not in a combination therapy, spinal cord stimulation was shown to be more effective in decreasing pain from diabetic neuropathy.

Bottom Line:
What does the evidence mean? The evidence of the research studies show that there are alternative treatment options for adults suffering from diabetic neuropathy. Varied treatment options may mean that more of the diabetic population suffering from neuropathy can live a fuller, more pain free life and have the ability to do more.

Implications for Nursing:
As nurses, it is our responsibility to advocate for our patients. This means utilizing evidence-based research to ensure that patients are receiving the most effective care that we can provide. Peripheral neuropathy can be debilitating and stop patients from performing daily activities and living to their fullest extent. With research showing the addition of alternative methods successfully treating pain at more successful rates than basic medical treatment alone, we need to push for research to further these studies and potentially implement them into practice ensuring improved care and patient outcomes.

Nurse to Resident Ratio

Appraised by:
Christina Fish, RN, David Larson, RN, & Abbey Machado, RN Mayville State University RN-to-BSN students

Clinical question:
How does nurse-to-resident ratios impact nurse job satisfaction and retention in the long-term care setting?

Articles:

Blankhart C. D., Foster A. D., & Mor V., (2019). The effect of political control on financial performance, structure, and outcomes of US nursing homes. *Health Services Research. 54*, 167-180. doi: 10.1111/1475-6773.13061

Hairr, D. C., Salisbury, H., Johannsson, M., & Redfern-Vance, N. (2014). Nurse Staffing and the Relationship to Job Satisfaction and Retention. *Nursing Economic$*, 142-147.

Mchugh, M. D., Kutney-Lee, A., Cimiotti, J. P., Sloane, D. M., & Aiken, L. H. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs, 30*(2), 202-210. doi:10.1377/hlthaff.2010.0100

United States Department of Labor. (2019). *Occupational outlook handbook*. Retrieved from: https://www.bls.gov/ooh/healthcare/registered-nurses.htm

Synthesis of evidence:
This synthesis includes four studies related to evidence supportive of the proposed research question. Hairr, Salisbury, Johannsson, & Redfern-Vance (2014) communicated on the Institute of Medicine (IOM) report from 2004 regarding patient safety and recognizing that appropriate nurse staffing ratios are essential for patient safety. A quantitative correlation research study was conducted and completed regarding the relationship between nurse staffing, their job satisfaction, and the retention of nurses in an acute care hospital setting. Hairr et al., (2014) mention the mandatory nurse-patient ratio law that was put into action in California, and how it greatly improved nurse satisfaction in the workplace. The key to keeping experienced nurses at patient's bedsides it to improve their satisfaction with their jobs. In order to greatly improve that, staffing ratios for nursing need to be addressed and improved across the board.

In a separate article written by Mchugh, Kutney-Lee, Cimiotti, Sloane, and Aiken (2011), the manuscript explained how dissatisfaction in nursing leads to increased turnover. Nurses strive for patient satisfaction and when that is not being met it makes their job stressful and less appealing, thus resulting in nurse turnover or even nurses leaving the field all together. When staff ratios are unsafe or insufficient, this negatively affects the nurse herself and then can negatively impact the patient and their care. A survey was conducted to analyze overall nurse satisfaction with work setting, role, work environment, burnout, and psychological exhaustion. Burnout is a result of being under-staffed in relation to patient numbers and acuity. Alleviating the burnout factor and improving overall work conditions can greatly improve nurse satisfaction which will lead to increased nurse retention.

Within the article written by Blankhart, Foster, and Mor (2019), there was an outlook on staffing for the nursing homes in the US. Politicians play a major role in what is accepted in the cares provided through Medicaid, especially considering the reimbursement structure to the nursing home facility. This is often why minimal staffing ratios, lower wages, care guidelines, and staff education may lack in the nursing home. There was never clear evidence on staffing related to retention, only assumptions.

Bottom Line:
Collective evidence from all of the above sources suggests that appropriate nurse staffing ratios are essential for patient safety. There was a demonstrated inverse relationship between job satisfaction and nurse retention which indicates as job dissatisfaction increases, the more likely a nurse will think about leaving his or her nursing position. Proper support and improvement in education can help supplement the retention in a nursing home. In addition to the nurse to patient ratio, the United States Department of Labor reported that the expected demand for nurses will reach up to one million by 2022. This indicates that job satisfaction is crucial as nursing job supply and demand will rise.

Implications for nursing practice:
Relationships between job satisfaction and an appropriate patient assignments will aide in reducing the number of patients a nurse is responsible for during a work shift and will improve job satisfaction, improve patient outcomes, and save health care dollars related to nurse turnover. Patient satisfaction is much lower in institutions where many nurses feel burned out and dissatisfied with their work conditions than in other institutions. It may be possible to improve patient satisfaction and avoid other adverse patient outcomes while also improving nurse satisfaction and retention by improving working conditions for nurses. The other point that needs to be addressed is the involvement of management and the education that is given to improve the retention in a nursing home. Lower wages are coupled with the reimbursement available to the care facility (Blankhart, Foster, & Mor, 2019). All in all, nurses need to be involved in their facilities and advocate for themselves and their co-workers. Nurses need to speak up about their concerns and promote ideas to alleviate the burnout and retain the nurses. If nothing changes, nothing changes.

NDNA 2019 Annual Business Meeting and Fall Conference

Thank you to all who attended, spoke, sponsored (and/or were vendors), planned and conducted the North Dakota Nurses Association Annual Business Meeting and Fall Conference! The events took place Thursday and Friday, September 19 and 20, at the Ramkota Hotel in Bismarck.

Thursday started with the NDNA Board of Directors' monthly board meeting. Following the board meeting was the Annual Business Meeting. The Annual Business Meeting was very well attended by members and student nurses alike. New NDNA Board Members were installed at the meeting. The Bylaws Revisions from 2018 were announced that they are now published to the website. Great discussions took place and there were some important votes, so please look to future website postings for some significant changes to NDNA membership and benefits! One Main Motion was passed at the Annual Meeting. Melanie Schock moved that," the NDNA Board investigates the possibility of opening our association's membership to LPNs." The rationale was "LPNs are a significant and valuable part of the North Dakota nursing workforce. As extensions of the registered nurse, we owe them their opportunity to network within a cohesive group and relish in the initiatives, projects, and strides that we make as the NDNA." The Main Motion was seconded by Elizabeth Brodell.

The Fall Conference started the next morning and drew around 80 individuals from all over the state for learning, networking, and some fun vendor-visiting. The overall theme of the event was Healthy Nurse, Healthy Nation and this year the focus was on stories and strategies.

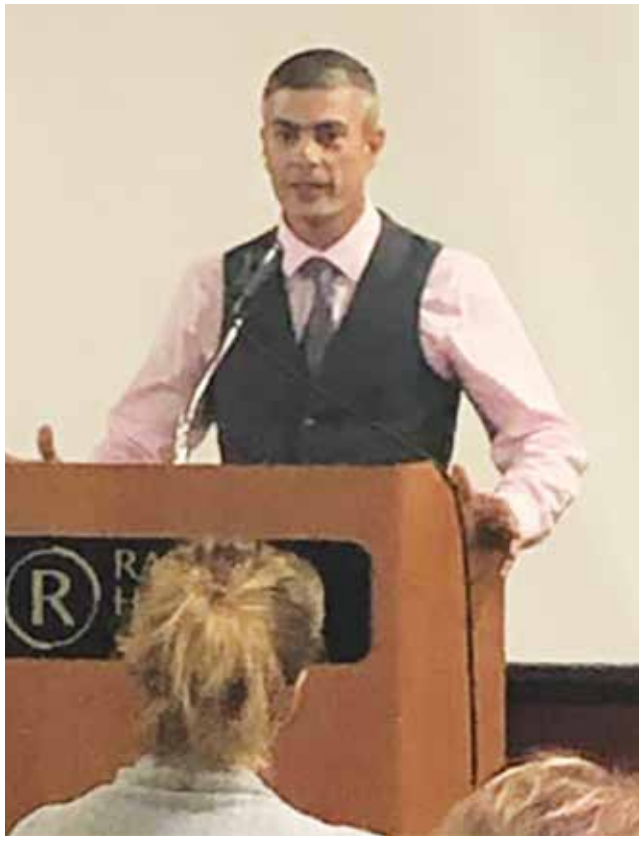
The speakers all provided various perspectives and stories and invited the attendees to do the same. The speakers were: Lyn Telford of Fargo (an NDNA Board Member!) who spoke on Generational Difference in Nursing, Wendy Baumgarten of Dickinson who spoke on Self-Care for Nurses, Danielle Olauson of Fargo who spoke on the Whole Health Model of Care, Chase Breitbach of Dickinson who spoke on ACEs Informed Care: What Nurses Need to Know, and Chris Nolden of Bismarck who shared Medical Cannabis: A Personal Story. Our Keynote Speaker this year was the First Lady of North Dakota, Kathryn Burgum, who spoke from the heart on her own story and provided a message to nurses to work to eliminate the stigma associated with addiction.

It was a great success and NDNA looks forward to the Spring of 2020 where we hope to replicate this event in Fargo

ND First Lady Kathryn Burgum tells her story - visit recoveryreinvented.com.

Speaker Wendy Baumgarten being introduced by Jerico

VP of Membership Kami Lehn, greeting attendees



Chris Nolden shared his story with nurses.

NDNA 2019 Fall Conference – left to right: DeeAnna Opstedahl – VP of Finance; Kami Lehn – VP of Membership; Tessa Johnson - President; Kayla Kaizer – VP of Communications; Sherri Miller – Executive Director; Jerico Alicante – VP of PEAR; Not pictured: Lyn Telford – VP of Government Relations and Jessica Vos – Director at Large: Recent Graduate

NDNA 2019 Annual Business Meeting and Fall Conference

Delicious supper break during the Annual Business Meeting

Speaker – Chase Breitbach on ACEs Informed Care: What Nurses Need to Know

NDNA President Tessa Johnson and VP of PEAR Jerico Alicante Present at speaker certificate to Danielle Olauson who spoke on Whole Health.

NDNA President Tessa Johnson, VP of Government Relations/Conference Speaker, Lyn Telford, and VP of PEAR Jerico Alicante

Installation of NDNA Board Members and other positions for the 2020-22 term

Lunch time!

NDNA would like to thank the very generous sponsors below for their support of our nurses association!!

SANFORD HEALTH

Get Back To Life
PRAIRIE ST. JOHN'S

ALD
Arthur L. Davis Publishing Agency, Inc.

Homes for Heroes

CHI St. Alexius Health

JOHNS HOPKINS SCHOOL of NURSING

Dickinson Medical Center

TRINITY HEALTH

CountryHouse Residence for memory care

ND

Employee Owned
Thrifty White PHARMACY
Est. 1884

Workplace Violence: How Can We Feel Safe at Work

Jessica Vos, BSN

No one should have to go to work with fear of physical violence, verbal threats, or threatening behavior. Unfortunately, many nurses do. According to the American Nurses Association, one in four nurses are assaulted. Of those one in four, only 20-60% of those incidents are reported. Nurse abuse, also known as workplace violence, attributes to 13% of missed worked days (American Nurses Association, n.d.)

In order to address work place violence, we need to first be able to identify what it is. According to Joint Commission's Sentinel Event from April 2018, workplace violence can be described as intimidating, harassing behavior, physical assaults or threats of assaults and verbal, written, or physical aggression intended to control or cause death, serious bodily injury or damage to property (Joint Commission, 2018.) According to the American Nurses Association (ANA), the violence includes incidences by patients, patients' family members and external individuals and includes physical, sexual and psychological assaults (ANA, 2019). Workplace violence can be further dissected into sub groups of bullying and incivility by co-workers, but for the sake of this article, we will be discussing workplace violence and nurse abuse from other sources other than co-workers.

Some of us may never personally experience workplace violence and that is a good thing, but "workers in health care settings are four times more likely to be victimized than workers in private industry" (Joint Commission, 2018.) The Joint Commission also has 68 reported sentinel event incidences of homicide, rape, or assault of hospital staff members over an eight-year period, (Joint Commission, 2018.) This is outrageous! There is no better time than now to raise awareness and support for safe work environments, especially for the most trusted profession taking care of the most vulnerable populations.

It is the nurses' caring nature to feel empathy for their patients. With this empathy comes a downside as nurses tend to underreport workplace violence "because they often believe that their assailants are not responsible for their actions due to conditions affecting their mental state. The most common characteristic exhibited by perpetrator of workplace violence is altered mental status associated with dementia, delirium, substance intoxication, or decompensated mental illness," (Joint Commission, 2018.) The empathy nurses feel for their patients can overwhelm their rational senses and may brush off the violent act as "the patient didn't know what they were doing" as justification for the abuse. According to ANA's 2019 issue brief on reporting incidents of workplace violence other barriers to reporting include:

- A health care culture that considers workplace violence as part of the job
- A perception that violent incidents are routine
- A lack of agreement on definitions of violence; e.g. does it include verbal harassment?
- Fear of being accused of inadequate performance or of being blamed for the incident
- Lack of awareness of the reporting system
- A belief that reporting will not change the current systems or decrease the potential for future incidents of violence
- A belief that the incident was not serious enough to report
- A practice of not reporting unintentional violence; e.g., incidents involving Alzheimer's patients
- Lack of manager and employer support
- Lack of training related to reporting and managing workplace violence
- A fear of reporting supervisory workplace violence

With this list of barriers to reporting workplace violence, it can almost be guaranteed that incidents happen at a substantially higher number than we anticipated. It is especially difficult if nurses don't know when or even how to report these incidents.

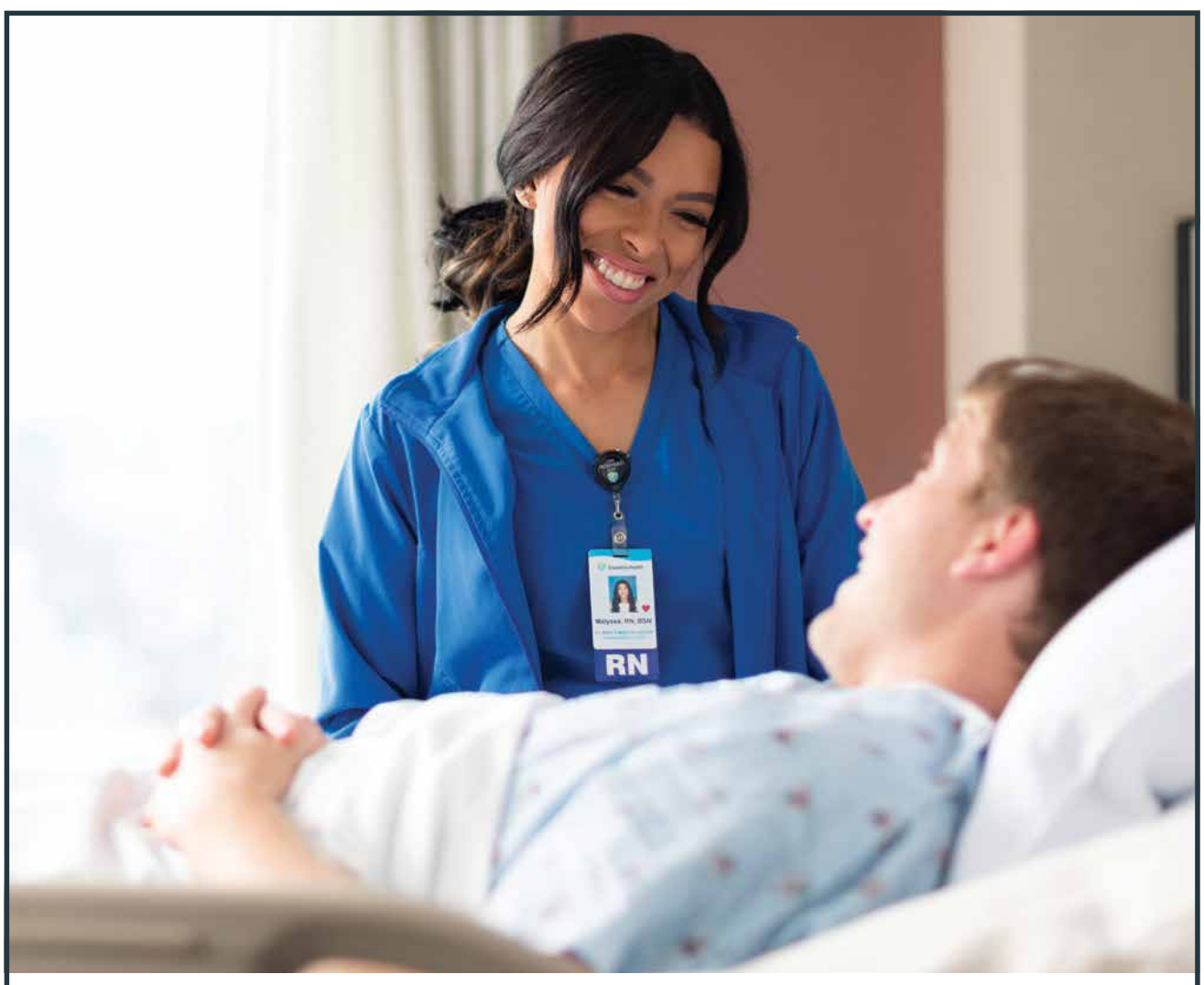
No matter who inflicts the act of violence, it is the nurses duty to report any and all acts of workplace violence. It is the organizations duty to train nurses to identify workplace violence and have an effective reporting system that is continually addressed. No one benefits from workplace violence as it "results in low staff morale, lawsuits, and high worker turnover," (Joint Commission, 2018.) This is no good for the nurses, the organization, or the patients. Organizations should also be responsible to provide training to employees in preparation for disruptive behaviors, self-defense/self-protection, and de-escalation of these incidents. Being proactive and having staff be able to identify escalation of events that could lead to violence, could greatly help in de-escalation before the violent acts can occur. Organizations should also debrief with employees after these disruptive events occur to better determine what went well, what didn't go well, and how things could be handled more effectively in the future.

Everyone needs to feel safe at work and we need to be able to report acts of violence no matter how small; if the incident causes physical or mental distress, or makes the nurse feel unsafe in any way, the incident should be reported and followed up with by management or the security team. Nurses should not feel shame for reporting workplace violence, the concerns should not be minimized by management. Workplace safety is everyone's job and collaboration between management, security and staff is a must if we are to provide sustainable culture of safety.

American Nurses Association (2019). Issue Brief Reporting Incidents of Workplace Violence. https://www.nursingworld.org/~495349/globalassets/docs/ana/ethics/endabuse-issue-brief-final.pdf. (Retrieved August 27, 2019.)

American Nurses Association (n.d.) End Nurse Abuse. https://www.nursingworld.org/practice-policy/work-environment/end-nurse-abuse/. (Retrieved August 27, 2019.)

Joint Commission (April, 2018.) Sentinel Event Alert Physical and verbal violence against health care workers. https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf



Aromatherapy for Agitation

Appraised by:

Macey Lauinger SN, Eric Appiah SN, Cynthia Berglind SN, and Emily Nutsch SN (NDSU School of Nursing at Sanford Bismarck BSN Students)

Wanda Rose PhD, RN, Associate Professor of Practice (Faculty)

Clinical Question:

In patients with dementia, what is the effect of adjunctive aromatherapy on agitation compared with no aromatherapy?

Sources of Reference:

Dimitriou, T., Verykouki, E., Papatriantafyllou, J., Konsta, A., Kazis, D., & Tsolaki, M. (2018). Non-pharmacological interventions for agitation/ aggressive behaviour in patients with dementia: A randomized controlled crossover trial. *Functional Neurology, 33*(3), 143-147.

Forrester LT, Maayan N, Orrell M, Spector AE, Buchan LD, Soares-Weiser K. (2014). Aromatherapy for dementia. *Cochrane Database of Systematic Reviews*. Issue 2. Art. No.: CD003150. DOI: 10.1002/14651858.CD003150.pub2.

Man-Hua Yang, Li-Chan Lin, Shiao-Chi Wu, Jen-Hwey Chiu, Pei-Ning Wang, & Jaung-Geng Lin. (2015). Comparison of the efficacy of aroma-acupressure and aromatherapy for the treatment of dementia-associated agitation. *BMC Complementary & Alternative Medicine,* 15(1), 1–8. https://doi-org.ezproxy.lib.ndsu.nodak.edu/10.1186/s12906-015-0612-9

Snow, L. A., Hovanec, L., & Brandt, J. (2004). A controlled trial of aromatherapy for agitation in nursing home patients with dementia. *The Journal of Alternative and Complementary Medicine,* 10(3), 431-437. doi:10.1089/107555304132369

Synthesis of Evidence:

Four research studies were reviewed as research for this report. A systemic review and three randomized control trials were evaluated.

Dimitriou et al. (2018) conducted a randomized control trial including 60 patients diagnosed with dementia, Alzheimer's, disease, vascular dementia, frontotemporal dementia, Parkinson's disease dementia, mixed dementia or dementia due to AIDS from the Neurological Department of the General Hospital of Athens, Greece. The interventions used included physical exercise, music, and massage and aromatherapy. The findings indicated that massage and aromatherapy was the second most effective in decreasing agitation in those patients.

Forrester et al. (2014) conducted seven random control trials with a total 428 elderly patients were used in a systematic review, of ages 66-85 years old, diagnosed with dementia of any type and severity, Alzheimer's disease and agitation. Only two RCT had useable data and were used in the meta-analysis. The benefits of aromatherapy on agitation are uncertain. There were inconsistent effects on measures of agitation, behavioral symptoms and quality of life for patients diagnosed with dementia.

Man-Hua Yang et al. (2015) conducted a randomized control trial at three veteran retirement homes and three long-term care facilities in Taiwan to study the difference in effects of aroma-acupressure, just aromatherapy or standard care on dementia related agitation. There were 186 participants split into three groups. One group received standard treatment, one received aroma-acupressure for two minutes at each of five identified acupressure points followed by five minutes of a warm up exercise and the third received aromatherapy on the same five acupressure points for two minutes followed by five minutes of warm up exercises. A blinded research assistant analyzed a long form Cohen-Mansfield Agitation Inventory (CMAI) worksheet completed by staff at the facility as well as a heart rate variability analyzer (HRV) which was worn by participants to track heart rate. The authors found that using aroma-acupressure provided the most relief from dementia related agitation, while using only aromatherapy also made a difference. The authors suggest that though more research should be done, these alternatives may help provide some relief for both dementia patients and their caregivers.

Snow, Hovanec, and Brandt (2004) conducted a controlled trial of aromatherapy to decrease agitation in persons with dementia. Seven agitated nursing home residents with advanced dementia. Two participants were able to perform slightly better than chance for a task of olfactory discrimination. Some participants did show a decrease in one lavender condition that was not duplicated in the other lavender condition, but there was no consistency across participants regarding which lavender phase caused the effect. Cutaneous application of the essential oil used may be necessary to achieve the effects reported in previous controlled studies. The study found no support for the use of a purely olfactory form of aromatherapy to decrease agitation in severely demented patients.

Conclusions:

The articles by Dimitriou et al. (2018) and Man-Hua Yang et al. (2015) showed a decline in agitation in those with dementia, while the other two articles, Snow et al. 2004 and Forrester et al. (2014) did not show a correlation between the use of aromatherapy and agitation.

Implications for Nursing Practice:

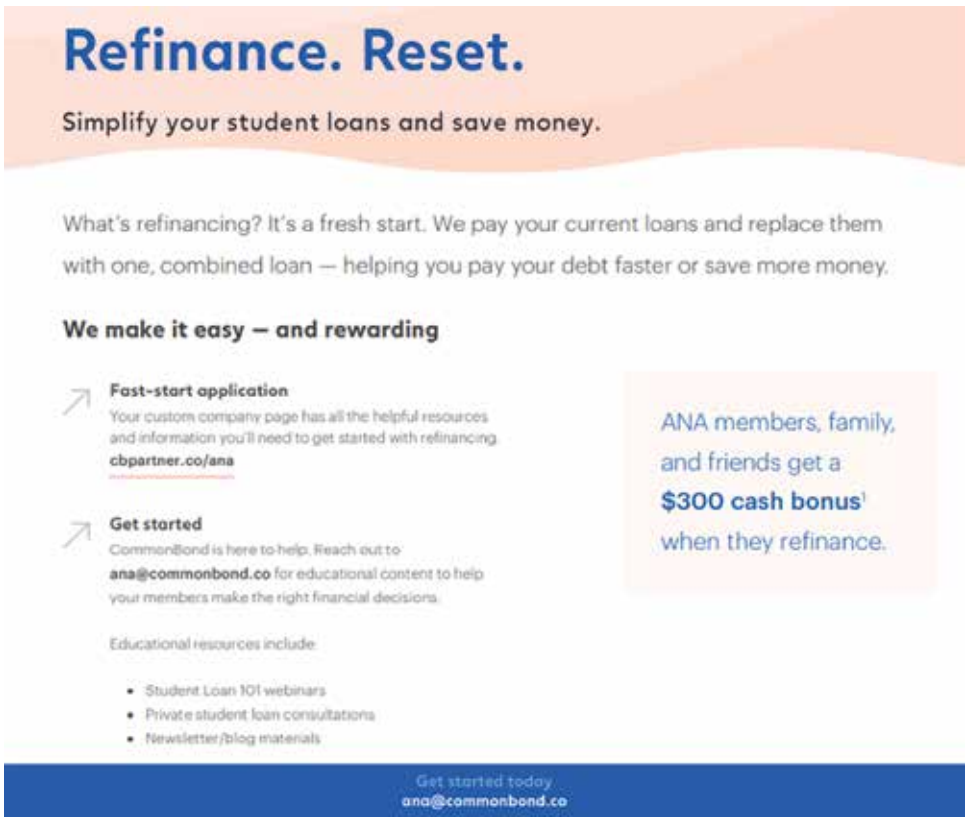
There is some evidence that has shown a decrease in agitation in those with dementia with the use of aromatherapy, however there are also studies that do not show a correlation. A few of the studies said that further studies need to be done to assess the effectiveness of aromatherapy, however, it is important for nurses to explore nonpharmacologic remedies for agitation to decrease addiction and the side effects of polypharmacy.

ANA/NDNA Membership Benefits

Don't forget!

When you sign up for membership, you have the below benefits available to you! For more information on any of the below – email: director@ndna.org or call: 701-335-6376.

- **Mercer** – professional liability insurance discount
- **Anchor** – discount with long term care insurance provider of Mutual of Omaha
- **Commonbond** – student loan refinancing
- **BookingCommunity** – hotel and travel discounts



Nurse Staffing and Patient Outcomes

Appraised by:

Andrea Winbauer SN, Hailee Thomas SN, Marie Loegering SN and Selena Wolff SN

(NDSU School of Nursing at Sanford Bismarck BSN Students) Wanda Rose PhD, RN, Associate Professor of Practice (Faculty)

Clinical Question:

In acute care hospitals does increasing the nurse to patient staffing ratio increase patient safety and quality of care?

Sources of Evidence:

Griffiths, P., Maruotti, A., Saucedo, A. R., Redfern, O.C., Ball, J. E., Briggs, J., . . . Smith, G. B. (2018). Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study. *BMJ Quality & Safety,* 1-9. doi:10.1136/bmjqs-2018-008043

Hill, B. (2017). Do nurse staffing levels affect patient mortality in acute secondary care? *British Journal of Nursing, 26*(12), 698-704. doi:10.12968/bjon.2017.26.12.698

Hinno, S., Partanen, P., & Vehvilainen-Julkunen, K. (2011). Nursing activities, nurse staffing and adverse patient outcomes as perceived by hospital nurses. *Journal of Clinical Nursing JC, 21*, 1584-1593.

Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *The New England Journal of Medicine, 346*(22), 1715-22.

Synthesis of Evidence:

Four articles were reviewed as evidence in this report. Griffiths et al. (2018) conducted a retrospective longitudinal cohort study of 138,133 adult patients spending >1 day on general wards between April 1, 2012 and March 31, 2015. The hazard of death was increased by 3% for every day a patient experienced RN staffing below ward mean. Lower RN staffing and higher levels of admissions per RN are associated with increased risk of death during admission to the hospital.

Hill (2017) is a systematic review in which five research articles were chosen to be examined. Their intent was to look into the connection between nurse staffing levels and patient mortality rates, and to identify common themes. All of the articles had common themes such as relationship between quality of care provided and patient outcome, that outcomes are underreported, and that nurses are over worked and burnt out from taking care of increased numbers of acute patients. Two of the articles supported the idea that decreased nursing time correlates with mortality rates, but two did not, however, they did show that patients were affected negatively in a number of ways.

The cross sectional study using a descriptive questionnaire by Hinno, Partanen, and Vehvilainen-Julkunen (2011) investigated the relationship between registered nurses staffing and nursing activities as well as adverse patient outcomes. The study included 869 registered nurse total between Finland and the Netherlands. Each nurse was given a questionnaire survey addressing nursing activities such as oral hygiene, activities of daily living, skin care, pain management, patient education, family guidance, and patient discharge as well as patient falls and how the nurses felt about their time available to do these activities. The questionnaires asked the RN to evaluate whether they felt they had enough time to perform the listed tasks in their available time. In conclusion of the article nurses often feel they had to neglect nursing activities related to direct patient care and reported the occurrence of adverse patient outcomes more frequently; such as patient falls. The results provide further evidence that adverse patient outcomes are related to staffing patterns.

Needleman, Buerhaus, Mattke, Stewart, and Zelevinsky (2002) examined the relationship between the levels of nurse staffing in hospitals and the rates of adverse outcomes among patients. They used administrative data from 799 hospitals in 11 states and conducted regression analyses in which they controlled for patients' risk of adverse outcomes, differences in the nursing care needed for each patient. A higher proportion of hours of nursing care provided by registered nurses and a greater number of hours of care by registered nurses per day are associated with better care of hospitalized patients. The same results were not repeated with LPNs.

Conclusion:

All four articles indicated an increase in the quality of patient care when nurse to patient staffing ratios are increased. The research evidence does address the issue of nurse-patient staffing and gives promising outcomes when nurses are able to spend more time assessing and treating patients.

Implications for Nursing Practice:

There is evidence to suggest that increasing nurse to patient staffing ratios in acute care hospitals has a positive impact on patient outcomes. When nurses are able to spend more time assessing and treating patients, patient safety and quality of care increases.

Music Therapy for Adults with Dementia

Appraised by:

Chelsea Condon SN, Orlando Machado SN, Kayla Wentz SN (NDSU School of Nursing at Sanford Bismarck BSN Students), Wanda Rose PhD, RN, Associate Professor of Practice (Faculty)

Clinical question:

In adults with dementia, does music therapy improve behavior and quality of life?

Sources of evidence:

Cho, H. (2018). The effects of music therapy-singing group on quality of life and affect of persons with dementia: a randomized controlled trial. *Frontiers in Medicine,* 5, 279. doi:10.3389/fmed.2018.00279

Pederson, S., Andersen, P. N., Lugo, R. G., Andreassen, M., & Sütterlin, S. (2017). Effects of music on agitation in dementia: A meta-analysis. *Frontiers in Psychology,* 8, 742. doi:10.3389/fpsyg.2017.00742

Van der Steen, J. T., Smaling, H. J., Van der Wouden, J. C., Bruinsma, M. S., Rob JPM Scholten., R.J , Vink, A.C., (2018). Music-based therapeutic interventions for people with dementia. *Cochrane Database of Systematic Reviews,* (7), 1-4. doi:10.1002/14651858.CD003477.pub4.

Synthesis of Evidence:

Three studies were reviewed as evidence in this report. This report includes a meta-analysis, randomized controlled trial, and a systemic review.

Cho (2018) conduct a randomized controlled trial. This study was conducted to compare the possible effects of a music therapy-singing group on the quality of life and affect of persons with mild, moderate, and severe dementia living in a long-term care facility with those of a music medicine-listening group and a control-TV group. This study included 52 dementia residents who had a documented diagnosis of dementia between 65 to 100 years of age in a Veteran's Home in upstate New York. The participants were assigned to three intervention groups, including a music therapy-singing group, a music medicine-listening group, and a control group-TV. The intervention groups were divided into two sub-groups, one group held in the morning and the other held in the afternoon. The participants in each group were engaged for 40 minute sessions twice a week for four consecutive weeks. The findings demonstrated that the short-term music therapy-singing group led by a music-therapist had the larger effects on the quality of life and affect of persons with dementia, than the music medicine-listening group or the TV-control group. Due to the small number of participants and the short length of the intervention, the findings of the current study should be interpreted with caution.

The second study by Pedersen, Andersen, Lugo, Andreassen, and Sütterlin (2017) conducted a meta-analysis. The purpose of this meta-analysis, music intervention was defined as the controlled use of music in a therapeutic setting to accomplish individualized goals with psychological, physiological, and emotional well-being during the treatment of an illness or disease. This meta-analysis included 12 articles that were composed of randomized controlled trials fulfilling minimum standards. Music interventions included active music interventions that involves the participants actively singing, dancing, or instrumental playing. Passive music interventions, the participants listened to live or recorded music without being actively engaged. Active listening was shown to reduce stress and negative behaviors while passive listening is reported to have a beneficial effect on agitated behavior by eliciting repressed feelings. The overall effect of this meta-analysis suggest that music interventions can reduce agitation in people with dementia. For further studies, there needs to be a differentiate between diagnoses, clinical samples, and various degree of severity

A systematic review study was written by Steen et al., (2018) Music-based therapy intervention for people with dementia. This study analysis of multiple studies that meet the same criteria. The author evaluates the effectiveness of interventions in a real-life routine using music therapy. The study uses a variety of assessment tools in addition to the collaboration from other authors to verify the inclusion criteria and effectiveness of music therapy in this particular population. This study was a Systematic review that includes 22 studies with 1097 randomized participants. A total of 21 with 890 participants in the study meet the criteria (dementia of varying degrees of severity). The result showed that music therapy probably reduces depressive symptoms and behavioral problems, but it may not have little or no effect on agitation, aggression or on cognition. The authors also suggested future studies to extend the duration of the therapy for a minimum of five weeks in order to obtain a better outcome and improve patients' quality of life.

Conclusions:

Two of the studies indicated improved behavior and quality of life in adults diagnosed with dementia. However, the study by Steen et al., stated that musical therapy is effective to decrease depression symptoms and behaviors, but it might have little or no effect on agitation, aggression, or cognition. Two of the studies indicated that future studies should have a longer duration of music therapy to show a more effective outcome.

Implications for Nursing Practice:

Evidence recommends studies complete a longer study period to get more accurate results on whether or not music therapy improves behavior or quality of life in adults with dementia. The effects of music therapy would be very beneficial to adults diagnosed with dementia to help improve behavior and quality of life.

NDBON, NDNA and NDCFN: What's the Difference?

There is some confusion regarding the differences between the North Dakota Board of Nursing (NDBON), the North Dakota Nurses Association (NDNA) and North Dakota Center for Nursing (NDCFN). Hopefully, the following will help clarify some of the confusion.

A COMPARISON OF THE THREE ORGANIZATIONS

North Dakota Board of Nursing (NDBON)	**North Dakota Nurses Association (NDNA)**	**North Dakota Center for Nursing (NDCFN)**
919 S 7TH Street, Suite 504 Bismarck, ND 58504-5881 Phone: (701) 328-9777 Fax: (701) 328-9785 Website: www.ndbon.org	1515 Burnt Boat Dr, Suite C #325 Bismarck, ND 58503 Phone: (701) 335-6376 E-mail: Director@ndna.org Website: www.ndna.org	3523 45th Street South Fargo, ND 58104 Phone: (701)639-6548 Website: www.ndcenterfornursing.org
Mission: *ND Board of Nursing assures North Dakota citizens quality nursing care through the regulation of standards for nursing education, licensure, and practice.*	***Mission:*** *NDNA promotes the professional development of nurses, and advances the identity and integrity of nursing to enhance healthcare for all through practice, education, research, and development of public policy.*	***Mission:*** *The mission of NDCFN is to through collaboration guide the ongoing development of a well-prepared and diverse nursing workforce to meet health care needs in North Dakota through research, education, recruitment and retention, advocacy and public policy.*
Description: • Governmental regulatory body established by state law under the North Dakota Century Code 43-12.1 Nurse Practices Act to regulate the practice of nursing and protect the health and safety of the public • Regulates the practice of individuals licensed and registered by the Board • Establish standards of practice for RNs, LPNs, and APRNs • Establish standards and regulate nursing education programs • Discipline licensees and registrants in response to violations of the Nurse Practices Act	***Description:*** • 501(c)6 non-profit association • Professional Association for Registered Nurses. • Constituent member of the American Nurses Association (ANA) • Influences legislation on health care policies and health issues and the nurse's role in the health care delivery system • Promotes the continuing professional development of Registered Nurses • Advances the identity and integrity of the profession to enhance healthcare for all through practice, education, research, and development of public policy • Promotes the Scope and Standards of Nursing Practice and the Code of Ethics for nurses	***Description:*** • 501c3 non-profit organization • All nurses and over 40 nursing organizations, education programs, grant programs, state agencies and other stakeholders are members and are invited to volunteer on ND Center for Nursing Leadership Team. • Works to unify voice of nursing in North Dakota through connecting nursing organizations interested in policy issues. • Develops statewide programming to fulfill mission across multiple areas including nursing education faculty and resources, workplace planning, research and development and practice and policy. • Tracks supply, demand and education of nursing workforce.
Board Members: Jane Christianson, RN member, Bismarck: *President* Michael Hammer, RN member, Velva: *Vice President* Jamie Hammer, RN member, Minot: *Treasurer* Janelle Holth, RN member, Grand Forks Mary Beth Johnson, RN member, Bismarck Bonny Mayer, LPN member, Minot Wendi Johnston, RN member, Kathryn	***Board of Directors:*** *President* - Tessa Johnson, MSN, RN president@ndna.org Board of Directors listed at https://ndna.nursingnetwork.com/page/72991-board-of-directors	***Board of Directors: 13 organizations represented. List available on website at:*** http://www.ndcenterfornursing.org/board-of-directors/
NDBON Staff: Stacey Pfenning, DNP, APRN, FNP FAANP-Executive Director - spfenning@ndbon.org Tammy Buchholz, MSN, RN-Associate Director for Education - tbuchholz@ndbon.org Melissa Hanson, MSN, RN-Associate Director of Compliance - mhanson@ndbon.org Maureen Bentz, MSN, RN, CNML Associate Director for Practice - mbentz@ndbon.org Chris Becker, Accounting/Licensure Specialist-cbecker@ndbon.org Gail Rossman, Technology Specialist II-grossman@ndbon.org Kathy Zahn, Administrative Assistant III kzahn@ndbon.org Sally Bohmbach, Administrative Assistant II-bohmbach@ndbon.org	***NDNA Independent Contractor:*** Sherri Miller, BSN, RN Executive Director Director@ndna.org	***NDCFN Staff:*** Patricia Moulton, PhD Executive Director Patricia.moulton@ndcenterfornursing.org Kyle Martin, BS Associate Director Kyle.martin@ndcenterfornursing.org

Healthy Nurse, Healthy Nation in Action

Susan Indvik, BSN, RN, Newly Elected for 2020 NDNA Nominating Committee, has made some Healthy Nurse Healthy Nation Strides

Susan Indvik

Student health nurse promotes a healthy lifestyle at college campus. Every change, no matter how small, makes a difference in achieving long-term goals. Susan Indvik, BSN, RN and student health nurse at Dakota College at Bottineau, knows this firsthand. She's constantly thinking of new ways to promote a healthy lifestyle among the student population at the college.

One of her most successful initiatives so far is the Healthy Lifestyle Change Wellness Profile Check. It's a three month program that anyone on campus can sign up for. Components include:

- Access to a fitness app to track activity
- Weekly weigh-ins
- Weekly check-ins to gauge how participants are feeling (anxiety, stress, etc.)
- Support and wellness information from Susan

A Healthy Resource

Susan reaches the students using multiple outlets. She has access to all of the dorms; the Campus Connection (a channel displayed on TV screens across campus); the college Facebook page; posters in the cafeteria; and the student health bulletin board.

"As a nurse who sees people more when they're sick than when they're healthy, I want to get the word out that lifestyle changes students make now will make a difference long-term," said Susan.

The program is different from a traditional weight-loss challenge because any type of healthy lifestyle change is considered progress. A winner is chosen based on the person with the best lifestyle changes and significant nutrition changes to better their health outcomes.

The winner of the program's first run was a student who'd been on high blood pressure medications since age 11. Susan's program helped him lose 36 inches, 28 pounds, and get off his blood pressure medications.

Knowledge Is Power

Susan is also working with members of the administration to provide healthier food options in the campus cafeteria. One of those changes is a larger variety of fresh salad choices. Beyond that, Susan thinks it's important to make students aware of what they're eating.

The cafeteria is placing identifiable stickers on certain food items to help students quickly see which options are healthier than others. For example, a food that's considered heart healthy may have a heart sticker; or a food that has high sodium may have a sticker with a salt shaker and red line through it.

Susan is also working with the campus athletic trainer to develop healthy eating plans for members of the sports teams.

"Hockey players don't necessarily need the same type of diet as football players, or as volleyball players," said Susan. While still in development, her plan will help personalize eating habits based on the level of physical activity involved in the sport.

Susan's Advice

While Susan works primarily with students and staff, her observations apply to anyone in a nursing career, too. It's easy and convenient to eat unhealthy foods, like quick snacks out of vending machines, or fast food from a drive-through. But if fresh fruits and vegetables are available, try to choose them more often.

Other advice from Susan:

- **Focus on small changes:** As busy nurses with long shifts, we don't nourish ourselves like we should. Don't ever underestimate the power of one, simple change. Drink one less soda per day. Walk farther from your parking space to the door. The smaller you go with a change, the more likely it will become a new habit.
- **Never give up on yourself:** Try to live every day by what you teach and preach to your patients. It's still a struggle, but focus on what you can do with the day at hand.

Susan Indvik, BSN, RN, is a student health nurse at Dakota College at Bottineau in Bottineau, North Dakota.

Are you a #healthynurse? Share your stories with us! Send them to the editors of the North Dakota Nurse.

– Close to the Nurses' Station Affect Sleep Patterns for Healing –

Appraised by:
Carmen Carter, RN, Stephanie McCorry, RN & Sara Stevenson, RN Mayville State University RN-to-BSN students

Clinical question:
For inpatients ages 2-18 years old, does being close to the nurse's station affect sleep patterns for healing versus being farther away from the nurse's station?

Articles:

Delaney, L. J., Currie, M. J., Huang, H.-C. C., Lopez, V., & Van Haren, F. (2018). "They can rest at home": An observational study of patients' quality of sleep in an Australian hospital. *BMC Health Services Research, 18*(1), N.PAG. https://doi.org/10.1186/s12913018-3201-z

Goeren, D., John, S., Meskill, K., Iacono, L., Wahl, S., & Scanlon, K. (2018). Quiet Time: A Noise Reduction Initiative in a Neurosurgical Intensive Care Unit. *Critical Care Nurse, 38*(4), 38–44.

Paruthi, S., Brooks, L. J., Dambrosio, C., Hall, W. A., Kotagal, S., Lloyd, R. M., . . . Wise, M. S. (2016). Recommended Amount of Sleep for Pediatric Populations: A Consensus Statement of the American Academy of Sleep Medicine. *Journal of Clinical Sleep Medicine, 12*(06), 785-786. doi:10.5664/jcsm.5866

Salzmann, E. M., Lagerqvist, L., & Pousette, S. (2016). Keep calm and have a good night: nurses' strategies to promote inpatients' sleep in the hospital environment. *Scandinavian Journal of Caring Sciences, 30*(2), 356-364. https://doi.org/10.1111/scs.12255

Synthesis of evidence:
Sleep is a hard thing to come by while in a hospital setting. It is an important part of the healing process. Not everyone needs the same amount of sleep as others, but there are general guidelines for what most people need in order to heal and function on a day to day basis. There are many evidence-based articles on sleep alone as well as sleep in the hospital. There is little evidence to support sleep of pediatric patients while being hospitalized, so our team decided to try and research just how noise in the hospital affects pediatric patients from getting the required amount of sleep needed for adequate healing.

The aim of this first study by Delaney, Currie, Huang, Lopez, & Van Haren was to investigate the perceived duration and quality of patient sleep and identify any environmental factors associated with patient-reported poor sleep in hospital. Sleep disturbance in the clinical environment has been attributed to several extrinsic factors such as ambient noise and exposure to artificial lighting. The study showed comments provided by patients reveal that they expect to experience sleep disruption in hospital, and view this as an acceptable aspect of healthcare.

The second article entitled "Quiet Time: A Noise Reduction Initiative in a Neurosurgical Intensive Care Unit" was a study on showing noise levels in a neurosurgical intensive care unit. Increased noise levels can lead to sleep deprivation and increased pain perception. Staff conversations was found to be the main source of noise here. The staff there implemented a quiet time twice a day where lights were dimmed, and staff were encouraged to speak softly. This also gave a calm presence to the floor. They did not achieve the WHO's recommended noise level during quiet time, but, did have a significant reduction in noise. The study supports the fact that noise around the nurses' station is an issue.

The third article entitled "Recommended Amount of Sleep for Pediatric Populations: A Consensus Statement of the American Academy of Sleep Medicine" worked to come up with a consensus on the recommended amount of sleep that a child ages four months to 18 years of age should get in a 24-hour period. There were 13 experts who specialize in sleep medicine and research. Together they came up with these recommendations: infants four months to 12 months should sleep 12-16 hours per 24-hour period; children one to two years should sleep 11-14 hours per 24-hour period; children three to five years should sleep 10-13 hours per 24-hour period; children 6-12 should sleep 9-12 hours per 24-hour period; teenagers 13-18 should sleep 8-10 hours.

Finally, the aim of the last study by Salzmann, Lagerqvist, & Pousette was to explore nurses' experiences and their strategies to promote inpatients' sleep. The results yielded four categories of nursing interventions: prevention and planning, adaption of the environment, use of drugs, and caring conversations. The nurses created a plan at the beginning of the shift to cluster care and minimize sleep disruption. Adaption of the environment ranged from making the patient more comfortable, to reducing noise from alarms, staff and other patients/families. The authors concluded that by adopting these strategies, sleep may be improved.

Bottom line:
As a team, we concluded that pediatric patients should be placed a little farther from the nurses' station while hospitalized. There has been significant research to prove that sleep is in fact affected while inpatient and most of the noise stemming from the nurses themselves and the nursing station. There has been little research as to exactly how it affects the pediatric population, but there has been evidence as to how much sleep a pediatric child should receive in a 24-hour period. We would say it is safe to conclude that if sleep is affected in a hospitalized patient then no matter what age they are, they are not receiving the recommended amount of sleep and therefore should be in a room where they can get adequate rest to promote proper healing. Even after extensive research, we decided that more research is needed on this topic.

Implications for nursing practice:
There are many implications for nursing regarding this research question. Nurses must be aware that sleep is important for their patients' recovery. Nurses must also be aware of the causes of sleep disruption on their specific unit. These studies show that there are many causes of noise in the hospital (including the nurses' station). They must also be informed of nursing interventions that can be implemented in order to help their patients achieve better sleep while in the hospital. These studies support the need for a more calm and restful sleep environment to enhance patient's healing.

Intermittent Fasting: Is it right for you?

Terri-Ann Kelly, PhD, RN, CPT, FNS, Assistant Professor, Rutgers University—Camden, NJSNA Region 5 Member and Healthy Nurse Healthy New Jersey team member

Reprinted with permission from New Jersey Nurse October 2019

Everywhere you turn, you'll find articles or hear celebrities touting the benefits of intermittent fasting (IMF). Unlike traditional diets, with IMF, the focus shifts from "what should I eat" to "when should I eat?" IMF, also known as cyclic fasting, is a method of eating that cycles between periods of fasting, with either no food or significant calorie reduction, and periods of unrestricted eating. Extensive research suggests that IMF increases fat burning and weight loss by using up fat stores as fuel, helps regulate blood sugar levels, supports a healthy inflammatory response, promotes heart health by lowering LDL ("bad") cholesterol and triglycerides, and supports cognitive health.

The most common types of IMF you can include in your daily routine include:

- **16:8 fasting**, also known as time-restricted feeding: fast for 16 hours every day and limit your eating to an eight-hour window. Most often, individuals skip breakfast but eat lunch and dinner.
- **Alternate-day fasting**: eating only every other day. On the fasting days, you can choose to eat no food at all or limit caloric intake to 500 calories.
- **5:2 diet**, also known as the fast diet: For 5 days of the week you eat normally, and for two nonconsecutive days, you restrict your caloric intake to 500-600 calories.
- **Eat Stop Eat**: Choose one or two days out of the week where you only consume non-caloric beverages (ex. herbal tea, water, black coffee) for 24 hours. For example, eat nothing from dinner one day until dinner the next day. On non-fasting days you can eat normally.

Is IMF right for everyone? Absolutely, NOT! Fasting would not be appropriate in instances where extra calories or nutrients are needed for growth and development during childhood or adolescence and when pregnant or breastfeeding. Also, individuals should abstain from IMF if they have conditions such as gallstones or thyroid issues, eating disorders that involve unhealthy self-restriction (anorexia or bulimia nervosa), and use medications that require food intake. As always, it's best to consult with your healthcare provider to determine if IMF is appropriate for you.

As a beginner, the 16:8 method is the easiest to implement. Below are my top tips for success with 16:8:

- Start your day off with a glass of water and continue to drink water until you've reached your goal. Staying hydrated is important as it will help curb your appetite and make fasting much easier.
- When you break your fast, make sure you eat plenty of fiber and nutrient-dense whole foods, and try to keep your intake of sugary beverages and high carbohydrate foods to a minimum.
- Track your daily fasting with an app such as the Zero Fasting Tracker.
- Stay consistent and don't expect overnight weight loss.

If you're looking for a way to lose weight while also getting additional benefits, there are many types of IMF to choose from with variations to fit any lifestyle. But also keep in mind that IMF may not be for everyone! If you need help with making health and wellness a priority, the Healthy Nurse Healthy New Jersey team is here to help. You can find support for your Healthy Nurse journey on NJSNA's website: https://njsna.org/healthy-nurse/. You can also find Healthy Nurses on Facebook and Pinterest—*New Jersey State Nurses Healthy Nurse*.

Good luck and happy fasting!

Reference:

Varady, K.A., Bhutani, S., Klempel, M.C., Kroeger, C.M., Trepanowski, J.F., Haus, J.M.,...Calvo, Y. (2013). Alternate day fasting for weight loss in normal weight and overweight subjects: A randomized controlled trial. *Nutrition Journal,* 12(1).

Patient Turning Study

Appraised by:
Pamela Guiles, RN; Marice Coughlin, RN;
Mayville State University, RN to BSN Students

Clinical question:
In patients with impaired mobility and/or sensation, how does turning the patient every two hours compared to the use of pressure mattresses affect the incidence of pressure ulcers?

Articles:
Fletcher, J., Tite, M., & Clark, M. (2016). Real-world evidence from a large-scale multisite evaluation of a hybrid mattress. *Wounds UK, 12*(3), 54–61.

Gillespie BM, Chaboyer WP, McInnes E, Kent B, Whitty JA, Thalib L. Repositioning for pressure ulcer prevention in adults. *Cochrane Database of Systematic Reviews* 2014, Issue 4. Art. No.: CD009958. DOI: 10.1002/14651858.CD009958.pub2.

Ratliff, C. R., Droste, L. R., Bonham, P., Crestodina, L., Johnson, J.J., Kelechi, T., Varnado, M. F. (2017). WOCN 2016 guideline for prevention and management of pressure injuries (ulcers). *Wound, Ostomy, and Continence Nurses Society 44*(3), 241 - 246.

Yap, T. L., Kennerly, S. AM., Bergstrom, N., Hudak, S. L. (2016). An evidence-based cue- selection guide and logic model to improve pressure ulcer prevention in long-term care. *Journal of Nursing Care Quality, 31*(1), 75 - 83.

Synthesis of evidence:
Pressure ulcers increase a patient's risk of infection and may delay overall healing time. Incidences of pressure ulcers also add to a healthcare facility's overall cost of operation. Nurses are responsible for daily assessments, implementing treatments, and evaluating their effectiveness. Prevention and effective treatment of pressure ulcers contribute to quality patient care as well as responsible use of facility resources. There was no research found to directly compare the use of alternating pressure air mattresses (APAMs) and repositioning in preventing and/or treating pressure ulcers. APAMs are often used in conjunction with repositioning.

A systematic review was performed by a team of certified wound, ostomy, continence nurses, and certified wound care nurses. This task force reviewed 195 full-text articles in order to evaluate the level-of-evidence of these articles and determine the strength of the recommendations in these articles. Devices that aide in the redistribution of pressure on the patient's body such as alternating pressure air mattresses (APAMs) should be used as adjuncts rather than used as replacements for repositioning of the patient. It is important to understand that there is no single factor of pressure injury risk, but rather the increase risk for pressure ulcers comes from a combination of factors, (Ratliff, et al, 2017).

Yap, et al (2016) researched the effectiveness of staff implemented pressure ulcer prevention techniques and methods. 11% of Long-Term Care residents in the United States develop a pressure ulcer or injury during their stay with some Long-Term Care facilities having a prevalence rate of up to 20%. The TURN study was implemented to test out the effectiveness of repositioning patients at different time intervals including 2-hour, 3-hour, and 4-hour. One of the implementations put into practice by this study was the use of an alarm or a device to remind staff members when it was time to reposition a resident. This was a helpful reminder for the staff members because throughout the day there are many things happening at the same time, and the use of the bell as a reminder ensured that they knew what time the resident was to be turned.

Studies of the use of hybrid mattresses in conjunction with a regular rotation schedule showed the effectiveness of these tools in preventing pressure ulcers. This study is a large-scale multi-center retrospective evaluation of the implementation of powered hybrid mattresses across eight acute care facilities in England. Tissue Viability Nurses (TVNs) provided information on the challenges of implementing the use of hybrid mattresses as well as the effectiveness of the mattresses on treating and preventing pressure ulcers. TVNs reported an overall reduction of 56% in the number of pressure ulcers in a six month period after mattresses were installed. These mattresses were used in conjunction with repositioning as part of a pressure ulcer prevention and treatment program, (Fletcher, et al, 2016).

While APAMs are a useful tool in pressure injury prevention, rotation angle or tilt as well as frequency must be considered as well. Gillespie, et al, (2014), reviewed studies and found three studies with 502 randomized subjects compared 30 and 90-degree tilt positions and alternating repositioning frequencies. There was a lower instance of pressure ulcers in those in a 30-degree tilt compared to a 90-degree tilt. Studies indicate that the greater the interval between repositioning, the higher chance of developing a pressure ulcer. Current studies are lacking due to the complexity of patients as well as the introduction of newer technologies such as alternating pressure air mattresses.

Bottom line:
Research suggests that pressure ulcers are a complex health issue, not limited to any singular cause or circumstance. Multiple factors affect treatment, but prevention is the primary defense against pressure injuries. Prevention and treatment involve a multitude of techniques and technologies including, but not limited to repositioning and alternating pressure air mattresses. Further study is needed as there has been no research to isolate the use of alternating pressure air mattresses (APAMs) from repositioning for prevention and treatment. APAMs have been used in conjunction with repositioning. Studies indicate that the use of APAMs with repositioning does decrease pressure ulcer incidences and severity. Regardless of inadequate current studies, the practice of repositioning should continue based on our knowledge of how pressure ulcers form. The combination of implementing repositioning schedules, along with using other preventative measures may aide in the prevention of pressure ulcer development.

Implications for nursing practice:
Patients with decreased sensation and/or limited mobility are at an increased risk for pressure ulcers. This increases the patient's risk of infection as well as increasing the cost of care for both the patient and the facility. Nurses play an integral role in prevention and treatment of pressure injuries. Current evidence-based practice of repositioning patients is based on older studies, often before newer technologies were available. Studies have shown however that repositioning is an effective method in prevention and treatment of pressure injuries. Studies are not conclusive but seem to indicate that the degree of tilt and frequency of repositioning affect the incidence of pressure injuries. Alternating pressure air mattresses (APAMs) used in conjunction with repositioning is another tool nurses may use in the prevention and treatment of pressure injuries. Prevention remains key when it comes to pressure injuries. By educating staff members on proper use of assessment tools to determine patient's risk for pressure ulcer development; we can implement preventative measures in a timelier manner.

What the Mirror Doesn't Tell You

Tracey Long, PhD, RN, MS, MSN, CDE, CNE, CHUC, CCRN

"I hate my body." "Where did all these ugly gray hairs and wrinkles come from?" "How could anyone find me attractive when I look like this?" "My body is such a burden."

If you're like 97% of the American population, you've probably said something like this to yourself. According to a repeat survey done by *Glamour* magazine 30 years ago and updated in 2014, 54% of women are unhappy with their body and 80% claim the mirror makes them feel bad about themselves. Even men admit to body image angst; from 1997 to 2001, the number of men who had cosmetic surgery increased 256%. Unhappiness about body image has been reported among girls as young as age six. Clearly, we need to evaluate the messages the mirror is sending to us.

Mirror, mirror, on the wall

Although many of us rely on mirror messages as the absolute truth, we need to be aware of the inherent distortions the mirror may hold. Ever since 8,000 B.C., when the mirror made its first appearance, people have been evaluating their personal worth based on their physical appearance. Two opposite attitudes exist: Some people are fixated by their own faces, as shown by an obsession with "selfies." Others declare their body hatred throughout the day as we often see on social media. We have a love-hate relationship with the mirror—but the mirror may not always tell the truth.

People with anorexia nervosa see a distorted view in the mirror; some view themselves as fat even though they're dangerously thin. The mere act of focusing on something, such as a nose or a mole, may make it look larger in the mirror. Even your mood may affect the way you see yourself. When you're tired, angry, or anxious, the mirror may reflect your emotions more than your true physical image.

What the mirror tells you

Relying on the mirror to tell you "who is the fairest of them all" may not give you the whole truth. Despite potentially negative messages people get from the mirror, it can provide helpful information. It can tell you a lot about both the outside *and* the inside of your body. Although we focus on our exterior image, the mirror can provide information about the internal health of your body.

Using your nursing assessment skills, take an objective look at your skin and hair. The skin, the body's largest organ, can provide a lot of feedback on your sleep (or lack thereof) and nutrition. Without adequate vitamin intake or sun, your skin may be pale and flaccid; without adequate essential fatty acids, it may be dull or dry. Stress, overwork, and lack of purpose in your life may reflect in the empty eyes that stare back at you.

What the mirror doesn't tell you

Shakespeare's Hamlet exclaimed, "What a piece of work is man! How noble in reason, how infinite in faculty! In form and moving how express and admirable! In action how like an angel! In apprehension how like a god!"

The mirror *doesn't* tell you about the amazing functions of your body systems, or that you and your body are the most brilliant creations in the universe. For instance, your endocrine system is an amazing creation of numerous autonomic functions working through feedback loops of chemicals to regulate many systems. It also balances your energy levels through the thyroid gland. When is the last time you thanked your adrenal glands for helping regulate your blood pressure via cortisol and aldosterone?

Thanks to auto-regulation, your body can maintain its temperature within the same general range even when the environment around it changes constantly. Breathing is controlled by tissues in your carotid arteries that track carbon dioxide (CO_2) concentration and send messages to the brain's respiratory center. Your body breathes faster or slower to eliminate CO_2 as needed, all without your conscious awareness.

Your pancreas produces both insulin and glucagon, which naturally oppose each other, but work in harmony to balance blood glucose levels. These levels affect the function of all three trillion cells in your body. Your glucose level rises in the morning to awaken you and give your cells energy to start the day automatically. Somatostatin regulates the endocrine system, balancing insulin and glucagon to work in complete balance without your attention. When is the last time you thanked your pancreas?

The mirror also doesn't tell you how well your liver detoxifies drugs and chemicals and maintains your blood glucose level when you're asleep. Nor does it reveal that your immune system constantly monitors and patrols your blood for foreign pathogens, which it then kills through a complex chemical cascade. Does the mirror tell you that your spleen has been working hard to store white blood cells and recycle red blood cells? When did you last thank your spleen?

What the mirror doesn't tell you about your magnificent self is far more interesting and exciting than the cellulite you may glimpse in the mirror. It doesn't let on that your body has innate abilities, such as auto-regulation, self-defense, and self-healing. Your body has the ability to detect injury and immediately goes into repair. Your natural self-healing includes the inflammatory process and movement of white blood cells to the site of damage to destroy pathogens that may have caused or entered the injury. Your body moves gracefully through tissue repair and healing autonomically, usually. We often treat our bodies so poorly and then expect them to perform without our support. An example is giving our bodies Styrofoam (such as poor food choices) and expecting it to repair like steel.

The nursing reflection

Ironically, some nurses who care for sick patients and help promote health and healing are unhealthy themselves. Research shows that occupational stress, poor coping behaviors, and lack of support create anxiety and depression in nurses. The longitudinal Nurses' Health Study, which began in 1988, examines relationships among hormone replacement therapy, diet, exercise, and other lifestyle practices and chronic illnesses. It found female nurses' health was no better than that of the general populace. Ideally, a nurse's health should reflect their education and knowledge of the human body. Unfortunately, knowledge alone doesn't create vibrant health. We should sing along with the Disney character Mulan, who asks, "When will my reflection show who I truly am?"

You're invited to join the American Nurses Association campaign for action improving nurses' health and wellness. For more information please visit http://www.healthynursehealthynation.org/ and view the free webinar on the grand health challenge for nurses at https://campaignforaction.org/webinar/improving-nurses-health-wellness/

As nurses, we can do better to reflect the true inner beauty of our bodies—and project that beauty in our lifestyles. Balancing the mirror's messages is the key. What the mirror *doesn't* tell you can inspire you to honor your body. What it *does* tell you can motivate you to care for yourself, so you can better model healthy behaviors for patients.

Fixing the mirror's reflection

In our society of quick fixes and limited warranties, it's easy—and often necessary—to replace just about everything. Most material objects can be replaced when they're worn out.

The only thing that can't be replaced is the human body. We can misuse and abuse it or treat it with loving care. Despite the amazing advances of medical science (and plastic surgery), your body is still your physical essence. Although it comes with a lifetime warranty, its quality isn't guaranteed; that's up to you. Our decisions can determine our destiny with health. Saying you don't have time for your health today may leave you with no health for your tomorrow.

What does your mirror say to you? Will you listen?

AUTHOR BIO

Tracey Long is a Professor of nursing in Las Vegas, Nevada for Chamberlain and Arizona College. As an identical twin, she regards her twin sister as her better reflection.

Selected references

Coditz GA, Manson JE, Hankinson SE. The Nurses' Health Study: 20-year contribution to the understanding of health among women. *J Women Health*. 2009;6(1):49-62.

Dove® Campaign for Real Beauty. www.dove.us/Social-Mission/campaign-for-real-beauty.aspx

Enoch JM. History of mirrors dating back 8000 years. *Optom Vis Sci*. 2006;83(10):775-781.

Mark G, Smith AP. Occupational stress, job characteristics, coping, and the mental health of nurses. *Br J Health Psychol*. 2012;17(3):505-21.

Cleveland Clinic. Fostering a better self-image. Retrieve from http://my.clevelandclinic.org/health/healthy_living/hic_Stress_Management_and_Emotional_Health/hic_Fostering_a_Positive_Self-Image

American Nurses Association health nurses campaign. Retrieved from http://www.nursingworld.org/healthynurse

Song, M. and Iovannucci, E. Nurses Health Study. JAMA Retrieved from http://oncology.jamanetwork.com/article.aspx?doi=10.1001/jamaoncol.2016.0843

Scrub Laundering

Appraised by:
Brianna Makovsky, RN, Hannah Abell, RN, Linnea Tracy, RN Mayville State University RN-to-BSN students

Clinical question:
Is there a difference in hospital acquired infections among admitted patients when heath care workers use professional laundry service as opposed to home laundering?

Articles: (in APA format)

Akrami, K., Coletta, J., Mehta, S., & Fierer, J. (2017, July 14). Gordonia sternal wound infection treated with ceftaroline: Case report and literature review. Retrieved from https://www.google.com/search?client=firefox-b-1-d&q=Sternal wound infection caused by Gordonia bronchialis scubs

AST. (2017). AST Guidelines for Best Practices for Laundering Scrub Attire. Association of Surgical Technologists. Retrieved from http://www.ast.org/uploadedFiles/Main_Site/Content/About_Us/Standard Laundering Scrub Attire.pdf

The Joint Commission. (2019). Laundering - Guidelines For Surgical Scrubs or other Surgical/Procedural Attire. Retrieved from https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1294

Synthesis of evidence:
A Case Reports and Series study regarding the spread of *Gordonia bronchialis* in post-operative patients who underwent a sternal surgery, and later presented with *Gordonia bronchialis* in their sternal wounds. *Gordonia bronchialis* had contaminated a CRNA's surgical scrub attire from inadequate temperature during laundering. It was found that the CRNA's washing machine did not heat its water up enough, allowing organisms to grow and contaminate the laundry to be washed inside. In conclusion, *Gordonia bronchialis* was able to spread as a direct result from poorly laundered hospital attire. Once the CRNA replaced the washing machine, the surgical scrub attire no longer was contaminated with *Gordonia bronchialis*. (Akrami, Coletta, Mehta, Fierer, 2017).

The article by The Joint Commission relates to our research topic because it uses data to explain the importance of sanitizing the scrubs. If healthcare workers had their scrubs professionally laundered versus at home laundering, would this help decrease hospital-acquired infection rates among admitted patients. This article provides tables to help display the statistics. Our team would agree with the stance provided in the article, that professionally laundered scrubs decrease the infection rates among admitted patients. "An OR person wearing home-laundered scrubs who is beginning a shift is wearing scrubs that have the same number of bacteria as the scrubs of an OR person finishing a shift." (AST, 2017, para 2).

If scrubs are visibly soiled, then they must be changed for clean scrubs. To define clean scrubs, they offered two options for a facility to follow, it does not matter which one, but they must choose to follow one of the guidelines. Option one is per CDC/HICPAC Recommendation Laundry and Bedding I: the employers must have the person protective equipment of the workers' that are soiled to be laundered. Option 2: per AORN's 2015 Guideline for Surgical Attire Recommendation II: this is for all individuals who enter the restricted and semi-restricted areas need to wear scrub attire which is laundered via a health care accredited laundry facility or wear disposable scrub attire. Working in the hospital it is easy to get scrub attire soiled, which is an infection risk to our patients. Visibly soiled garments, scrubs, or personally owned items that become contaminated must be laundered by the employer at no cost to the employee per the OSHA Blood borne Pathogen Act. (The Joint Commission, 2019).

Bottom line:
In our extensive research, we found that there are direct patient benefits when scrubs are laundered professionally/commercially verses at home. In the long run, it may be more expensive to think of at first. However, it is more expensive for a health care facility to pay for the treatment of a hospital acquired infection.

Implications for nursing practice:
If the healthcare facility you work at does not offer professional/commercial laundering, ensure your own at home laundry system is effective to kill any contaminants located on your uniform. If not, it is a good idea to take the uniform elsewhere for professional laundering.

From the North Dakota Department of Health

From July 2019:

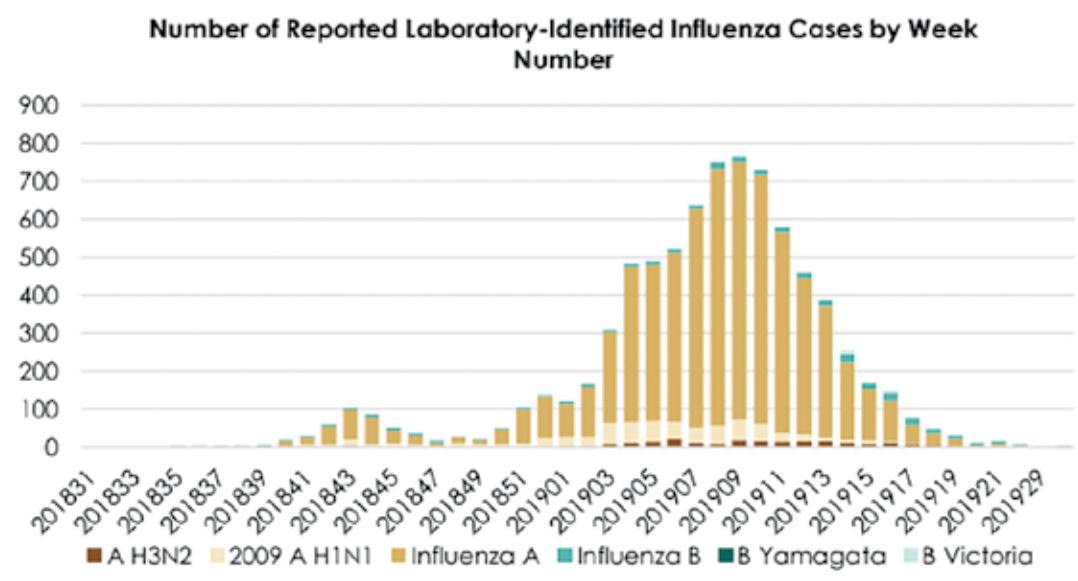
A look at final estimates for the 2018-19 influenza season: The North Dakota Department of Health (NDDoH) identified nearly 8,000 cases of influenza, with 546 hospitalizations and 22 deaths. The season peaked Morbidity and Mortality Weekly Report (MMWR) week 09 (ending March 2, 2019). The predominant strain this season was 2009 Influenza A H1N1, which differed from the previous season of AH3N2. As usual, the influenza AH3N2 strain circulated as well, only in much lower numbers, as did both influenza B lineages, with B Yamagata making up a large majority of the influenza B cases. According to the Centers for Disease Control and Prevention (CDC), the 2018-19 season was one of the most severe seasons on records, and the second most severe since the 2009 pandemic. While influenza surveillance continues year-round, the season typically begins on week 40 (ending October 5th) and continuing until week 20 of the following year (ending May 18th). Pump Handle The August 2019 North Dakota Department of Health – Division of Disease Control Pump Handle - 2 August 1st represents the beginning of a new influenza morbidity season, and with it comes a wave of preparation. Influenza season kickoff preparation is in the works; the preliminary date for the kickoff event, partnered with Families Fighting Flu, will be Tuesday, September 24th. The Advisory Committee on Immunization Practices, along with the North Dakota Department of Health, recommends that everyone age six months and older receive their influenza vaccine.

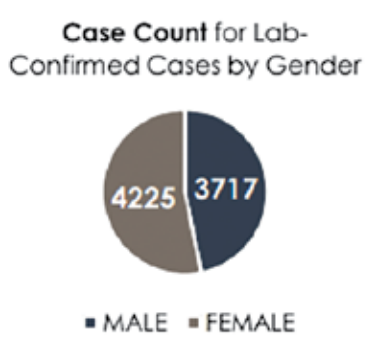
West Nile Virus Update

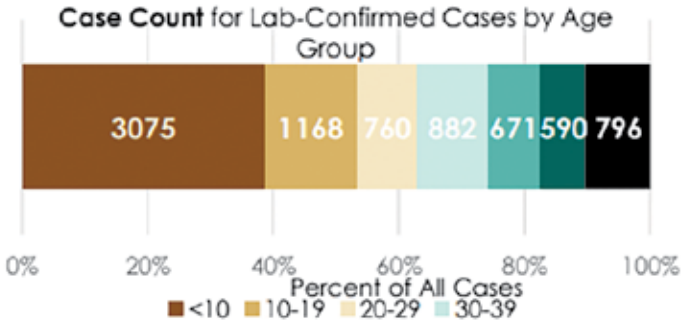
As of September 5, 2019, there have been six confirmed cases of West Nile virus (WNV) reported in North Dakota. The individuals reside in McHenry, Mercer, Golden Valley, Grand Forks, Burleigh and Trail counties and none were hospitalized.

WNV has also been identified in mosquito pools used for surveillance in Stutsman, Stark, Ward and Grand Forks counties. There have been no reports of birds or any other animal identified with WNV so far in 2019. As of September 4, 2019, 326 human cases of WNV have been reported to the CDC, with 207 (63%) cases identified as neuroinvasive.

For more information about West Nile virus, contact Evan Bischoff, North Dakota Department of Health, at 701.328.2378 or visit www.ndhealth.gov/wnv.







Fall Recipes

Apple Pie

Ingredients

- 1 double-crust All-Butter Pie Dough shell
- 8 cups (960g) apples, peeled and chopped into bite-sized pieces (roughly 1 inch long by 3/4 inch thick [2.5cm by 19mm])
- 1 (16g) tablespoon lemon juice
- 3/4 cup (150g) granulated sugar
- 3 tablespoons (45g) dark brown sugar
- 1 tablespoon plus 1 teaspoon (10g) tapioca starch
- 1 tablespoon (9g) cornstarch
- 1 teaspoon (2g) Chinese five-spice powder
- 1/2 teaspoon (1.5g) kosher salt
- 1 tablespoon (14g) unsalted butter, cut into small pieces

Instructions

1. Place the apples in a medium bowl. Add the lemon juice and toss with a spatula until the apples are well coated.
2. Place the granulated sugar, brown sugar, tapioca starch, cornstarch, Chinese five-spice powder, and salt in a small bowl and whisk to combine. Pour the dry ingredients into the bowl of apples and mix until the apples are again well coated. Set aside to macerate for at least 25 minutes.
3. Place a colander over a medium bowl and transfer the macerated apples to the colander, making sure to scrape down the side of the bowl to get all the juices, sugars, and starches. Let the apples drain for 25 minutes.
4. Pour the drained juice into a small saucepan, scraping down the side and bottom of the bowl to get every drop. Bring the apple juice to a boil over medium-high heat, stirring constantly. Reduce heat and continue to boil the apple juice gently until it thickens, about two minutes. Remove from the heat and set aside to cool. Once it is room temperature, chill the saucepan in the refrigerator for about 20 minutes.
5. Pour in the apples, making sure to scrape out any dry ingredients or juices that stick to the side of the bowl. Make a well in the middle of the apples and pour in the thickened apple juice. Gently smooth the pie filling with a spatula and dot with the butter. Finish the pie according to the double-crust instructions, then freeze for at least 20 minutes.
6. Preheat the oven to 400 degrees F (200 degrees C).
7. Brush the top of pie with pie wash and bake for 45 minutes to one hour, rotating 180 degrees every 20 minutes, until the crust is dark golden brown and the juices are bubbling thickly through the vents. Cool for at least two hours before slicing.

Apple Streusel Pumpkin Muffins

Ingredients

- 2 tbsp (25 mL) all purpose flour
- ¼ cup (50 mL) granulated sugar
- ½ tsp (2 mL) ground cinnamon
- 4 tsp (20 mL) butter
- 2½ cups (625 mL) all purpose flour
- 2 cups (500 mL) granulated sugar
- 1 tsp (5 mL) baking soda
- 1 tbsp (15 mL) pumpkin pie spice
- ½ tsp (2 mL) salt
- 2 eggs, beaten
- 1 cup (250 mL) canned pumpkin puree (not pie filling)
- ½ cup (125 mL) vegetable oil
- 2 cups (500 mL) finely chopped apples
- Muffin tins, greased or paper-lined

Instructions

1. Preheat oven to 375°F (190°C).
2. Prepare the topping: In a bowl, combine flour, sugar and cinnamon. Cut in butter; mix until coarse and crumbly. Set aside.
3. Prepare the muffins: In another bowl, combine flour, sugar, baking soda, pumpkin pie spice and salt. Make a well in the center.
4. In another bowl, combine eggs, pumpkin and oil; stir just until blended. Add apples; blend well. Add to dry ingredients; stir just until moist.
5. Spoon batter into prepared muffin tins. Sprinkle with topping. Bake in preheated oven for 25 to 30 minutes.

Cowboy Cookies

Ingredients

- 2 cups unbleached white all-purpose flour (see Note below)
- 1 teaspoon baking soda
- 1/4 teaspoon baking powder
- 1/4 teaspoon salt
- 1 cup butter, at room temperature (2 sticks)
- 1/2 cup sugar
- 1/2 cup packed brown sugar
- 2 large eggs
- 1 teaspoon pure vanilla extract
- 2 cups rolled oats
- 2 cups semisweet chocolate chips or chunks (12 ounces)
- 1 1/2 cups raisins, dried cranberries, or chopped dried cherries (optional)
- 1 cup coarsely chopped toasted walnuts (optional)

Instructions

1. Preheat the oven to 350 degrees F.
2. In a mixing bowl, sift together the flour, baking soda, baking powder, and salt. Set aside. In a large mixing bowl, using an electric mixer, cream together the butter and sugars. Add the eggs and vanilla and beat well. Add the dry ingredients and blend well. Stir in the oats. Fold in the chocolate chips and the dried fruit and the nuts, if using. The dough will be fairly stiff.
3. Drop spoonfuls of dough onto unoiled baking sheets. For large cookies, place rounded blobs of dough about the size of a ping-pong ball on the baking sheets, placing then about four inches apart. For smaller cookies, drop rounded tablespoons of dough onto the baking sheets, placing them about two inches apart. Bake for 12 to 15 minutes until golden brown.
4. Transfer the cookies to wire cooling racks. Cool completely before storing in a sealed container.

Strengthening Workplace Violence Prevention

Donna M. Fountain, RN, PhD

Reprinted with permission from New Jersey Nurse October 2019

In 2018, the Joint Commission acknowledged the seriousness of physical and verbal violence against healthcare employees, particularly among nurses, and other health care workers as a Sentinel Event (TJC). Federal policy against workplace violence is vital. However, dependency on legislative action alone is not enough. A dynamic leadership presence across patient-care units is needed to enforce efforts to prevent violence. Typically, sources of violent behavior against nurses vary from patients and family, visitors, and other colleagues. The nursing profession desperately needs stronger policy guidelines to identify, prevent, and mediate all forms of violence at work. Studies have shown that violence against hospital nurses reduces their:

- job satisfaction
- self-esteem
- health and well being
- engagement levels
- retention rates
- ability to provide optimal levels of patient-centered care

The American Nurses Association (ANA, 2015) Position Statement on Incivility, Bullying and Workplace Violence has driven the charge among nurses to increase their awareness of the problem of violence in health care settings and to devise effective strategies on a system-level (2015, 2018). Since health care organizations respectively create their unique set of policies against employee violence, also referred to as "Zero-tolerance" or "Anti-Workplace Violence" policies, this continues to pose a challenge for researchers. In a recent ANA Workplace Violence webinar (2019, June 6) presenters, Fountain and Zankowski asked nurse participants to respond to the following two-part poll question "Does your organization have a workplace violence policy in place?" Reporting yes were 68.3% of nurses who had a workplace violence policy at work; 9.9% reported *No* policy, and 21.8% indicated that they were *Unsure*. Moreover, for the participants who reported *Yes* to having a violence policy in place, when asked if they perceived it to be effective, 28.1% indicated *Yes*; while 42% indicated *No*; and 29.9% indicated that they were *Unsure*.

The ANA End Nurse Abuse Professional Panel (2019) recommends a system-level approach to prevent workplace violence using the three levels of prevention:

1. Primary prevention through education and prompt identification of the occurrence of workplace violence, such as a Zero-tolerance employee education program.
2. Secondary prevention by screening, ongoing surveillance, and treatment of employees of workplace violence incidents with swift interventions to mitigate the potential negative consequences; such as a reporting and a systematic improvement program.
3. Tertiary prevention to provide rehabilitative services and employee assistance to minimize the long term post-violence employee limitations; such as Employee Assistance Programs and After-care.

More research is needed to cultivate and sustain effective strategies to improve healthy work environments for all healthcare providers, particularly for nurses. Health care managers and staff should align to ensure daily efforts are made to prevent workplace violence through the use of realistic policies and ongoing monitoring of violent incidences and prompt remediation.

References:

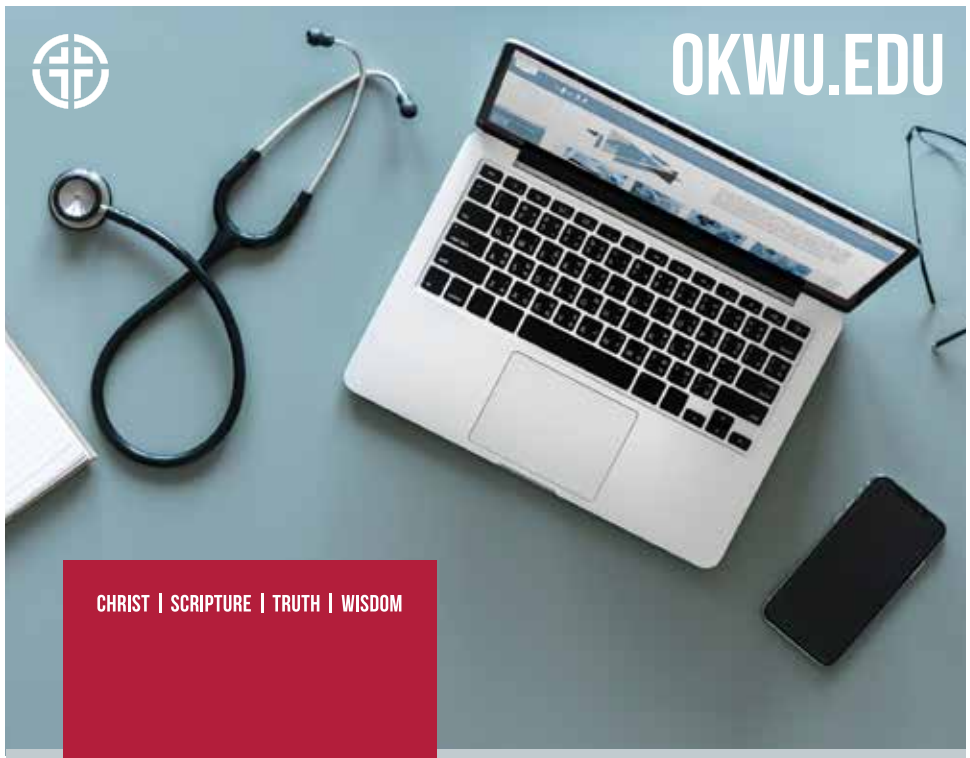
American Nurses Association. (2019). ANA Professional Issues Panel, END RN ABUSE: Issue Brief: Reporting Incidents of Workplace Violence, Silver Spring, MD.

American Nurses Association. (2015). ANA Professional Issues Panel, Position Statement: *Incivility, Bullying, and Workplace Violence*, Silver Spring, MD. Retrieved from https://www.nursingworld.org/practice-policy/work-environment/violence-incivility-bullying/

Free Live Webinar: American Nurses Association ANA Webinar. (2019, June 13). Presenters: Fountain, D. M & Zankowski, D. L. *What Every Nurse Needs to Know – and Do- about Workplace Violence*. Silver Spring, MD.

Stockwell, S. (2018). Joint Commission Issues Alert Addressing Violence Against Health Care Workers. AJN *The American Journal of Nursing:* July 2018, 118(7): 14. doi: 10.1097/01.NAJ.0000541417.67605.8f In the News.

The Joint Commission. (2018). Addressing violence against health care workers. Sentinel Event Alert, Issue 59. Retrieved from https://www.jointcommission.org/sea_issue_59/



OKWU.EDU

CHRIST | SCRIPTURE | TRUTH | WISDOM

MSN OR RN-BSN COMPLETELY ONLINE

CCNE ACCREDITED

ENROLLING NOW

- CCNE ACCREDITED
- ACCELERATED COURSES
- AFFORDABLE, LOCKED-IN TUITION
- FINANCIAL ASSISTANCE AVAILABLE
- VA APPROVED - NNEI APPS ACCEPTED
- DESIGNED FOR YOU, A WORKING ADULT

LEARN MORE ABOUT PROGRAM REQUIREMENTS

OKWU.EDU/MSN OR OKWU.EDU/NURSING

866.225.6598 | AGS@OKWU.EDU

THE BACCALAUREATE DEGREE IN NURSING AND MASTER'S DEGREE IN NURSING AT OKLAHOMA WESLEYAN UNIVERSITY ARE ACCREDITED BY THE COMMISSION ON COLLEGIATE NURSING EDUCATION, HTTP://WWW.AACN.NCHE.EDU/CCNE-ACCREDITATION

NDSU NORTH DAKOTA STATE UNIVERSITY

ADVANCE YOUR NURSING CAREER

Choose from educational options that fit your needs.

- With locations in Fargo and Bismarck, North Dakota, the NDSU School of Nursing offers small class sizes, experienced faculty and an excellent value.
- An RN to BSN blended online part-time program provides flexibility to transform your professional practice
- Pre-licensure BSN program — Bismarck and Fargo
- LPN to BSN blended online program
- Doctor of Nursing Practice (BSN to DNP)/Family Nurse Practitioner program — Bismarck and Fargo

NDSU offers programs to part- and full-time students, working professionals and those seeking online educational opportunities.

ndsu.edu/nursing

BEING GREAT AT DOING GOOD

Join our Team!

Employment incentives may be available.

CHI St. Alexius Health
Bismarck, ND
RN - KDU
RN – Operating Room
RN – Surgical
RN – Progressive Care Unit

CHI St. Alexius Health
Dickinson, ND
RN - ER
RN – ICU
RN – MSP
RN – OB

CHI St. Alexius Health
Williston, ND
RN – OB

CHI Health At Home
Williston, ND
RN – Home Health & Hospice

CHI Health At Home
Fargo, ND
RN – Home Health & Hospice

CHI Lakewood Health
Baudette, MN
RN – Acute Care
RN – RN Coordinator

CHI Oakes
Oakes, ND
RN – Clinical Coordinator
Nurse– Acute Care

CHI MN/ND Market
RN – Traveler

CHI Mercy Health
Valley City, ND
RN – Patient Care Unit

To apply, visit catholichealthinitiatives.org and click on careers.
Catholic Health initiatives is an EEO F/M/Vet/Disabled Employer

Catholic Health Initiatives