Hello Alabama Nurses! As the holidays are upon us with 2019 drawing to a close, I’ve often found myself, like many of you I’m sure, reflecting on the events of this year. Alabama nurses certainly witnessed a great milestone with the passing of the compact licensure legislation, but we came together in a unified voice to also say to the legislature and the public that violence against nurses, or any healthcare worker for that matter, is not okay. The law which gives felony status to physical violence against nurses has been on Alabama’s books for over a decade, but few have even known about the law. Therefore, little has been done over the years to emphasize the existing law. However, we’ve all rejoiced in recent months that the legislature passed ASNA’s Joint Resolution requiring healthcare facilities to post signage stating that “striking a healthcare worker is a felony in Alabama!” Healthcare facilities across the state are posting the signs in their patient waiting areas, and the word is now getting out! Once again in its 105 year history, ASNA has worked to protect Alabama’s nurses. Our latest accomplishment is evidence of what nurses can do when we unite, and we must unite to shape our future and that of healthcare. A loved one once said, “Sarah, make life happen for you, not to you.” I would like to suggest that nurses make practice happen for us, not to us! The year might be coming to an end, but we are beginning a new decade with numerous opportunities ahead of us to impact healthcare. If Alabama nurses will continue to unite in bringing about change across our state just as we have done this year, think about the positive difference that we can make in the lives of our patients and future nurses in our state. Nurses should be making decisions for the nursing profession and not allow other entities to make them for us! With over 100,000 nurses in our state, our profession is in a prime position to impact the next decade of healthcare in Alabama. In the words of the American Nurses Association’s (ANA) President, Dr. Ernest Grant, “If you are going to call yourself a professional nurse, then you have an obligation to belong to your state’s professional nursing organization so that you have the opportunity to participate in shaping our future.” I look forward to welcoming you to ASNA in the new year!
ASNA Congratulates the New Alabama Association of Nursing Students (AANS) Officers!

Tiffany Tucker – President (UAH)
Anna Beth Franks – Vice President (UAH)
Christopher Leone – Secretary (UAH)
Candice Davis – Treasurer (Blevill State Community College – Fayette campus)
Kassidy Spurgeon – Communications Director (Wallace State Community College – Hanceville)
Tonja Grace – Breakthrough to Nursing Director (Wallace State Community College – Hanceville)
Stahler Heath – Community Health Director (UAH)
Landon Nichols – Legislative Chair (Blevill State Community College – Fayette campus)
Laura Bowman – Director South (Tuskegee University)
MaKayla Davis – Director North (UAH)

Condolences:
The ASNA Board of Directors and ASNA Staff extend their deepest condolences to the following:

Dr. Casey Norris, ASNA District 5 member on the loss of her mother
The Family and EAMC family of Ms. Sharon Gess, Notasulga, AL
Ms. Jeri Cornett, Meridianville, AL
Margaret Parnell, Tibbie, AL

Does your campus have an AANS Chapter?
Contact your AANS President, Tiffany Tucker at presidentaans@gmail.com.

ALBERTA NURSE
2019-2020 AANS Executive Board

ASNA Board of Directors
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Our Mission
ASNA is committed to promoting excellence in nursing.

Our Vision
ASNA is the professional voice of all registered nurses in Alabama.

Our Values
• Modeling professional nursing practices to other nurses
• Adhering to the Code of Ethics for Nurses
• Becoming more recognizably influential as an association
• Unifying nurses
• Advocating for nurses
• Promoting cultural diversity
• Promoting health parity
• Advancing professional competence
• Promoting the ethical care and the human dignity of every person
• Maintaining integrity in all nursing careers

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The Alabama Nurse is published quarterly every March, June, September, and December for the Alabama State Nurses Association, 360 North Hull Street, Montgomery, AL 36104

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It is not popular to write about, what many describe as our “broken” mental health system. But, you are nurses and you see, we know about, patients who have fallen through cracks in the system. Like other serious chronic illnesses, mental illness requires effective continuity of care by professionals and compliance to treatment modalities by patients. Anyone who has worked in a mental health provider setting will tell you that the system is under resourced and that continuity/compliance issues are very, very difficult to solve. I worked at the Alabama Department of Mental Health as Public Information Officer for over 10 years and served under three Commissioners. During that time, the State was closing hospitals and facilities and working to enhance community and contract provider services. Patients who were fortunate to have facilities and working to enhance community and contract provider services. Patients who were fortunate to have

health system was under Federal Court control for 33 years! The good thing about Wyatt was that it required rights and humane environments for patients who were in care providers to determine compliance with care. Anyone who has worked in a chronic illness. Nothing I can do to change the patient at this time like I would any person with a chronic illness. Nothing I can do to change the system. It’s way bigger than me…so I just do my job. A chronic illness. Nothing I can do to change the patient at this time like I would any person with a chronic illness. Nothing I can do to change the system. It’s way bigger than me…so I just do my job.

treatment and appropriate discharge when stabilized. Other cases, asked the right to live in a least restrictive environment and the right to refuse to take medicine if they chose not to do so. Given many of the atrocious pre-Wyatt systems, these new “rights” were celebrated by mental health advocates and are ideals that permeate our modern mental health system today. So, how does all this affect you… the nurse? One in five Americans will experience a mental illness in their lifetime. More than 65% of the homeless population are people with a serious and persistent mental illness. (I believe the stats are much higher). Nurses in almost any setting of care encounter patients with some form of mental illness. Not to mention, family members and some co-workers. Nurses are not immune just because they are nurses…. It is everywhere! My observation suggests three ways clinicians think about this “swirl” of mental illnesses all around them with what appears to be broken continuity of care (as they assess the patient’s history) and sketchy compliance to treatment plans by the patients themselves.

1. Pessimism: Bring em’ in, shoot em’ up, turn em’ loose. I do not mean to be offensive to the vast majority of mental health clinicians who treat people with respect and compassion.

But, I also realize that all too often nurses see the same patients over and over again through what feels like a revolving door of admission, stabilization and very soon…discharge. Professionally done, discharge includes a continuity of care plan with case management, etc. However (remember Wyatt v. Stickney) the patient does not have to comply and if they don’t…they may decompensate, become sick again and become a familiar recidivist at your facility. Sadly, it is easy to become a pessimist.

2. Realism: It is what it is…I just do my job and help this patient at this time like I would any person with a chronic illness. Nothing I can do to change the system. It’s way bigger than me…so I just do my job.

(Sounds a little pessimistic doesn’t it?)

3. Professional – Angry – Advocate: I’ll do my job. I see the system has flaws and people fall through the cracks as a rude health providers try to do the best they can. But, #&%$@#$ I am going to find a way to speak out about this and advocate for people with mental illness and a better service system to keep them healthy!!

Which one of these mindsets do you have about revolving door mental health patients and the “broken” system? If you are in 1 or 2 above…who can blame you? If you are a number 3…ASNA can help your voice be louder.

the legislature, would NOT LET A WOMAN SPEAK before the body – so she stood in the hall while a legislator read her speech. She had no passion. But her words were so powerful, history reports that many men were in tears before the reading ended! A few years later, they appropriated funds for building Bryce Hospital in Tuscaloosa, Alabama. Not too many years ago, a nurse in Massachusetts received a “needle stick” while treating an AIDS patient. Later, she tested positive for HIV. She began an advocacy campaign through her Nurses Association to require RED NEEDLE boxes in every clinical setting. The issue rose to the US Congress. Eight years after her advocacy began, Senator Ted Kennedy gave a passionate speech and legislation passed and became law! She and her association are the reason RED NEEDLE BOXES ARE IN YOUR CLINICAL ROOMS TODAY. One person and one association – have saved untold lives from accidental needle stick disease transmission. Are you a number 3? JOIN ASNA AND RAISE A RUSCUS!

If you are not familiar with this case, Wyatt v. Stickney began in 1971 and was settled in 2002. Alabama’s mental health system was under Federal Court control for 33 years! The good thing about Wyatt was that it required rights and humane environments for patients who were in institutions. In essence, it was the “Civil Rights” case law for people with mental illnesses and disabilities! Patients had the right to hearings before commitment, humane

Excellent Nurse Opportunity!

The Alabama Department of Public Health is now hiring for the position of:

LICENSURE AND CERTIFICATION SURVEYOR classification number 40726, nurse option.

This involves professional work surveying health care providers to determine compliance with state and federal regulations. To qualify, you must have a Bachelor's degree in Nursing with 2 years of direct patient care nursing experience OR an Associate’s degree or diploma in Nursing with 5 years of direct patient care nursing experience.

This position offers competitive compensation with excellent benefits, including paid time off. Extensive overnight travel is required.

For more information and to apply please go to: alabamapublichealth.gov/employment or personnel.alabama.gov

If you have questions, please contact: Lakesha Hopkins at lakesha.hopkins@adph.state.al.us.

The University of South Alabama is a place of unlimited possibilities and exceptional accomplishments. The College of Nursing, one of the largest nursing programs in the United States, is accredited by the Commission on Collegiate Nursing Education (CCNE). For information, visit SouthAlabama.edu/nursing.

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December 2019, January, February 2020 Alabama Nurse • Page 3
Wisdom – Blessing or a Curse?

GREGORY HOWARD
LPN

Those of us who have been around the block a time or two have learned some valuable lessons. We have learned what works and what does not work, in addition to our text book education.

Sharing what we have learned does not diminish what we know. So why not help new colleagues or healthcare workers with less experience. Why not share if it promotes competent care for the people we serve. This also applies to helping others in their personal growth in the Nursing Community. I personally owe my personal accomplishments in the nursing community to C.J.D. and S.M., who were key in my accomplishments while serving on the Alabama Board of Nursing and to my position on National Committees. Without their encouragement and support, I would not have had the experience that I did. This was truly an act of sharing one’s knowledge, experience and human kindness.

Sharing is only half of the equation, acceptance is the other part. Gaging someone’s acceptability is key in sharing. It is always best to share even if it is poorly received.

Wisdom is the result of hard work and experience. So, let us celebrate those who have put in the work for their accomplishments. Acknowledge that they are blessed. The other part is, we let us celebrate those who have put in the work for their accomplishments. Acknowledge that they are blessed. The other part is, we

Do Your Best but Don’t Live in Fear

JON D. BARGANIER
J.D.

Nursing can be scary, no doubt about it. Anxiety about being sued for alleged negligence or even prosecuted for crimes against patients, insurers or the government can cause concerns that drive you to the end of your rope. I never want to add to that anxiety in this column. Unfortunately, that’s the part of nursing I worry about and feel incumbent to share with our readers but I don’t share this to scare you but to help you avoid pitfalls that could lead you down that scary road.

I had a nurse say to me something like, “Why can’t I just be a good nurse? Why do I have to worry about being sued for doing the work I love and doing my best to take care of my patients to the best of my ability?” All I can say to that is the worn-out trite comment, “It is what it is.” If I could reverse the course of part of my professional colleagues, predatory plaintiff lawyers who are willing to file suits with scant evidence of any negligence, I would.

Until the legal environment changes, we are stuck in a litigious society and health care providers, in particular, are targets for the trial bar. So how do you mitigate the situation as much as possible? First, you practice your profession to the best of your ability and you seek help in uncertain situations. You put the patient first, you follow procedure and you deliberately and thoughtfully document.

In a previous issue of The Alabama Nurse I borrowed from a list of good practices written by Deanna Reising, Professor of Nursing at Indiana University and it’s worth repeating here. She advised: (1) know and follow your state’s nurse practice act and your facility’s policies and procedures; (2) stay up to date in your field of practice; (3) assess your patients in accordance with policy and their physicians’ orders and more frequently, if indicated by your nursing judgment; (4) promptly report abnormal assessments, including laboratory data, and document what was reported and any follow-up; (5) follow up on assessments or care delegated to others; (6) communicate openly and factually with patients and their families and other health care providers; (7) document all nursing facts truthfully and thoroughly and ensure that the documentation reflects the nursing process and never chart ahead of time; (8) promptly report and file appropriate incident reports for deviations in care.

To be more specific about concerns that have come to my attention, I recently talked to a respected local attorney, Ben Wilson with the firm, Rashion Stakely, here in Montgomery. Ben spends a lot of his professional life representing hospitals and their employee healthcare practitioners, including nurses, in negligence cases. I asked Ben if there are trends in negligence cases involving nurses of which I should caution nurses. Without hesitation, he responded, “electronic medical records,” more broadly defined, digital records of all kinds utilized by nurses. I want to go into more detail about his concerns in the next issue of The Alabama Nurse, but suffice it to say here that digital records have, in Ben’s words, “been exploited to great effect by personal injury attorneys.” I hope a more in depth look at his concerns will be helpful. I began by saying that I didn’t want to heighten your anxiety about your practice, but I’m sure I did. What you do is too important to live in fear. That’s what I told the young nurse I mentioned earlier who just wants to do her job but is fearful of lawsuits. The truth of the matter is, you can be sued for anything. Your dog can bite your next-door neighbor. You can have a traffic accident. In one real case, an 8-year-old child was sued by his aunt when he jumped into his aunt’s arms, causing her to fall and break her wrist. She was awarded $127,000. You can only call that a frivolous lawsuit but it really happened. If you are going to live in fear of lawsuits, you might as well vastly expand the possibility of your worry. It’s not just in nursing. So be concerned but not unreasonably. Do your best but don’t live in fear.

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If you are in pursuit of excellence and want to join a patient focused team, email your resume to careers@ballhealth.com. We offer an excellent benefit package and salaries commensurate with experience.

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But HealthCare Services, Inc. is an equal opportunity employer.
Alabama has the third-lowest breastfeeding rate in the nation, according to the Centers for Disease Control. That’s a statewide health problem because breastfeeding is considered the gold standard for feeding infants by government and medical organizations. It’s been shown to reduce the rates of long- and short-term health conditions for babies including asthma, obesity, SIDS, respiratory infections and diabetes.

Only about 39 percent of Alabama mothers are still breastfeeding by the time their babies reach 6 months old, the milestone recommended by the American Academy of Pediatrics. The national average is 58 percent.

Many mothers fall short of meeting their goal of exclusive breastfeeding for six months, when they meet employer resistance on their return to work. The Alabama Breastfeeding Committee has established a program to assist both mothers and employers on the new mother’s return to work.

Extensive information regarding creating a breastfeeding friendly workplace is listed on the Alabama Breastfeeding Committee’s (ABC) website at (www.alabamabreastfeeding.org). Mothers can provide this information to their employers prior to her delivery or employers may download the information for their use.

To become a Breastfeeding Friendly Workplace, the employer must meet the following criteria:

• Provide a clean, comfortable space (not a bathroom), with an electrical outlet, in order to pump milk or breastfeed
• Allow employees to take a break as needed to pump milk or breastfeed
• Space should include a table and comfortable chair, with a sink, soap, water, and paper towels nearby
• Provide a refrigerated space to store breastmilk
• Have a written breastfeeding policy that is communicated to all employees
• Training for personnel on showing respect for employees and/or patrons who wish to breastfeed at the business
• Provide a list of community resources for breastfeeding support

Employers who meet these requirements will receive recognition as a Breastfeeding Friendly Workplace. This includes a certificate for framing, vinyl stickers that can be placed on the door/window, listing on the ABC website as a Breastfeeding Friendly Workplace, and a press release regarding the program.

The Alabama Breastfeeding Committee wishes to thank the Alabama State Nurses Association Foundation for providing grant money to assist in starting this program. The funding has been used to create and print the vinyl stickers and to print booklets for employers.

Questions or comments may be directed to Glenni Lorick at anm@knology.net or Gayle Whatley at gwhatley53@bellsouth.net.

Scholarships and Grants

When you buy a nurse tag, you’re helping provide nursing scholarships statewide!

In addition to scholarships, up to four different $500 grants are awarded each year on an ongoing basis throughout the year.

All proceeds from tag purchases and renewals benefit ANF. Get your tag at any Alabama license office!

Helen Wilson Leadership Scholarship – Awarded at Elizabeth A. Morris Clinical Education Sessions – FACES Deadline to apply is March 1 Annually.

Academic Scholarships – Awarded annually at the Elizabeth A. Morris Clinical Education Sessions – FACES in April - Deadline to apply is March 1 Annually.

Open to:
1. Alabama students pursuing an Associate or Baccalaureate degree - $1,000
2. ASNA members, awarded based on academic performance, nursing leadership, and commitment to ASNA (2 awarded each year) - $2,000
3. Any Alabama nurse based on academic performance, professional activities, and commitment to nursing (2 awarded each year) - $2,000

Learn more about ANF and funding opportunities by visiting https://alabamanurses.org/foundation/.

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Meet Your District Presidents

**District 1**
Jeanette Atkinson, MSN, RN

**District 2**
Mary Beth Bodin, DNP, CRNP, NNP-BC

**District 3**
Adrienne Curry, DNP, RN

**District 4**
Jacqueline Smith, EdD, MSN, RN

**District 5**
James Hardin, MSc, BSN

District 1 Citation of Excellence Presentation

Kim Driggers (L) presented her co-worker Ms. Wanda Smith Wilson (Center) with the Citation of Excellence Award

Today I had the honor of presenting my good friend and long time co-worker with an award that celebrates excellence in nursing.

I work with and have worked with many amazing nurses over the years, they all have their unique qualities. Wanda Smith Wilson is a nurse that, despite fiery darts that are thrown at her, she maintains her composure. She shows love and compassion to all of her patients, despite the circumstances. She is patient and caring with the students she precepts. She is nothing but kind to her co-workers. In the many years I have worked with Wanda, I have seen her go through many challenges, she has faced them with her head held high. I do not remember her ever muttering unkind words about situations or people. I am proud to call Wanda a friend and co-worker.

Meet Your New ASNA Officers

**Vice President**
Frederick Richardson, BSN, RN

**Secretary**
Sharon Engle, MSN, RN, CCRN-K

District 4 Highlights

Members of ASNA District 4 presented check to Mr. Andy Wynne from the Child Advocacy Center

ASNA District 4 President Dr. Jacqueline Smith (L) and Dr. Bobbie Holt-Ragler ASNA 2019 Convention Chair present Mr. Andy Wynne with a check for the Child Advocacy Center
THE ASNA LEADERSHIP ACADEMY is designed for nurses by nurses to help participants develop excellent leadership skills. Each individual is guided through the program by experienced nurse mentors and supported by peers in the group. Mentors will help you create a project that can be implemented in the workplace or the community. Past projects have significantly improved efficiencies in the workplace, have led to improvements in patient care, and have instituted creative new wellness initiatives.

Participants are expected to attend the three class days in Montgomery and participate in quarterly conferences to discuss project development progress. The class days include leadership development presentations to the Cohort with mentor-time related to individual projects. For busy nurses who want to grow…this is the way to go!

REGISTRATION DEADLINE: APRIL 1, 2019.

EXAMPLES OF 2020 PROJECTS INCLUDE:
• Incorporating Video Orientation on the Outpatient Clinical Decision Unit
• Economic impact of Registered Nurses Within Chilton County Alabama
• Making a Seat at the Table: The Importance of Organizational Goal Alignment
• The Five “Ds” of Deprescribing: A Structured Approach to Decreasing or Eliminating Psychotropic Medications
• Career Beyond the Paycheck: Increasing Nurse Advocacy and ASNA Membership in Correctional Nurses
• LGBT+ Health Care: Minimizing Disparity Through Education
• Developing an Electronic Tracking Mechanism to Monitor Compliance With Pain Assessment and Reassessment
• Exploring a New Model for Utilizing a Nurse Practitioner in the ER Triage
• Learning to Hear a Silent Scream… Suicide: Warning Signs and Resources
• Factors Affecting Burnout and Stress in the ER
• Exploring Social Determinant Impact on Nurse Practice with Interview Techniques
• Advanced Role Transitions
• Ins & Outs of the Wiki/Communications

Day 1: Monday, April 20, 2020
• Overview & Expectations
• Leading with Trust, Integrity, & Compassion

Day 2: Tuesday, April 21, 2020
• Attend Plenary Sessions at FACES ‘20
• Public Policy
• A Message Driven Interview – includes practice with interview techniques
• Advanced Role Transitions
• Ins & Outs of the Wiki/Communications

Day 3: Saturday, July 18, 2020
• Distributed Professional Network Role
• Global initiatives in nursing and healthcare
• Community focus
• Interprofessional Issues
• Nurses Serving on Boards & Mentor Time

2019 Leadership Academy graduates

Congratulations New ASNA Leadership Academy Members

Congratulations to the newest members of Alabama State Nurses Association’s (ASNA) Leadership Academy (LA) 2019! The inaugural meeting of the ASNA LA 2019 was on Monday, April 15, 2019 at Grace Episcopal Church in Pike Road, AL. The group also attended FACES at Eastmont Baptist Church in Montgomery, AL on Tuesday, April 16, 2019. This meeting was a wonderful outlet for the participants to collaborate with other nursing leaders and share ideas about potential LA projects. The participants were paired with a mentor, who will work with them throughout the 6-months of the LA. The group will meet monthly via conference call to share progress on LA projects. In September, the group will present their projects at the ASNA Convention in Point Clear, AL.

The ASNA Leadership Academy started eight years ago in 2012. Since that time, several of the participants have entered leadership roles on the district, state, and national level. Three ASNA presidents were past participants of the leadership academy, as well as, the current president-elect. Many participants have served as district presidents and other leadership roles within the district.

Our belief is that every nurse is a leader. The ASNA Leadership Academy empowers nursing leaders. The organization has many leaders that are invested in helping each other flourish in their roles. Leaders are also recognized for the excellent work that they accomplish through awards presented at the ASNA Awards Ceremony every fall at convention. Citations for excellence in nursing are also presented annually to leaders in the Alabama nursing community.

Our association is making a big difference in Alabama through leadership activities and other initiatives to promote excellence in nursing. Consider getting involved on the district level and attend convention in September. You will be very glad that you did this for yourself. Next year, we hope to see you as a participant in the ASNA Leadership Academy!

See application for the 2020 Leadership Academy at www.alabamanurses.org.
ASNA Gives Job Seekers a FREE CAREER COACH and Employers a High-Demand HOT JOBS Site!

The Alabama State Nurses Association is proud to announce a fresh UNIQUE opportunity for job seekers and employers. Our new Career Center, HOT JOBS marries two services that have great benefits for job seekers and employers. The HOT JOBS site, alabamanurses.org/hotjobs, helps the prospective employee (nurse) enhance their chances in the application / interview process with FREE consultation from ASNA’s professional career coach, Bridget Stevens. Bridget has over 25 years experience as a recruiter in the medical field and is widely respected by major employers in the state. You can ask for her help at the email provided below.

Employers will love using HOT JOBS to prioritize high demand positions in their posts. Bridget can help employers get set up on HOT JOBS and refer qualified candidates with no recruiting fee! If you are a job seeker or HR staff, give Bridget a call or email and find out how ASNA’s HOT JOBS can help you.

Set up your first job now at alabamanurses.org/hotjobs

Questions? Contact: Bridget Stevens
ASNA Career Coach
(205) 266-7562
bstevens@alabamanurses.org

At the Alabama Board of Nursing, we see every day the devastating effects of the disease of addiction, which destroys families, careers, and lives. But we also see the hope that comes with successful recovery.

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   Paying just $50 extra every month can knock about two years and more than $15,000 of interest off your total mortgage loan payback. Adding $100 to your mortgage payment every month lets you pay that mortgage off four years early, and can save you more than $28,000 over the life of your loan.

2. **Switch to bi-weekly payments.**
   When you use a bi-weekly mortgage payment plan, you make a payment every other week—not twice a month. And since there are 52 weeks in a year, you'd make 26 payments, the equivalent of 13 monthly mortgage payments, every year. Not only would that shave about $35,000 off the total interest over the life of the loan, you'd also pay off a 30-year loan in 26 years.

3. **Make extra payments when you receive bonuses or refunds.**
   Almost any time you make an extra payment on your mortgage, 100 percent of the payment can be applied to your principal balance (as long as you tell the mortgage company that’s where you want the money to go). You can use a tax refund, an annual bonus, even scratch-off winnings to take a bite out of your mortgage. Depending on how much extra you pay, and how often you do it, you could pay off your mortgage years early, and save yourself thousands of dollars in interest over the life on your loan.

4. **Make 13 mortgage payments a year.**
   Simply making one extra mortgage payment every year could slash around $34,000 in interest off of the total, and reduce your loan term by four years. Make sure your mortgage lender knows you want the extra payment applied to your principal balance and not counted as an early regular monthly payment.

   You can do that by writing a note on the check, or sticking a post-it on it. If you use online banking, put a note in the payment memo line. On your next mortgage statement, make sure the payment was applied properly. If not, simply call your mortgage company and have them fix it.

5. **Refinance to a 15-year loan.**
   If your salary has gone up since you took out that 30-year mortgage, consider re-financing to a 15-year loan. Yes, your payment will go up, but your lifetime savings will be astronomical.

   Consider our scenario: You took out a $300,000, 30-year mortgage at a 4% interest rate. After five years, you re-finance to a 15-year loan on the remaining principal balance of $71,340 at a 3.2% rate (rates on 15-year loans are typically lower than on 30-year loans). Not only will your mortgage be paid off 10 years early, you’ll also save close to $20,000 in interest.

6. **Refinance to a lower rate, but keep making the same payments.**
   Your credit rating has a big impact on your mortgage interest rate. Many people see their credit scores improve as they make regular on time loan payments—and that can translate into lower interest rates when they refinance. A lower rate on a lower principal balance (because you’ve already paid down at least some principal) brings a lower monthly payment, too.

   But since you’re already used to making the bigger payment every month, every dime you pay that’s greater than the current payment goes toward paying down extra principal. Depending on the difference in the two payments, you could pay off your mortgage anywhere from two to eight years early, and save thousands of dollars in interest.

7. **Tap funds (other than your regular paycheck) to make extra payments.**
   Instead of waiting for the occasional windfall (like a bonus or a tax refund) you can actively seek out a steady way to put more money towards your mortgage.

   Not sure where to find extra cash? One source could be starting a second job to supplement your regular paycheck, where all the money from your second job goes toward extra mortgage payments. If you’ve got a permanent life insurance policy with a healthy cash value balance, you could tap into that through sensible withdrawals or policy loans to quickly minimize your mortgage. **Or, you could finally go through your attic and sell some of those stashedaway goodies on eBay to bring in some extra cash, transforming your collectibles into mortgage principal pay downs.**

   Remember: Every extra amount you send to your lender reduces your principal balance, which in turn decreases the total interest you pay on the loan. And that helps you pay it off faster than expected.

   *Examples are for a $300,000, 30-year mortgage with a 4% interest rate.
   **Withdrawing funds from your permanent life insurance policy will reduce the policy benefit.
Early Placement of PICC Lines and Early Removal of VC to Reduce CLABSIIs in the NICU

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University of Alabama at Birmingham, School of Nursing

PROBLEM DESCRIPTION
A critical need exists for long term central venous access in extremely low birth weight (ELBW) preterm infants admitted to the neonatal intensive care unit (NICU). Central line associated bloodstream infections (CLABSI) associated with central venous catheters result in increased morbidity and mortality in the NICU. CLABSI contributes to increased health care costs, length of hospital stay, mortality and morbidity. Due to the relation between CLABSI and duration of time, current practice standards developed by the Centers for Disease and Prevention (CDC) suggest that umbilical venous catheters (UVC) should be used as long as possible, but the procedure can be up to 15 days as long as aseptic technique is followed (Centers for Disease Control and Prevention, 2017). Despite these standards, the occurrence of CLABSI in the NICU continues to impact this already compromised population (Taylor, McDonald, & Tan, 2014). A substitute for the UVC is the peripherally inserted central catheter (PICC). Without complications, PICC lines have a lower risk of CLABSI and have a longer duration time compared to the UVCs (Shepard, et al., 2015).

AVAILABLE KNOWLEDGE
Infants born prematurely have an increased risk of CLABSI, mortality, and death in the NICU (March of Dimes, 2015). Health complications such as chronic respiratory disease, intellectual delays, and vision impairments are some of the complications surviving premature infants undergo (March of Dimes, 2015). Health complications linked with CLABSI. The National Healthcare Safety Network (NHSN) reported for the year 2012 that the mean CLABSI rate was 2.5 per 1000 catheter days, with birthweight ≤ 750 grams compared to 0.6 per 1000 catheter days in preterm infants with a birthweight >2500 grams (Shepard, et al., 2015). Although obviated, CLABSI continues to elevate in the NICU. The literature impacts outcomes for CLABSI rates improve when a intervention such as the bundle approach and evidenced based strategies are used (Li, Vincent-Faustino, & Golombek, 2013).

A quality improvement (QI) project using the model of implementation (MFI) and evidence based interventions experienced a decline in CLABSI rates. The QI team was able to reduce CLABSI rate by 89% catheter days from 6% to 1.43% in less than 2 years and sustain success with a 0.68% per 1000 catheter days for more than 5 years with strategies that include senior executive leadership engagement, huddles at the bedside among clinical and infection control personnel, the use of chlorhexidine antiseptic, and the establishment of PICC teams to accommodate units who infrequently place PICCs less often (Shepard, et al., 2015). An 89% decrease in CLABSI rate and over 430 CLABSI were prevented with the use of the model of improvement and evidence based interventions (Shepard, et al., 2015). The use of care bundles has proven to be effective in reducing CLABSI in the NICU. Due to the increase in morbidity and mortality association with CLABSI and the increase in hospital costs, central line bundles have been created and implemented across NICUs nationwide (Pogorzelska-Maziarz, 2016). Although the use of care bundles is the cause of a decline in CLABSI incidences, no one bundle has proven to be better than the other. This conclusion leads to the need for further research to determine the effectiveness of individual components and when combined to produce the best evidence based practice (Pogorzelska-Maziarz, 2016).

With CLABSI concerns on the rise over the last several years, the interest in studies on the prevention of CLABSI continues. The NICU has also increased pressure on quality evidence have transpired. Limitations include insufficient sample sizes for trials, expanded external pressure to reduce CLABSI rates, and the challenges of constructing a definition of CLABSI. The definition for CLABSI is constantly being amended with the notion to improve misclassification. This is crucial for healthcare organizations due to the adverse consequences affiliated with health care associated infections (HAI) (Li, Vincent-Faustino, & Golombek, 2015). Policy makers have placed weight on the health care organizations to reduce HAI by implementing policies such as the Patient and Protection and Affordable Care Act of 2010. This law enforces performance based pay and quality purchasing strategies and have forced compliance in an effort to reduce HAI. The estimated cost per infection was reported at nearly $45,000 and the same number of pediatric intensive care units disclosed a savings of $31 million in a period of 3 years by reducing the incidence of CLABSI (Li, Vincent-Faustino, & Golombek, 2013).

RATIONALE
In a response to an increase in incidence in CLABSI in the NICU, an internal analysis was performed using Failure Modes and Effects Analysis (FMEA). It was determined that often UVC indwelled greater than 7 days increasing the incidence of CLABSI. Due to inability to observe and the critical status of the patient, the UVC often dwelled longer than the goal of 7 days. A proposal from the CLABSI committee was to decrease the incidence of CLABSI by reducing the longevity of the UVC remained in place to 3-4 CLD. In addition, the team proposed placing a PICC line once the UVC was removed. The CLABSI committee also elected to incorporate a care bundle approach with the hypothesis that using this approach would decrease the incidence of CLABSI more effectively opposed to implementing one intervention change.

CONTEXT, PURPOSE, AND AIM
Families and healthcare organizations are impacted as an increased concern exists for infant mortality, morbidity, and healthcare costs as the rate of CLABSI continues to embark on preterm infants in the NICU. The purpose of this quality improvement (QI) project and report was to decrease the incidence of CLABSI in the NICU. The aim was to determine if implementation of the care bundle approach, reducing the UVC by 7 days and replacing with a PICC line would reduce the incidence of CLABSI in the NICU.
INTERVENTIONS
Two level III NICUs, within the same hospital system, with a capacity total of 56 beds and more than 500 infant admissions yearly, developed a CLABSI focus committee in response to an increased incidence of CLABSI. The development of the team included a wide scope of professionals and through collaboration developed an aim statement, proposed a solution, and implemented change into practice. For guidance on improvement and application of new processes, the MFT in conjunction with the PDOS cycle was used (American Academy of Pediatrics, 2000). A standardized evidenced base policy in alignment with the measurable aims was designed and submitted to the organization for approval and implementation. The plan included identifying barriers and planning for improvements.

The solution included a care bundle approach that consisted of elective early removal of umbilical lines prior to the 7th day of life and replacing with a PICC line; ideally within 3-4 days of life. Education classes were implemented for the nurses on using sterile technique when changing and managing central lines, nurse practitioners attended a PICC line insertion review course, and increase accountability performed with chart audits were included in the bundle approach. In addition, the use of Stat Seal® was implemented as a barrier to prevent infection and replaced the use of the Biopatch®.

Monthly chart audits to check for proper documentation of the need for central line assess, compliance sterile technique on insertion of central lines and changing out fluids. In addition, the infection committee provided quarterly reports on CLABSI rates. Three aims were developed to assess improvement in CLABSI rates: 1. Assessment of standard provider practices associated with UVC and PICC line placement, 2. Compliance sterile technique on insertion of PICC lines. Evidenced based policy developed for insertion of PICC lines. With the conception of the aims, a target for a 25% improvement in CLABSI rate over the baseline was set.

ETHICAL CONSIDERATIONS
The University of Alabama at Birmingham’s Institutional Review Board (IRB) reviewed this project and approval was received. All data for the project was de-identified, secured on a password protected computer, and only accessible to a secured login. The Principal Investigator (PI) worked closely with the staff to ensure that confidentiality and data security was maintained. All data is presented in the aggregate.

MEASUREMENT
Variables for the project included birthweight, day of life, number of PICC lines placed, and removal, incidence of CLABSI number, and if StatSeal® was used. The occurrence of CLABSI was measured as infection in a selected over 1,000 catheter days. Inclusion criteria for the project included infants with ELBW weighing 1500 grams or less, UVC and PICC line placement, and number of days central lines were placed. Exclusion criteria included: infants with pre-existing infection by ELBW weighing 1500 grams or less, UVC and PICC line placement, and if StatSeal® was used. The occurrence of CLABSI was measured as infection incidence per 1,000 catheter days. StatSeal® was used. The occurrence of CLABSI was measured as infection incidence per 1,000 catheter days. StatSeal® was used. The occurrence of CLABSI was measured as infection incidence per 1,000 catheter days.

RESULTS
SPSS version 25 for Macintosh® was used for statistical analysis reviewing basic descriptive statistics and a t-test on the pre/post intervention. There was no significant difference in the occurrence of CLABSI events (4 at the larger campus and 3 on the smaller) with only 2 having a PICC line inserted at DOL 23 and DOL 26. The date of CLABSI at DOL 20 and DOL 14 respectively. In the remaining 5 CLABSI where the occurrences were only when a UVC was in place. The PICC line insertion meeting the study criteria for the PICC line insertion meeting the study criteria. The PICC line insertion meeting the study criteria. The study criteria was not met when a PICC line was inserted on the same date of the CLABSI event and the cause was determined to be from the UVC that was removed on that same day. The remaining PICC lines were placed between DOL 6-10 with the date of CLABSI occurrence ranging from 7-10 DOL (Humphries & Smith, 2019).

BARRIERS AND LIMITATIONS
Due to limited data, this quality improvement project showed that there was no significant difference in the outcomes of infants’ post intervention. This project contained a small sample size. Only 106 out of 120 randomly selected charts met the inclusion criteria. Additionally, a bulk of the requested data was not obtained due to multiple factors. Charting software procedure notes were not reviewed. The use of StatSeal®, was not obtained during data collection. Procedure notes were not reviewed. The use of StatSeal®, was not obtained during data collection. Procedure notes were not reviewed. The use of StatSeal®, was not obtained during data collection. Procedure notes were not reviewed. The use of StatSeal®, was not obtained during data collection.

Other limitations include issues with unsuccessful PICC lines attempts which resulted in UVCs indwelled longer than recommended. Limitations to current evidence supporting the avoidance of StatSeal® in the NICU generates gaps in standard practice. There is also a discrepancy in NICUs in aseptic technique and care bundles for prevention of CLABSI (Fraser, Harren, Dalton, Gilbert, & Oddie, 2018).

INTERPRETATION
Although there were no significant differences in the pre and post intervention analysis, changes in guidelines, awareness and ownership in preventing CLABSI improved in the NICU. The bundle approach was adopted into NICU current practice, the use of StatSeal® continues to be used and the providers continue to replace UVC with PICC lines with a goal of less than DOL 7. This project revealed that the quality improvement methods implemented in the project could overtime result in improvement in the quality of care, possibly decrease hospital duration and costs and mortality rates. With a larger sample size and further projects related to reducing CLABSI, these approaches could forecast the benefits of replacing UVC with a PICC line within the first week of life.

SUMMARY
Premature infants admitted to the NICU are in critical need for long term central venous access. The standard practice is to place a UVC on the first DOL due to the ability to obtain quick access. UVC have increased risk of infection associated with prolonged duration, therefore the recommendation is to allow dwell time no longer than 7 days. PICC lines is an alternative to the UVC. Although risks for infection associated in PICC lines, studies have shown that the incidence is greater in a UVC. In addition, PICC lines can indwell longer than standard UVC, which can potentially reduce CLABSI. This remains an ongoing problem in all NICUs that result in detrimental outcomes for the infants and healthcare facilities.

When compliance is sufficient, the use of a bundle approach to reduce CLABSI in the NICU is effective. Nurses participated in daily rounds and discussed changes in practice.

Reduce CLABSIs continued on page 12

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Reduce CLABSIIs continued from page 11

with the healthcare providers the need for central line access, central line care, and removal date expectations. Additionally, chart audits, 2-person fluid change in a sterile fashion, and reduced lab draws from central lines demonstrated increased compliance with keeping sterilization.

In conclusion, CLABSI remains the most complicated and leading cause of morbidity and mortality in the NICU. Strategies should be implemented to reduce CLABSI and promote better outcomes in neonates. A structured policy needs to be implemented and followed in order to aid in CLABSI prevention. Care bundle approaches is ideal when designing a strategy for standardized care. It is essential that the nursing staff and health care providers are adequately trained and educated on insertion and management of central lines.

References


Perinatal and Neonatal Nursing, 30(2), 148-159. doi: 10.1097/JPN.0b013e3182086d77


Suicide Assessment and Prevention

Author: Charlene Roberson, MEd, RN-BC

Disclosures: The author and Planning Committee have declared no conflict of interest.

Contact Hours: 1.5 (ANCC) and 1.8 (ABN) contact hours valid November 18, 2019 - November 17, 2021

Target Audience: All RNs, LPNs, and Advanced Practice Nurses. Especially Psychiatric/Mental Health Nurses

Purpose/Goal: Nurses will be aware of suicidal warning signs and risk factors, where to find help for their own negative feelings and fears, and how to locate resources for patients.

Fees: ASNA Member - $ FREE 
Non-Member - $15.00

InSTRUCTIONS FOR CREDIT: Participants should read the purpose/goal and objectives and then study the activity on-line or printed out. Participants must complete the post test and evaluation on line and submit the appropriate fee to receive continuing nursing education credit. The certificate of attendance will be generated after the evaluation has been completed. ASNA will report continuing nursing education hours to the ABN within 2 weeks of completion.

Accreditation: The Alabama State Nurses Association is an Approved Provider of Continuing Education in Nursing by the Mississippi Nurses Foundation, Inc., an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Alabama Board of Nursing Provider Number ABPN0002 (expires April 6, 2021).

Alabama State Nurses Association
360 N. Hull St.
Montgomery, AL 36104

https://alabamanurses.org/cne/

Suicide, a public health concern has reached epidemic proportions in both the United States (U. S) and globally. The World Health Organization has estimated that roughly 1 million individuals die each year from suicide. CDC published in 2013 that there were 41,149 suicides in the U. S., or one person every 13 minutes. During this same timeframe 1.3 million attempts were made in the United States. Included in this number is that 200,000 did not make a suicide plan. To further emphasize the magnitude of suicide are the results from a 2002 investigation by the Institute of Medicine (IOM) when they provided a comparison to the 58,000 who died during the Viet Nam War (1968-1973) due to war related causalities to the 220,000 U.S. citizens who took their own life during that same timeframe. The number of suicides exceeds homicides by a ratio of 3:2. In 2010 SAMHSA (Substance Abuse and Mental Health Services Administration) stated that yearly over 1,100,000 people attempt suicide and 8.4 million adults were congestive heart failure, chronic obstructive lung disease, moderate to severe pain, urinary incontinence, any diagnosis of a terminal illness, HIV +, and anxiety disorders.

Women are more likely to attempt suicide as compared to men. Their usual methods are overdose or cutting their wrists - both methods have a lower incidence of success. Older Caucasian men have the highest rate of suicide as compared to other population groups. Often they are widowed. Their suicidal rate outnumbers women 3:1. The usual method is a gun, which has the highest rate of success. Men have fewer attempts per completed suicide as compared to other groups. Men usually plan well in advance; however, they often provide clues as to the proposed intent with non verbal clues such as changing their will, giving possessions away, and expressing thoughts about nothing to live for anymore. Suicide rates are higher in rural areas especially the Rocky Mountain and Western states. Individuals in this part of the country usually use a firearm and as stated before a firearm has been completed. ASNA will report continuing nursing education hours to the ABN within 2 weeks of completion.

The National Institute of Mental Health has identified certain medical conditions with a higher correlation with suicides as compared to other diseases. They are congestive heart failure, chronic obstructive lung disease, moderate to severe pain, urinary incontinence, any diagnosis of a terminal illness, HIV +, and anxiety disorders.

Women are more likely to attempt suicide as compared to men. Their usual methods are overdose or cutting their wrists - both methods have a lower incidence of success. Older Caucasian men have the highest rate of suicide as compared to other population groups. Often they are widowed. Their suicidal rate outnumbers women 3:1. The usual method is a gun, which has the highest rate of success. Men have fewer attempts per completed suicide as compared to other groups. Men usually plan well in advance; however, they often provide clues as to the proposed intent with non verbal clues such as changing their will, giving possessions away, and expressing thoughts about nothing to live for anymore. Suicide rates are higher in rural areas especially the Rocky Mountain and Western states. Individuals in this part of the country usually use a firearm and as stated before a firearm has the highest rate of death.

Continuing Education continued on page 14
Suicide is the second leading cause of death for adolescents and young adults (ages 15-24). Although, they are less apt to be successful with approximately 11 deaths per 100,000. Several factors are involved. One is increased alcohol and substance abuse, availability of firearms, and the onset of depression and schizophrenia. This group tends to have a dual diagnosis or impulsive/aggressive behavioral problems and legal issues (often related to aggression).

Unemployment is associated with an increased rate of suicide. It is known that alcohol consumption and marital discord increases with unemployment and both are indicators of an increased suicide rate. Economic stress has an impact. Research has shown that the lowest - low incomes and highest - high income levels have the most incidences of suicide.

There are some protective factors in the prevention of suicide. One is being married. Divorced, widowed, or single individuals have a higher rate of suicide. Being a parent, especially being a mother has protective factors for prevention of suicide. Women who are pregnant have a much lower rate of suicide. Religion tends to have protective factor. There is really no quality research demonstrating which religion has the most protective impact. However, areas of the country with fewer individuals with religious affiliation have higher incidences of suicide. It is believed that religion provides a social support system and way to cope with stressors and it provides a sense of purpose. Also individuals with religious affiliation tend to abuse alcohol and drugs less often and have fewer divorces - all of which are associated with higher suicidal risks. All industrialized countries have higher rates of suicide as compared to more rural or agrarian economies. An exception is the U.S. which has only a moderate level of suicides especially as compared to Russia and Eastern European countries.

Myths about suicide include the following: Myth #1 is a belief that if individuals threaten suicide they are seeking attention & not really suicidal and often seeking secondary gains just to gain admission to a hospital. The truth - take all suicidal talk seriously and evaluate appropriately. Myth #2 is that if a person directs their anger at someone else they will not consider suicide. The truth - individuals may be suicidal and homicidal at same time. Myth #3 is the reliability of having a person sign a ‘no harm contract’ or ‘no suicide promise’. The truth - these are not reliable, often misleading and do not prevent suicides. Myth #4 People who talk about suicide rarely harm self. The truth - over 80% of all individuals who attempt suicide have spoken to a health care professional, especially nurses before the attempt and the majority have visited a healthcare provider in the preceding month. Sometimes the clues are covert such as, "No one will care if I lie or not". Take all clues seriously, assess body language that might imply suicidal thoughts. Myth #5 if a person attempts suicide and is unsuccessful they rarely try again. The truth - somewhere between 25% and 50% (depending on references) of those with successful suicide attempts have previously attempted suicide.

Nurses’ attitudes and beliefs about suicide impact their delivery of care. Before discussing appropriate intervention by healthcare workers - especially nurses it is imperative to review attitudes and beliefs influencing care. The literature cites several reasons impacting nurses’ attitudes. They include prior experience with suicidal patients, religious beliefs, and level of education. Nurses also cite lack of knowledge and training and unfavorable attitudes of some nurses regarding suicide. Cultural aspects can also factor into the equations. The game can run from believing that suicidal patients are not connected to their disease and not knowing how to respond or run from believing that suicidal patients are not connected to their disease and not knowing how to respond.

Nurses are referred to Ghana to the belief that suicide is a crime and the suicidal person is blameworthy. Nurses with negative attitudes frequently exhibit anxiety, avoidance, hostility, and rejection. Negative attitudes impact the quality of care and result in patients feeling helpless, rejected, and worthless. The literature suggests that most nurses just do not know what to say to a suicidal patient and therefore choose to remain silent. The reason being a fear of making matters worse which could lead to additional harm. Other nurses are said to be unsure if the patient is really serious and choose just to remain silent. Nurses are not the only health care providers skeptical about prevention of suicide. Some relate apathy and do not think the person is truly ill. Nurses with intense personal responses about suicide may have difficulty in communicating about suicide. They will admit to having feelings of sympathy and not empathy and therefore are unable to assess the patient adequately. An overriding theme is fear that if I cannot help it then becomes a personal failure if the person commits suicide.

Assessing for suicidal ideation is a crucial part of nursing care. Several tools are available. Two common ones are the Beck Depression Inventory (21 items) and the Suicide Risk Assessment Form (SRAS). The Beck Depression Inventory is a psychological self-report rating scale that measures degree of depression symptomatology. The instrument consists of 21 items and is scored from 0-63, with higher scores indicating more severe depression. The SRAS is a structured interview designed to assess suicide risk. It consists of 30 questions and is scored from 0-4, with higher scores indicating a higher risk of suicide.

Suicide prevention programs are available. Two common ones are the Gatekeeper training which enables the learner to communicate by interviewing using structured and evidence-based questions and the ASAP (Applied Suicide Intervention Skills Training) program. ASAP is an evidence-based suicide prevention program that teaches nurses how to identify and respond to suicidal patients. The program includes a variety of strategies, including cognitive-behavioral techniques, motivational interviewing, and cultural competence.

Context includes knowledge and attitude about suicide, increasing the nurse’s comfort level to assess suicide, perform a triage assessment (acute risk, address immediate patient safety needs, and determine most appropriate setting for care). ASAP (www.ihs.gov/net/programs/asist/) is 14 hours. The participant is taught “suicide first aid.” You learn about suicide risk and how to respond in a manner to improve safety and how to link to resources. It does employ simulations for skill development. Other very successful programs include the Oklahoma Department of Mental Health and the Tennessee Lives Count Project. All of the programs contain the same basic information - knowledge and attitudes about suicide, interviewing in a non-threatening way using indirect interrogation to assess immediate safety needs, and determine a safety plan.

Recognition of the warning signs in the before mentioned are formal time consuming programs. However, many nurses at the point of direct care may not have access to these programs. The nurse’s role is to identify the potential suicidal patient. There are assessments available that you can use keep your patients safe. Many screening tools are available. Two common ones are the Beck Depression Inventory (21 items)
and the Geriatric Depression Scale, both readily available online. In fact the Geriatric Depression Scale is available as a phone app in the iStore. Screening tools are only for identification of at-risk individuals needing follow up. Depression and suicide often go hand in hand. There are several screening measures specific to suicidal ideation. They are the Index of Potential Suicide, Reasons for Living Inventory (available for various ages) and Suicide Attempt Self-Injury Interview. These are available online. The screening tools mentioned in this paragraph are somewhat lengthy and often only used by psychiatric/mental health nurses for a more in depth assessment. Multiple different short answer screening tools are available from local Mental Health associations. The tools may be completed by patients in the waiting room and provide a basis for discussion. Most of the tools involve yes/no answers and are 5 - 10 questions in length. Specific assessment questions that all nurses can use include the following:

- evaluate changes in behavior
- discuss with them (and family/significant others) that the underlying cause of the physical complaints may be depression or (other mental health concerns)
- let patients know there are other options to feeling depressed and you can help them find resources for help
- be alert to warning signs of suicide
- home health nurses should be alert to special adolescent signs and symptoms such as volatile mood swings or sudden changes in behavior, abusive relationships, unexplained signs of trauma, self-mutilation, eating disorders, gender identity issues, sudden deterioration of appearance, fixation with death, depression
- Once the realization is made that the patient is at risk for potential suicidal ask addition screening questions in a non-threatening manner such as:
  - Sometimes when people are sad they have thought of harming or killing themselves. Have you had these thoughts?
  - Do you wish you could just go to sleep and never wake up again?
  - Are you thinking about hurting or killing yourself?
  - Have you been thinking about death recently?
  - Are you feeling hopeless?
  - Have you made a plan for suicide?
  - Do you have a plan for suicide? Will you share that plan with me? (NOTE: if they refuse to share the plan that are at greater risk of suicide.)

It is important to know that asking individuals if they have suicidal thoughts does not reinforce or initially give them the idea of suicide. The act of asking the questions implies that you care and the patient's welfare is important to you. Most mental health professionals feel the initial assessment often do not include enough question to ascertain the essential evidence of a suicidal thought. The morale of the story is to ask more than one question more than one in a different format.

Once warning signs are identified, the next move is to keep the patient safe, while providing empathy and support. Call for help and depending on the severity of the issue either 911 or their mental health professional. If the person is not hospitalized it is imperative to access the mental health system or social services. Ensure that the person has a safe home appointment. Find someone close to the patient to not only monitor behavior but also ensure they keep the follow up appointment. Emphasize the need to never leave the patient alone until they keep the follow up appointment. Support the family and significant others and let them know how important they are in helping the patient through the crisis. It is absolutely necessary to limit access to a means of suicide, i.e., removing all firearms, or knives/other sharp objectives if a plan includes cutting their wrist, have someone else assume responsibility for all medications and remove stockpiles of medications, etc. In short, ascertain desired means of suicide and remove that object, but the one exception is always removal of firearms regardless of the person's plan as firearm are the number one means of suicide in the U. S.

Options for treatment include hospitalization, additional psychiatric evaluation, and close out patient supervision. Not every suicidal patient needs to be hospitalized if there is someone who can remain with them and ensure that the can be followed up immediately. At times patients are hospitalized against their will if they are in imminent danger of hurting self or others. Wherever the setting the usual treatment plan includes treatment for any underlying issue(s) such as depression, substance abuse, etc.; medication adjustment; counseling; self management techniques and education. Ongoing treatment will be evaluation of suicidal thoughts, developing self esteem and social support. Nursing care is essential in these areas.

Additional Resources include 911 if you feel there is imminent danger and remain with the patient (or on the telephone) until help arrives. Another resource is National Suicide Prevention Lifeline (1-800-273-TALK (8255). Carry this number with you if a home health nurse or have the number posted at home if there is a prior history of suicide. If the person is a veteran contact - the Veterans Crisis Line at (1-800-273-8255) (same as the National Suicide Prevention Lifeline) and press 1 for veterans. Veterans can also access an online chat at www.VeteransCrisisLine.net. Other resources include the Suicide Prevention Resource Center (http://sprc.org/) and Suicide Prevention at the National Institute of Mental Health. Additional resources include American Foundation for Suicide Prevention (www.afsp.org); American Association of Suicidology (http://www.suicidology.org), American Psychiatric Nurses Association (www.apna.org/lead/pages/index.cfm?pageID=1141), Indian Health Service (www.ih.gov/suicideprevention), and Emergency Nurses Association Practice Guidelines (www.en.org/pactice-research/research/cpg/documents/suicidereassessmentcpg.pdf). American Foundation for Suicide Prevention (http://www.afsp.org/), National Center for Injury Prevention and Control (http://www.cdc.gov/niosh/); Suicide Prevention Action Network USA (http://www.spanusa.org/); and National Suicide Prevention Lifeline (http://www.suicidepreventionlifeline.org).

Nurses can and do make a difference in the prevention of suicide. It involves asking a few additional questions, observing body language, and reflecting on past history. The take home message is that suicide is a preventable public health concern and we the front line workers can make a difference.

Selected bibliography:

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