The North Dakota Nurse

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 to approximately 18,000 RNs and LPNs in North Dakota

Vol. 89 • Number 1 **January, February, March 2020**

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We are excited to announce that the North Dakota Nurse is going GREEN! Beginning with the January 2020 issue, the publication will be available as an e-newsletter to every nurse licensed in North Dakota. It will also be printed exclusively as a member benefit for the North Dakota Nurses Association members.

If you want to continue to receive a printed copy of the North Dakota Nurse, you need to become a member of the North Dakota Nurses Association to receive BOTH a digital AND a print version as part of your membership benefits!

If you have any questions or comments about the North Dakota Nurse, please contact NDNA Executive Director Sherri Miller at director@ndna.org or by phone 701-335-6376. You can join the North Dakota Nurses Association for just $20.50/month at http://www.nursingworld.org/joinana.aspx. Join us today!

Message from the President

Year of the Nurse

Tessa Johnson

2020! We have not only entered a new year, but a new decade! That gives us the ability to start fresh, to set goals and to focus on priorities. To start us out, the ANA Enterprise has announced its intent to elevate and celebrate the essential, robust contributions of nurses as the world recognizes 2020 as the "Year of the Nurse."

According to ANA, "The World Health Assembly, the governing body of the World Health Organization, declared 2020 the International Year of the Nurse and Midwife, in honor of the 200th anniversary of Florence Nightingale's birth. The celebration offers a platform to recognize past and present nurse leaders globally, raise the visibility of the nursing profession in policy dialogue and invest in the development and increased capacity of the nursing workforce. This declaration is an extension of work initiated by the Nursing Now campaign to elevate the profession and ensure nurses are leading efforts to improve health and health care." *The goal for declaring 2020 Year of the Nurse is to encourage inclusivity and participation of all nurses.*

In reflecting on nursing in North Dakota and our responsibility of participation and inclusivity, I believe that we are doing quite well! In all

Message from the President continued on page 2

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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 ***3/4/2020***. Send your submissions to director@ndna.org or info@ndna.org.

Welcome New Members

Virginia Torrelavega
Minot

Eric Leedahl
Fargo

Shalishah Stautz
Minot

Rebecca Dressler
Halliday

Heather Ray
Mandan

Marsha Resler Stansbury
Horace

Meghan Jorgenson
Leeds

Laura Ledoux
Fargo

Chloe Wylot
West Fargo

Hailey Hamilton
Fargo

Cassandra Kraft
Fargo

Allison Nirschl West
Fargo

Dulcia Anderson
Mandan

Averee Zent
Bismarck

Lynnette Huot
Grand Forks

Nicole Burke
Minot

Gwyn Gust
Jamestown

Janel Hodge
Fargo

Wendy Kopp
Bismarck

Erica Evans
Fargo

Nicolette Gietzen
Bismarck

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honestly, we should be proud of ourselves. As nurses and members of NDNA/ANA - we participate! I am proud to think and believe that we come to the table when needed, we get involved and we use our voices! At this time in our state, we have a respectful and purposeful collaboration with other nursing entities such as the Board of Nursing and Center for Nursing. We have spoken loud enough and participated enough to capture the attention of North Dakota Governor Burgum. In example, the Governor's Nursing Shortage Taskforce as well as the Nursing Culture Subcommittee are filled with nurses from our state who are actively participating and proudly using their voices to discuss issues in nursing practice with the hopes to make improvements.

Now to think about inclusivity in nursing in our state. I want you all to ask yourselves a few questions. Are we inclusive? Do we have a diverse group? Do we have diversity in our groups, in our workforce and in the areas in which we work? If we can start the conversation asking ourselves these tough questions, we can then get some data. If we don't, we need to do better. If we do, that's great. According to Minority Nurse (2018), "The American Nurses Association (ANA) defines diversity awareness as "acknowledgment and appreciation of differences in attitudes, beliefs, thoughts, and priorities in the health-seeking behaviors of different patient populations." But diversity is more than just a definition." If we don't get the answers we like to have in our self-assessment of the inclusivity in our state, then we need some suggestions on how to take action. Developing an inclusive and respectful mindset starts at building strong relationships and understanding, much like breaking down diversity barriers. While efforts have increased to teach transcultural nursing in the classroom, organizations have been created to help support nurses and patients where they can access resources and communities to help them adjust (Minority Nurse, 2018). Again, I encourage all nurses in the state to do their part. We can start by making changes in our practice and processionals to be honest with ourselves. As the President of our State Association, I want to say that we want ALL nurses in our state to be heard and participate. We care and respect the participation of nurses from different backgrounds, different areas of the world, various ages, various races, those who have various sexual preferences and many other levels of diversity and inclusion. We want you in our membership, we want your voice and we want your participation. Be well, we need all of you!

Year of the Nurse 2020. (2019). Retrieved from https://pages.nursingworld.org/yearofthenurse#about

The Importance of Diversity in Nursing: Breaking Down Stereotypes and Inclusivity Barriers. (2018). Minority Nurse. Retrieved from https://minoritynurse.com/the-importance-of-diversity-in- nursing-breaking-down-stereotypes-and-inclusivity-barriers/

The North Dakota Nurse

Official Publication of:
North Dakota Nurses Association

NDNA
NORTH DAKOTA NURSES ASSOCIATION

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Writing for Publication in The North Dakota Nurse

The North Dakota Nurse accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and submitted electronically in MS Word to director@ndna.org. Please write ***North Dakota Nurse article*** in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. **Deadlines for submission of material for upcoming North Dakota Nurse are 3/4/20.**

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.

ANA Enterprise Gears Up for Global 'Year of The Nurse' In 2020

Silver Spring, MD – The ANA Enterprise announced its intent to elevate and celebrate the essential, robust contributions of nurses as the world recognizes 2020 as the "Year of the Nurse."

The ANA Enterprise is the family of organizations that is composed of the American Nurses Association (ANA), the American Nurses Credentialing Center (ANCC), and the American Nurses Foundation. ANA Enterprise will celebrate Year of the Nurse by engaging with nurses, thought leaders and consumers in a variety of ways that promote nursing excellence, infuse leadership and foster innovation.

"As the largest group of health care professionals in the U.S. and the most trusted profession, nurses are with patients 24/7 and from the beginning of life to the end. Nurses practice in all healthcare settings and are filling new roles to meet the ever-growing demand for health and health care services," said ANA President Ernest J. Grant, PhD, RN, FAAN. "Despite the major role nurses play in health care delivery and community outreach, there are opportunities to increase understanding of the value of nursing in order to expand investment in education, practice and research, as well as increase the numbers of nurses who serve in leadership positions."

"We look forward to working with partner organizations to communicate a contemporary and accurate view of nurses and the critical work they do, as well as challenge boards and other influencers to commit to nursing and nursing leaders in order to improve the nation's health," said Grant.

Given the wide range of nursing roles in the U.S., ANA Enterprise will promote inclusivity and wide engagement of all nurses throughout Year of the Nurse. As an example, during 2020, ANA Enterprise will expand National Nurses Week, traditionally celebrated from May 6 to May 12 each year to a month-long celebration in May to expand opportunities to elevate and celebrate nursing.

The World Health Assembly, the governing body of the World Health Organization, declared 2020 the International Year of the Nurse and Midwife, in honor of the 200th anniversary of Florence Nightingale's birth. The celebration offers a platform to recognize past and present nurse leaders globally, raise the visibility of the nursing profession in policy dialogue and invest in the development and increased capacity of the nursing workforce. This declaration is an extension of work initiated by the Nursing Now campaign to elevate the profession and ensure nurses are leading efforts to improve health and health care. ANA Enterprise is leading Nursing Now USA along with the Chief Nurse, U.S. Public Health Service; the University of North Carolina Chapel Hill; and the University of Washington, School of Nursing.

Nurses are encouraged to use #yearofthenurse and follow us on social media as we celebrate nurses in 2020.

The ANA Enterprise is the organizing platform of the American Nurses Association (ANA), the American Nurses Credentialing Center (ANCC), and the American Nurses Foundation. The ANA Enterprise leverages the combined strength of each to drive excellence in practice and ensure nurses' voice and vision are recognized by policy leaders, industry influencers and employers. From professional development and advocacy, credentialing and grants, and products and services, the ANA Enterprise is the leading resource for nurses to arm themselves with the tools, information, and network they need to excel in their individual practices. In helping individual nurses succeed—across all practices and specialties, and at each stage of their careers—the ANA Enterprise is lighting the way for the entire profession to succeed.

ND POLST

2020 is the year Nancy Joyner hopes to truly make healthcare professionals aware and educated about the ND POLST: Physicians Orders for Life Sustaining Treatment. Nancy Joyner will be offering educational teleconferencing events, but has an article with her colleagues in ANA's ***Online Journal of Issues in Nursing.*** The article was released in October and again in January, and is available in the Journal

Nancy Joyner, MS, CNS-BC, APRN, ACHPN
Palliative Care Clinical Nurse Specialist
Nurse Consultant/Patient Advocate
Nancy Joyner Consulting, P.C.
Educator, Speaker, Consultant, Author
Board member, Honoring Choices North Dakota (HCND)
POLST Trainer
HCND POLST Program Coordinator

Giving Hearts Day is February 13, 2020!

The North Dakota Center for Nursing is pleased to announce we are participating again in Giving Hearts Day, held Feb. 13th, 2020. Each year, the proceeds from Giving Hearts Day are distributed to students for our Future Nurse Scholarship Program and also help us with statewide nurse recruitment efforts.

The Dakota Medical Foundation has provided us with a $3,000 match, which requires us to raise a preliminary $1,000 which we are in the process of fundraising for.

Thanks to the generous donations of our Board of Directors, we have raised $550. If you would like to contribute to our preliminary match, please submit to us a check to our address below with the current date (not the date of Giving Hearts Day).

North Dakota Center for Nursing
3523 45th Street South
Fargo, ND 58104

If you would like to contribute to the overall Giving Hearts Day campaign, please make a donation on Giving Hearts Day at www.givingheartsday.org or mail a check dated for February 13th, 2020 to our address above.

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/

How a Nurse Can Help a Patient Experiencing Anxiety or a Panic Attack Related to Post-Traumatic Stress Disorder

Renae Schimetz
Minot State University

Post-traumatic stress disorder (PTSD) is something we have all heard about, but how well do we really understand what is going on in the mind of a patient who is experiencing it? PTSD is associated with anxiety and panic attacks. Would one know how to incorporate nursing interventions to assist in managing patients experiencing one or both of these disorders? This article will cover information regarding PTSD, what goes on within the mind of a patient experiencing PTSD, and how the nurse can help the patient.

PTSD

PTSD is a mental disorder that occurs in some people after they experience a traumatic event. There are four categories of PTSD symptoms (U.S. Department of Veterans Affairs, 2019). It is important for the nurse to understand symptoms of PTSD to better assist in caring for their patients. The first category is reliving the event in which one experiences the same horror that took place during the trauma through nightmares, flashbacks, or through triggers that cause one to relive the trauma. The second category is avoiding situations, people, talking, or thinking about anything that can cause memories of the trauma. The third category is negative changes in beliefs or feelings about oneself or others including forgetting parts of the traumatic event. The final category is the feeling of hyperarousal where one can always be alert for danger (U.S. Department of Veterans Affairs, 2019).

The Mind

The mind is very interesting with regard to stress response following a traumatic event. This is especially true for a patient with PTSD like me. I have been dealing with PTSD for five years. The subsequent information comes from my personal experience with PTSD. When a patient relives events, has anxiety, or experiences panic attacks due to their trauma, it is usually caused by a trigger of some kind. A trigger could be a smell, the same weather as the time of the trauma, darkness, a tall person standing behind someone, or a specific noise. When the patient with PTSD is triggered, their mind could cause hypervigilance and/or anxiety. For example, when I am triggered, I become hypervigilant looking for places someone could be hiding to jump out and abduct me. I usually experience anxiety along with the hypervigilance. Keep in mind, this response occurs beyond my control. I can consciously tell myself there is no real danger, however, self-talk usually does not make the hypervigilance stop. I have to get myself to an environment my mind deems "safe" for the hypervigilance to stop. The patient could experience a panic attack in response to an irrational danger as well. For example, my husband and I were driving home late at night. My husband was tired, so he pulled over for a quick nap. My mind became convinced that we were being hunted by someone. I began to mildly hyperventilate, I became hypervigilant, and I instinctively curled up into the fetal position on the seat. My husband knocked on the window by accident. This sent me into a panic attack immediately because my mind thought someone was trying to break into the car.

Some people who suffer from PTSD will know their triggers and have a plan to cope with triggers when they occur, however, each specific trigger can cause a different response each time it is experienced. For example, one could watch a movie without being triggered, however, the next time they watch the movie they will experience a panic attack. I find this unpredictability associated with some triggers to be very frustrating because I cannot predict all my triggers and panic attacks. It is much easier to deal with triggers when I have a plan on how I am going to manage anxiety. If I can manage my anxiety early, I can better prevent panic attacks from occurring. People who suffer from PTSD can have triggers that do not relate to the trauma at all. For example, one of my triggers is snowboarding. I will start hyperventilating and feel an intense fear while snowboarding, however, snowboarding has nothing to do with my trauma. I speculate I am triggered by snowboarding due to the risk for injury that goes along with it.

It is important to note some patients who are aware of their PTSD can use self-talk to try to prevent flashbacks, anxiety, or panic attacks from occurring. As stated above, when I experience hypervigilance, I will consciously know my thoughts are irrational, however, I am usually unable to stop my mind from thinking the irrational danger actually exists. I also attempt to slow my breathing when I sense I am hyperventilating; however, this is not always successful either. When flashbacks or anxiety occur, despite my best effort to prevent them, I feel trapped within my mind because I am still able to think rationally during flashbacks and periods of anxiety, but I have no control over them.

Patient interventions. I find the best way to help your patient experiencing anxiety and/or hypervigilance due to PTSD is to identify what is triggering the patient. As stated above, some patients with PTSD will know their triggers and will be able to communicate them with you, however, not every patient with PTSD will know their triggers, or even that they have PTSD. In this case, you will have to discover what is triggering your patient. Removal of the trigger is then recommended. Once the trigger is removed, the patient's anxiety and/or hypervigilance should resolve or lessen. If removing the trigger is not successful, redirecting the patient's thoughts may help. Find a way to get the patient's mind off of what is triggering their anxiety and/or hypervigilance. I have found the best interventions to accomplish this are having conversation with the patient, using guided imagery, having the patient eat something while focusing on the taste, texture, or a good memory relating to the food, run cold water over their hand while instructing the patient to focus on the sensation of the water, or different guided breathing exercises to slow hyperventilation. The point of these interventions is to bring the patient's mind back to reality. When I am experiencing hypervigilance and/or anxiety, I feel like my mind has gone somewhere else, and I need to find some way to bring it back.

Panic attacks, on the other hand, will resolve on their own usually within 10 minutes (Anxiety and Depression Association of America, 2018). I have not found the interventions listed above help during a panic attack, however, I have found the interventions to be helpful in preventing panic attacks from happening as the interventions aid in reducing anxiety, so it does not reach panic level. During panic attacks, I will usually freeze, so I cannot move at all. The muscles in my neck and chest tighten up, and I usually cannot breathe beyond a few gasps. A common intervention we are taught to reduce anxiety is instructing the patient to take deep breaths, however, I do not find this effective during panic attacks as I have lost all control over my body. This means, I would not be able to take deep breaths even if I wanted to. I find removing the trigger, if one can be identified, getting the patient to a safe place, if possible, and assuring the patient you will stay with them until the attack is over are the best interventions during a panic attack.

Conclusion

PTSD is a mental disorder that can be very hard for a patient to live with especially because anxiety and panic attacks can occur without warning. A patient's triggers can also change unexpectedly. As the nurse, we can play an important part in PTSD treatment by helping to relieve anxiety and/or hypervigilance related to PTSD. By helping the patient work through their anxiety, it can assist the patient through the situation safely and therapeutically.

References

Anxiety and Depression Association of America. (2018). Understanding the facts. Retrieved from https://adaa.org/understanding-anxiety/panic-disorder-agoraphobia/symptoms

U.S. Department of Veterans Affairs. (2019). PTSD: National center for ptsd. Retrieved from https://www.ptsd.va.gov/understand/what/ptsd_basics.asp

The Endocannabinoid System: The Body's Great Regulator

By Gail Pederson, SPRN, HN-BC

I recently attended the inaugural American Cannabis Nurses Association's Cannabis Care Conference 2019: Nursing and Science, in New Orleans. There were over 200 nurses, researchers and others who provided cutting edge information on cannabis as medicine. I was fortunate to meet pioneers and medical leaders in the field, and finally physically meet many people who I'd already formed a very supportive nursing community with. Besides coming home with a brain overflowing, I came home with my heart overflowing, too.

There were several sessions on the Endocannabinoid system, a basic Endocannabinoid 101 class and The Care and Feeding of the ECS. This is something that we must ensure that we as nurses know and are being taught in the educational setting. I will refer back to the National Council of Nursing guidelines, listed below, as essential education for students and established nurses.

I remember hearing about the discovery of the Endocannabinoid System back in 1990's. For some reason the words "Anandamide" and 2-AG were about the only thing that stuck in my brain at that time. Anandamide - I liked the word. "Ananda" is the Sanskrit word for bliss. "Mide" means molecule. So essentially we have the "bliss molecule." I knew little else and didn't think any more about these names until they came back into my knowledge when I began to study cannabis as medicine.

In 1964, Dr. Raphael Mechoulam and colleagues in Israel isolated THC, identifying it as a psychoactive compound in cannabis. It would take almost 25 years to figure out how it works in the body, to discover the Endocannabinoid System in the '90s. The discovery of the endogenous cannabinoids, those that your body makes....2-AG and Anandamide (and a third recently identified) finally helped prove the system existed. These molecules are made as needed by the body. The ECS system is extensive. Neurons, neuronal pathways, receptors, cells, molecules and enzymes are working continually to provide and maintain homeostasis in the body. Because of the cannabis plant, a whole new body system was discovered, one we are continuing to learn so much about. It has been called the greatest discovery in medicine since the importance of sterile surgical procedure.

What does the Endocannabinoid system have a role in? It is involved in almost all body functions. The ECS is the most widespread receptor system in the body. It is how our internal body responds to external stressors. CB1 receptors are mostly found in the nervous system and brain. These are strong THC receptors and fit perfectly into this network. CB2 receptors are located in our organs, bones and skin....solid tissues. These work more with CBD and other phytocannabinoids, although it must be stressed that all receptors respond to any of these molecules. The ECS works with the activity of the GI tract, controls cardiovascular activity, maintenance of bone mass, hormone regulation, metabolism, immune function control, inflammatory reactions, protection of neurons, pain perceptions and inhibition of tumors.

One of the important abilities of the ECS is "retrograde signalling." An example of this is in the immune system. The ECS excites and inhibits immune response. You have an infection, your ECS tells your body to send the normal fighters out to contain the infection and they do. It is your endocannabinoid system that tells them to calm back down.... your body doesn't need them anymore. This also has strong implications in chronic pain conditions and hyper-responses to pain signaling, which is where medical cannabis may come in. Pointing to a condition known as an "endocannabinoid deficiency" and your body's inability to make enough of its own endocannabinoids, adding the phytocannabinoids of cannabis may help mitigate some chronic illnesses.

What can you do to maintain a healthy endocannabinoid system? As a holistic nurse, I have long pushed the basics of a healthy lifestyle and these are the exact things that maintain ECS wellness, with a few specifics included. These provide the upregulation of the ECS, the ability of your body to make its own cannabinoids and the receptors to respond more readily/easily.

To upregulate your endocannabinoid system, you can follow these points of self care:

- Diet: Follow a balanced, organic diet, high in Omega 3 and 6 fatty acids and flavonoids (those fruits and vegetables). A lot of people fail to add Omega 3's to their diet. Plant based fats such as those found in hemp hearts, flax and chia are the perfect addition to feed the nervous system and ECS. Your diet should be low in trans-fats, sugar and processed foods, a basic anti-inflammatory diet.
- Reduce toxins: this includes exposure to alcohol, sugar, tobacco and pesticides.
- Supplements and food which may be helpful include black peppercorn, rosemary, copaiba (an essential oil). These contain beta-caryophyllene a CB2 agonist which supports immune system function. Black truffles, chocolate, echinacea, Kava and liverwort are others.
- Exercise: That runners high is actually your endocannabinoid system kicking into high gear. It is that bliss molecule in action. Yoga, Tai chi and meditation fine tune the ECS system also.
- Acupuncture and osteopathic adjustments help reset the ECS and provide upregualtion of the endocannabinoids.
- Reduce chronic stress. Stress decreases naturally circulating endocannabinoids and inhibits the response of the receptors which decreases the attachment on the cells.
- Get quality sleep. This is probably the most difficult for everyone. Your body needs the repair time.
- Sing (especially with a group) and dance to increase your circulating endocannabinoids.
- End your shower or take a cold five minute shower. There are many ECS receptors in the skin. This helps stimulate the whole system. The Norwegians and their sauna idea of the cold dip in the snow or lake is actually doing something at the cellular level. The "Cold Shower" challenge....for 30 days, is making the rounds with a few cannabis nurses. I've been told it gets easier. Sorry not me right now!

Common knowledge of these wellness principles can help us enhance the function of our endocannabinoid system and maintain our best health. I know we all need it in The Year of the Nurse.

*I do want to make a clarification from my last article on the NCSBN guidelines. There are 6 Principals of Essential Knowledge for nurses caring for the patient who uses cannabis. The 6th principal, not given credit, was my last statement in the article. It is been a hallmark of holistic principals throughout my nursing career and I would like to emphasize it again. I hope your empathetic actions follow this principal.

"The nurse shall approach the patient without judgement regarding the patients choice of treatment or preferences in managing pain or other distressing symptoms."

https://ncsbn.org/The_NCSBN_National_Nursing_Guidelines_for_Medical_Marijuana_JNR_July_2018.pdf

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Konieczny, E, Wilson, L. (2018) Healing and CBD, 45-80

Goldstein, B. (2016) Cannabis Revealed, 25-48

https://www.leafly.com/news/science-tech/what-is-the-endocannabinoid-system

Clark, C.S, The Role of the Cannabis Care Nurse: The Care and Feeding of the Endocannabinoid System, Cannabis Care Conference 2019

Gail Pederson, SPRN, HN-BC, is a Board Certified Holistic nurse and trained Cannabis Nurse. Her business, Be Well Healing Arts, pllc can provide factual cannabis information and education for health care professionals. For more information, contact Gail at bewellhealingarts@gmail.com and like "Be Well Healing Arts' on Facebook, for more wellness/cannabis information.

From the ND State Health Department

Meningococcal Meningitis in North Dakota

Two cases of Meningococcal meningitis have been reported to the NDDoH so far in 2019. The last reported cases of meningococcal meningitis were in 2014. Meningococcal meningitis is a severe infection of the bloodstream and meninges (the thin lining covering the brain and spinal cord) caused by the bacteria, Neisseria meningitidis. It is a relatively rare disease and usually occurs as a single isolated event. Clusters of cases or outbreaks are rare in the United States. Meningococcal meningitis is spread through the exchange of respiratory and throat secretions like spit (e.g., by living in close quarters, kissing, sharing drinks). Many people carry meningococcal bacteria in the nose and throat without any signs of illness, while others may develop serious symptoms. High risk contacts of a diagnosed individual should receive proper chemoprophylaxis to prevent the spread of the disease. Getting vaccinated is the most effective way to prevent oneself against meningococcal meningitis. There are two types of meningococcal vaccines. Meningococcal conjugate vaccine (MCV4) protects against four serogroups (A, C, Y, and W-135) of Neisseria meningitidis and is recommended for all children 11 to 12 years of age. Adolescents should receive a booster dose at age 16. In North Dakota, all children entering seventh through tenth grade are required to be vaccinated with one dose of MCV4. Children entering eleventh through twelfth grade are required to be vaccinated with two doses of MCV4. North Dakota colleges and universities also require MCV4 vaccine. Vaccines that protect against Neisseria meningitidis serogroup B (Men B) are also available. These vaccines are routinely recommended for people ages 10 and older known to be at increased risk for meningococcal disease. People ages 16-23 may also be vaccinated. Men B vaccine is not required for school entry. Younger children and adults usually do not need meningococcal vaccines. However, the CDC recommends one or both types of meningococcal vaccines for people with certain medical conditions, travel plans, or jobs.

For more information about meningococcal meningitis and who should be vaccinated, please visit https://www.cdc.gov/meningococcal/index.htm

18th Annual Northwest Region North Dakota Collaborative Educational Nursing Conference

Trauma: The Lived Experience

April 3, 2020
8:00am – 3:45pm
The GRAND Hotel
1505 North Broadway
Minot, ND

Provided by:
District 1, North Dakota Nurses Association and Omicron Tau Chapter, Sigma Theta Tau International Honor Society of Nursing

Presenters
Jeff and Niki Brose
Austin Burns, Minot Fire Dept.
Rhonda Gunderson, BSN, RN
Robyn Gust, MS/ATC
Brad Johnson
Robert Klink, BSN, RN
Susann Krueger, MS, RN
Robin Pursifull, BSN, RN, SANE
Missy Regalado-Smith, MSN, RN, CCRN

Conference Planning Committee
Ashley DeMakis, MSN, RN
Sara Franstvog, MSN, RN
Carrie Lewis, MSN, RN
Danni Reinisch, MSN, RN
Amy Roberts, MSN, RN
Kim Tiedman, MSN, RN

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Address _____

City, State, Zip _____

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Food Allergies _____

I am a Member of:
_____ NDNA
_____ Omicron Tau, STTI

Registration Fee: (Includes Lunch)
_____ **$70.00 Non Members**
_____ **$60.00 Members**
_____ **$75.00 after March 29, 2019**
_____ **$30.00 for students**

(No refunds after March 20, 2020)

Breakouts (Please circle 2 sessions)

#1-Debrief #2-Flight
#3-Auto #4-SANE

Please make checks payable to:
Omicron Tau Chapter

Mail Registration and Fee to:

Sara Frantsvog
C/O Dept. of Nursing, MSU
500 University Avenue West
Minot, ND 58707
Questions call 701-858-4476

Agenda

7:30am – 8:00am	**Registration**
8:00am – 8:15am	**Welcome**
8:15am – 9:15am	**"Trauma: Close to Home"** Brad Johnson
9:15am – 10:15am	**"Our Personal Journey Through the Loss of a Child"** Jeff and Niki Brose
10:15am – 10:30am	**Break**
10:30am – 11:30am	**"Severe TBI from Injury to Discharge: Bridging the Gap in Family Communications"** Robyn Gust, MS/ATC
11:30am – 12:30 pm	**Lunch (Provided)**
12:30pm – 2:00 pm	**"Trauma From the Trenches"** Susann Krueger, MS, RN & Rhonda Gunderson, BSN, RN
2:00pm – 3:30pm	**Breakout Sessions**

1."Ins and Outs of Trauma Debriefing"
Suzann Krueger, MS, RN &
Missy Regalado-Smith, MSN, RN, CCRN

2. "Trauma and Flight EMS"
Robert Klink, BSN, RN

3. "Auto-Extrication Demonstration"
Austin Burns, Minot Fire Dept.

4."The Trained Sexual Assault Nurse Expert"
Robin Pursifull, BSN, RN, SANE

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

The committee is applying for six contact hours for this continuing nursing education activity with the North Dakota Board of Nursing.

The purpose of this educational offering is to recognize the impact of trauma on individuals, families and health care professionals.

New This Year!
Calling for Research Posters!
Please email abstract to sara.franstvog@minotstateu.edu by March 20, 2020

Conference Objectives Upon completion of this program, the participants will be able to:

1. Identify safe patient removal from a vehicle and reasons for modifying a vehicle.
2. Describe the role of the nurse when caring for families who experience the loss of a child.
3. Explain the role of the nurse when dealing with critical burns and the impact they have on the patient's life.
4. Define flight physiology and flight stressors that impact crew members, patients, and families.
5. Discuss the steps of debriefing after trauma and recognize the value of debriefing.
6. Identify emerging trends and treatments for the trauma patient.
7. Recognize ways to improve communication with family members of patients with traumatic injuries.
8. Explain the role of the Sexual Assault Nurse Examiner in minimizing trauma and promoting healing.

To access electronic copies of the North Dakota Nurse, please visit
http://www.nursingald.com/publications

North Dakota Community Foundation Nursing Scholarship Loan Fund (NDCF/NDNSLF)

Karen Macdonald, NDNA Member, Committee Chair

Sometimes when you've known something for quite some time, you just think everyone knows that too. At least that was my thought about the North Dakota Community Foundation Nursing Scholarship Loan Fund (NDCF/NDNSLF) until I attended the fall convention of the North Dakota Nurses Association and found out that what I knew, not many others did. So the purpose of this column will be to share what I know and perhaps spark some interest in this wonderful resource for the Association.

This loan fund was established in 1982 with monies from NDNA as well as many others.

Although most of the donors have been members of NDNA, a review of the Prairie Rose archives shows that donors included physicians, clinics, surgical associations, American Legion posts, district Nurses Assns, VFW's, the ND Assoc. of REC's and many others. For a period of ten or more years, the publication included a running total of the contributions as well as a listing of the contributors.

Unfortunately, I was unable find names of anyone who had been awarded a loan (to be converted to a scholarship upon completion of the program and employment in North Dakota). That information is included in the association archives but if any of our readers know of any recipients, please let me know so that can be featured in a later column.

What is the value of the foundation? Most of us are familiar with the adages that encourage putting away into savings some monies each pay day, but we are probably also familiar with the concerns that it is easy to dip into those funds for needs as well as wants. The beauty of a foundation is that the funds are established under guidelines that allow the donations to be tax deductible, and put into a larger pot for growth that would not be possible otherwise.

The NDNA chose the North Dakota Community Foundation as an organization that manages endowment funds and provides professional fundraising and grant-making support in North Dakota. The North Dakota Community Foundation Nurses Association Nursing Scholarship Loan Fund was formed in 1982 with monies from the North Dakota Nurses Association. Betty Maher, Executive Director at that time, is credited with the funds establishment and did a tremendous amount of fund raising from a variety of organizations. In 1985, NDNA designated funds raised from the Prairie Skies Art Show to go to the fund and set a fund goal of $100,000, with monies to be used for education and scholarship. The fund reached a balance in 1987 that allowed scholarship/loans to be granted. The fund is a permanent irrevocable fund. The total assets of the NDCF are over 83 million dollars and information about the foundation is available on their web site – (ndcf.net) So NDNA has had the advantage of the Foundation's expertise and management for over 35 years.

By 1987 the NDNA Board of Directors adopted the Scholarship criteria: applicant must be a North Dakota resident; have a GPA of 2.5 on a 4.0 scale; if an RN accepted into a baccalaureate program; and preference would be given to NDNA members. Application required a transcript, letters of reference, verification of ND residency, and verification of NDNA membership if applicable. In 1990, NDNA awarded five scholarships, two of them funded with the Community Foundation loan fund. (Information from The Prairie Rose)

Today, the total of the fund is $98,973.52. No disbursements have been made since 2013. Each year a spendable amount is determined by the Foundation based upon a complicated formula that equals about 3½% of the fund balance. If the fund goes over $100,000, the percentage increases to 4%. Disbursement of the funds must be consistent with the educational/scholarship intent. This determination would be the responsibility of the NDNA Board of Directors in concert with the NDCF.

This information was presented to the NDNA Board of Directors in November 2019 and the board agreed with the following recommendations:

1. Appoint a committee comprised of directors and/or other members to formalize requirements for either educational or scholarship loan grants. Include on the committee either the President of the NDNA or Executive Director and notify the NDCF of such.
2. Publicize the NDCF-NDNSLF in the North Dakota Nurse and encourage donations to honor past/present members.
3. Include a column in the North Dakota Nurse acknowledging both contributions and awards so ND nurses are aware of the fund and its purposes.

Hence, this column will begin the process of increasing awareness of the NDCF/NSLF (let's shorten that to the "Foundation") and encouraging contributions. I have contributed to the foundation in memory of my husband, in memory of significant mentors in my life, RNs that I have worked with. I have asked the NDCF to acknowledge that contribution to the family of the individual and I have been told this

NDCF Nursing Scholarship...continued on page 12

Is it Beneficial for Children to be Around my Loved One with Dementia?

Tessa Johnson, MSN, BSN, RN, CDP, NDNA President

Yes! The answer is most definitely yes! When a family member has dementia, it affects everyone in the family, including children and grandchildren. It's important to talk to them about what is happening. How much and what kind of information you share depends on the child's age and relationship to the person with Dementia. We at CountryHouse make it a priority for our residents to have opportunities to spend time with children here at the house and out of the house. We invite elementary school, middle school and high school children in to volunteer and spend time with the residents. Children often find this as rewarding and meaningful as the residents do. We also take smaller groups out in the community to a daycare/preschool to read to smaller children.

We know that one of the most significant relationships is the relationship between grandchildren and their grandparents. Unfortunately, dementia may take away the fullness of that relationship over the years. Communication with your children and frequent visits can help foster this relationship.

Start by talking to your child about what is happening with Grandma or Grandpa and don't try to pretend that nothing is wrong. Without an explanation, children may sense you're trying to hide something — or worse, they may become confused or frightened by their grandparent's behavior. Some may not talk about their negative feelings, but you may see changes in how they act. Problems at school, with friends, or at home can be a sign that they are upset. Sometimes younger children struggle to express the feelings to you so a school counselor or social worker can help your child understand what is happening and learn how to cope.

A teenager might find it hard to accept how the person with dementia has changed. He or she may find the changes upsetting or embarrassing and not want to be around the person. Don't force them to spend time with the person who has dementia as this could make it work. We at CountryHouse are always willing to set up a certain event or social gathering and help this process.

Regardless of age, we as humans like to do things in which make us feel valued and meaningful! It is also very beneficial to have your children regardless of their age volunteer in a senior living community especially those with dementia to see the benefit and feel more comfortable. Serving as a volunteer offers important opportunities for social interaction for both you and the people you work with in any senior living community. While volunteer opportunities may vary between communities, building relationships with the residents of the community can be most worthwhile. Giving a manicure, providing an escort for an outdoor walk, leading a discussion, or simply having a conversation, can not only put a smile on a resident's face, but also provide much needed support and encouragement!

The Effect of Closed vs. Open Tracheal Suctioning Systems on Reducing the Risk of Ventilator - Associated Pneumonia

By: Adrian Haugen, Allison Kisse, Kellie Kraft, Karly Kruckenberg, and Everlyn Sawe, University of Mary BSN Students; Kathy Roth, PhD, RN, Assistant Professor of Nursing

Clinical Question:

In adult patients who are mechanically ventilated, how effective is closed suctioning compared to open suctioning in reducing the rate of ventilator-associated pneumonia?

Synthesis of Evidence:

The systematic review by Solà and Benito (2007) examined 16 randomized control trials that focused on comparing effectiveness of closed tracheal suctioning systems (CTSS) versus open tracheal suctioning systems (OTSS) in decreasing the incidence of ventilator-associated pneumonia (VAP) in patients who were receiving mechanical ventilation treatment (MVT) for more than 24 hours. The findings of the review showed no significant differences in increased risk for VAP and time to infection with either suctioning system. Five studies reported significant increases in bacterial colonization with CTSS (Solà & Benito, 2007).

The systematic review by Kuriyama, Umakoshi, Fujinaga, and Takada (2014) examined 16 randomized controlled trials that compared the effect of CTSS to that of OTSS to determine if CTSS contributed to VAP less frequently than OTSS. Overall, the review found that CTSS led to a lower incidence of VAP; however, once sensitivity analyses were completed, there was not adequate evidence to conclude CTSS proved more effective against the development of VAP (Kuriyama et al., 2014).

The study by Hamishekar et al. (2014) assessed the effect of CTSS versus OTSS on the reduction of VAP in critically ill patients. In addition to comparing the suctioning systems, VAP prophylaxis techniques were employed. The study found that the incidences of VAP in OTSS and CTSS were 20% and 12%, respectively. However, when multivariate analysis was done, there were no significant differences in the occurrence of VAP between OTSS and CTSS (Hamishekar et al., 2014).

The study conducted by Hlinkova, Nemcova, and Bielena (2014) was completed to identify the influence that the type of suctioning system has on the minimization of the risk of VAP in ventilated patients. Patients' medical records were the primary resource used to collect the data for this study. A statistically significant relationship was confirmed between the type of suctioning system and the presence of microbial colonization, pointing in favor of OTSS. The conclusion derived from this study was that "the type of suction system does not affect the incidence of nosocomial respiratory tract infections in ventilated patients" (Hlinkova et al., 2014, p. 70).

Two qualitative studies were also reviewed to gain perspective of patients' emotional responses to being mechanically ventilated and suctioned. Karlsson, Lindahl, and Bergbom (2011) conducted a study aimed to delineate patients' statements, facial expressions, and communication while experiencing conscious MVT. The feelings that were most frequently expressed included fear, panic, pain, anxiety, and discomfort. With suctioning procedures, participants often felt panic during the procedure and relief upon completion (Karlsson et al., 2011). Engström, Nyström, Sundelin, and Rattray (2012) focused on describing reported experiences of patients who underwent MVT while in an ICU. The underlying themes gathered from the participants implied that patients felt vulnerable and dependent while ventilated as they struggled to communicate with staff and relatives (Engström et al., 2012).

Bottom Line:

Based on the conclusions of the preceding studies, the use of CTSS does not yield significant benefits in comparison to the OTSS in reducing the risk of VAP. In two clinical studies, findings suggested that the CTSS led to lower incidences of VAP; however, sensitivity analyses suggested that there was not adequate evidence to conclude effectiveness in the prevention of VAP (Kuriyama et al., 2014) as did multivariate analyses (Hamishekar et al., 2014). Although there was no conclusive evidence to support the use of one suctioning system over the other, other elements, such as the use of proper aseptic techniques and monitoring of patients' conditions, were found to impact the incidence of VAP. Additionally, accounting for patients' feelings and providing communication enhanced patients' comfort levels and experiences with the suctioning process (Karlsson et al., 2011). To fully conclude that the CTSS is more effective than the OTSS, further research needs to be completed to confirm the benefits. Further studies need to include larger sample sizes with improved quality design and outcome reporting (Solà & Benito, 2007).

Implications for Nursing Practice:

Suctioning is essential to maintaining airway patency and removing potentially infectious secretions of patients with artificial airways and mechanical ventilation. Although the research has not shown one suctioning system to be more effective than the other, specific measures have been proven to impact the respiratory infection rates of this patient population. Utilization of aseptic suctioning and care techniques, preventative measures, condition monitoring, and decreasing time spent on mechanical ventilation can improve patient outcomes and reduce the incidence of VAP (Solà & Benito, 2007). With the use of evidence-based research, proper nursing care techniques, and patient considerations, quality outcomes may be significantly enhanced. As nurses that directly care for this population group, due diligence with evidence-based practice needs to be applied to promote health and prevent complications in critically ill patients.

References:

Engström, Å., Nyström, N., Sundelin, G., & Rattray, J. (2012). Peoples experiences of being mechanically ventilated in an ICU: A qualitative study. *Intensive and Critical Care Nursing, 29*(2), 88–95. doi:10.1016/j.iccn.2012.07.003

Hamishekar, H., Shadvar, K., Taghizadeh, M., Golzari, S., Mojtahedzadeh, M., Soleimanpour, H., & Mahmoodpoor, A. (2014). Ventilator-associated pneumonia in patients admitted to intensive care units, using open or closed endotracheal suctioning. *Journal of Anesthesia & Pain Medicine, 4*(5): e21649. doi:10.5812/aapm.21649

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Solà, I., & Benito, S. (2007). Closed tracheal suction systems versus open tracheal suction systems for mechanically ventilated adult patients. *Cochrane Database of Systematic Reviews*, (4), 1–53. doi:10.1002/14651858.cd004581.pub2

Does Shift Length Matter?

Appraised by:
Jannelle Stevens, RN, LeAnn Bingham, RN, & Dylan Gjerde, RN Mayville State University RN-BSN students

Clinical Question:
Do nurses who work 12-hour shifts have a higher rate of burnout than nurses who work 8-hour shifts?

Articles:
Dallora, C., Griffiths, P., Ball, J., Simon, M., & Aiken, L. H. (2015). Association of 12 h shifts and nurses' job satisfaction, burnout and intention to leave: Findings from a cross-sectional study of 12 European countries. *BMJ Open, 5*(9). doi:10.1136/bmjopen-2015-008331

Khammar, A., Amjad, R. N., Rohani, M., Yari, A., Noroozi, M., Poursadeghian, A., Mahsa, H., Poursadeghiyan, M. (2017). Survey of shift work disorders and occupational stress among nurses: A cross-sectional study. *Annals of Tropical Medicine & Public Health, 10*(4), 978–984.

Ruotsalainen, J. H. (2015). Preventing occupational stress in healthcare workers. *Cochrane Database of Systematic Reviews,* (4). John Wiley & Sons, Ltd. doi: 10.1002/14651858.CD002892.pub5

Thompson, B. J. (2019). Does work-induced fatigue accumulate across three compressed 12 hour shifts in hospital nurses and aides? *PLoS ONE, 14*(2), 1–15.

Synthesis of evidence:
This synthesis includes four studies related to evidence supportive of the proposed research question. The first study was conducted by Dallora, Griffiths, Ball, Simon, & Aiken (2015), and focused on the concern that nurses who work 12-hour shifts have a higher job dissatisfaction and burnout rate compared to nurses who work 8-hour shifts. A cross-sectional survey was done on 31,627 RN's in 2,170 general medical/surgical units within 488 hospitals across 12 European countries. The study concluded that nurses who work 12-hour shifts experience an increased rate of job dissatisfaction when compared to a nurse working an 8-hour shift. The same results were reported for burnout described as, emotional exhaustion, depersonalization, and low personal accomplishment.

The second study was conducted by Khammar, Amjad, Rohani, Yari, Noroozi, Poursadeghian, Mahsa, & Poursadeghiyan (2017). This study performed a cross-sectional study on 100 randomly selected shift-working nurses from three hospitals in Iran. The study focused on the correlation of shiftwork-related problems and occupational stress, shiftwork, and job dissatisfaction. The conclusion of this study showed a high prevalence of shiftwork-related problems such as, psychological disorders, digestive problems, sleep disorders, and musculoskeletal complaints. The study did show there was a higher rate of job satisfaction when nurses were able to choose their shiftwork. Stress-related issues were more prevalent when there was a conflict with coworkers.

The third study was conducted by Ruotsalainen (2015). This study addressed the concern for healthcare workers suffering from occupational stress resulting in distress, burnout, psychosomatic problems, deterioration in quality of life, and lack of patient care. The purpose of this Cochrane review was to evaluate the effectiveness of work- and person-directed interventions compared to no intervention or alternative interventions in preventing stress at work in healthcare workers. A total of 58 studies (54 RCTs and four CBA studies), with 7,188 participants were reviewed. Organizational interventions discussed were changing working conditions, improving support or mentoring, changing content of care, improving communication skills, and improving work schedules. The study concluded that cognitive-behavioral training as well as mental and physical relaxation reduced stress moderately. Changing work schedules and having shorter work schedules also reduced stress. Other organizational interventions have no clear effects.

The purpose of the final study conducted by Thompson (2019), was to determine what performance-based fatigue symptoms presented after three consecutive 12-hour nursing shifts compared to a single 12-hour nursing shift. Participants were mentally tested on their reaction time and monitored for lapses of attention. Physical testing consisted of three vertical jumps and isometric strength assessments on the knee extensor/flexor, and wrist flexor muscle groups. The results showed fatigue-based impairments in several mental and physical performance tasks which occurred after a single 12-hour shift however, the impairments were exacerbated following three consecutive 12-hour shifts.

Bottom Line:
Evidence suggests that there is a correlation between the length of shift worked and an increased rate of burnout. It is necessary for healthcare institutions and nurses to evaluate the potential cause for burnout and make the appropriate changes. Institutions that implemented shorter shifts with stress intervention and prevention programs tend to have a lower nurse burnout rate than those without. Additionally, nurses who can be proactive with recognizing burnout in themselves and their coworkers will assure an optimal working environment and continue to provide our patients with exceptional care.

Implications for nursing practice:
It has become increasingly apparent that nurses are suffering from burnout. Healthcare institutions and nurses need to take the appropriate steps to recognize, reduce, and prevent burnout. Some steps aimed at reducing burnout are, developing modified shift-working programs, avoiding consecutive 12-hour shifts, provide education on stress reducing measures, reviewing workload, improving staff support, mentoring, and improving communication. Having these proactive interventions in place will be beneficial for the institution, nurses, and patients.

Responsible Use of Social Media

Reprinted with permission, Mississippi RN December 2019

Shonda Phelon, DNP, FNP-BC, PMHNP-BC, GNP-BC, Director, Council on Advanced Practice

Social media continues to be a very popular way for people to connect with the world, communicate with others, learn new information and entertain themselves. Approximately 70% of Americans use social media daily. Many nurses use social media to professionally network and are members of blogs, forums and social networking sites. At the recent MNA Convention, the House of Delegates adopted a resolution to support increasing awareness of nurses' responsibility in the use of social media.

Registered Nurses and Advanced Practice Registered Nurses are active on Facebook, Instagram, LinkedIn, Snapchat, YouTube, Twitter, and Pinterest among others. Social media is a great way to stay "connected" to family and friends, to reconnect with old friends, and to plan events such as family gatherings and reunions. Use of social media has become so common that we often forget the risk it poses due to the ease of instantaneous posting opportunities. At times we may find ourselves not reflective enough and may post things that may come back to haunt us and possibly cause professional or legal consequences.

There are many blogs and forums for nurses and nurse practitioners that may tempt the nurse to post an interesting or unique patient case. Some may even be compelled to share photographs to educate and inform colleagues and potential students. Although the intent is usually innocent and meant to share clinical pearls, results can often lead to professional and legal problems. Even in closed groups, many nurses find themselves in spirited conversations about practice, policy and education. Many of these discussions can be used by others to display us in an other than professional role.

However, social media can have some very positive outcomes when used appropriately. It provides a platform for keeping up with the latest evidence-based research. Networking and connecting with like-minded professionals is also another positive aspect of social media. MNA has a FB account that keeps us up to date on the latest happenings around the state. LinkedIn and other social sites often are great places to explore new career opportunities. When used correctly, social media can enhance practice and help one connect professionally to other healthcare professionals.

Here are some tips to remember before you click the post button or share that latest information.

1. Keep patient privacy and confidentiality to the highest standards. I see many nurse practitioners, nurses, and students of nursing posting clinical situations and even pictures about patients. Social media is not the place to do this or explore complex cases. Never post photos of a patient or identify them by name. Never refer to patients in a demeaning or negative manner. Instead of posting questions about clinical issues, find a mentor or consult with a colleague. You can also reach out to former professors, preceptors or colleagues to discuss any patient issues. Our detractors use these postings as fodder to make us look less educated or skilled.
2. Try to avoid connecting with patients or former patients on social media. This is difficult in small communities where you may know many people. It is very important not to give professional medical advice or discuss work related issues with patients on social media. Make sure your patients and staff know this, especially the ones with whom you have a personal relationship prior to the nurse-patient relationship.
3. Don't complain about your work place on social media. Facebook or Twitter is not the place to make negative comments or post negative pictures about a place of employment, coworkers, or administration. This type of behavior not only jeopardizes your job security but your reputation as well. If you have work related issues, meet with your employer, supervisors or human resources department to discuss the issues professionally. Make sure you review your employer's social media policy and follow the rules. It is also a good policy to never use a workplace email to affiliate you with a social media site, and to not access a social media website or post personal pictures, events, etc. while at work.
4. Keep all activity on social media professional. There are many posts that may be considered unprofessional and reflect negatively on the profession of nursing. Profanity, sexually explicit or racially derogatory comments, as well as posts about drug and alcohol use are unprofessional, question one's moral character and reflect negatively on the nursing profession. I personally wish the "sexy nurse" costume could be banned, but I routinely see nurses wearing it to costume parties and posting pictures on social media. In the worst case scenario posting unprofessional comments or pictures could lead to a charge of unprofessional behavior by an employer or the Mississippi Board of Nursing.

When using social media, always think before you post. Will your post benefit someone or is it a negative statement about you or the profession of nursing? Make sure your post adheres to relevant federal and state laws, state

Responsible Use of Social...continued on page 16

ANA 2019 LEADERSHIP SUMMIT

NDNA President Tessa Johnson and Executive Director Sherri Miller had the opportunity to attend the 2019 ANA Leadership Summit in Alexandria, Virginia on December 3rd, 4th, and 5th, 2019.

The three-day conference had an overall theme of collaboration and best practices to strengthen and build current relationships between ANA and the constituent states (C/SNAs). Events of the summit started with a wonderful Tuesday morning session entitled, "Thinking about our Thinking: The Impact of Unconscious Bias" by Marsha Hughes-Rease, MSN, MSOD, PCC. NDNA leaders sat with West Virginia and Kentucky leaders and engaged in small group discussions regarding how biases affect us in our work. The speaker provided us with thought-provoking materials and great discussion points.

The first day ended with a networking reception sponsored by our website hosts, Nursing Network. NDNA attained good information regarding how our website can assist us to engage current members and build our association. We were also able to share ideas with nurses across the country in a more casual and fun setting.

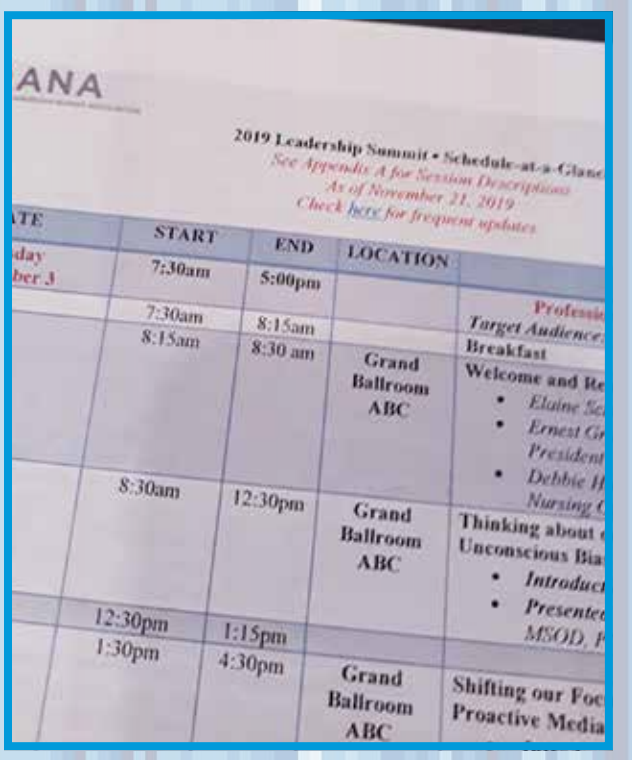
The Leadership Council Meeting started Wednesday's agenda with discussion of ANA's Enterprise Strategic Plan and Budget.

Collaboration among ANA and C/SNAs has clearly been growing as currently there are three Advisory Groups meeting. C/SNA Essentials Advisory Group, New Executives Orientation, and Personal Benefits Advisory Group representatives all spoke to give updates on what the purpose and status is of their groups. NDNA is participating in the C/SNA Essentials and Personal Benefits Groups.

The summit included other discussions on strengthening the partnerships between ANCC and the C/SNAs. Opportunities for synergy were discussed and communication channels were explored to facilitate the flow of information.

We learned some exciting news such as 2020 will bring a nursing podcast sponsored by Johnson and Johnson called "See You Now."

It was another great summit and we are so excited to see what 2020 holds for NDNA and ANA in terms of even more collaboration. Stay tuned!


ANA

2019 Leadership Summit • Schedule-at-a-Glance

See Appendix A for Session Descriptions

As of November 21, 2019

Check here for frequent updates

TE	START	END	LOCATION	
day ber 3	7:30am	5:00pm		
	7:30am	8:15am		Profess… Target Audience: Breakfast
	8:15am	8:30 am	Grand Ballroom ABC	Welcome and Re… • Elaine Sc… • Ernest Gr… President • Debbie H… Nursing C…
	8:30am	12:30pm	Grand Ballroom ABC	Thinking about … Unconscious Bia… • Introduc… • Presente… MSOD, P…
	12:30pm 1:30pm	1:15pm 4:30pm	Grand Ballroom ABC	Shifting our Foc… Proactive Media…

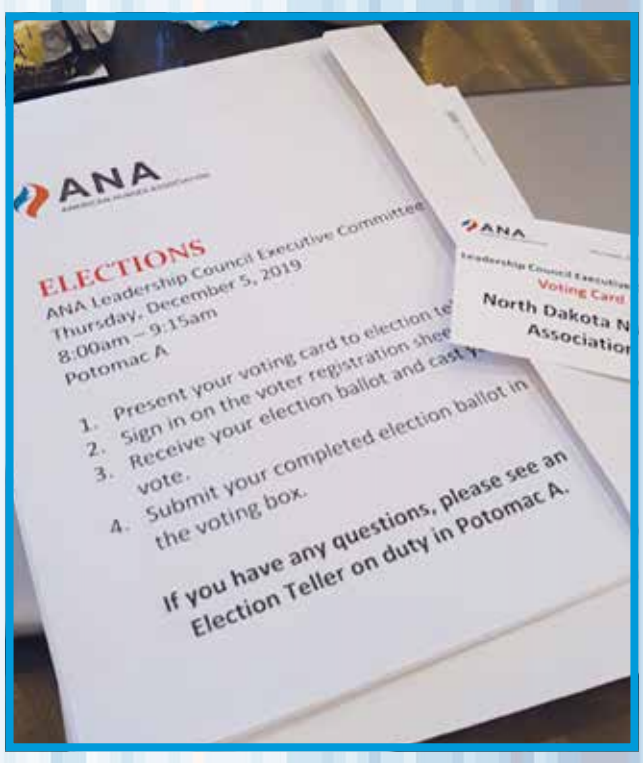
Our 2019 Leadership Summit agenda

Being welcomed!

Many opportunities to share ideas

ANA 2019 LEADERSHIP SUMMIT

Time to vote



Elections were Thursday morning

Lots of COLLABORATION!

Nursing colleagues from Kansas

Mid-meetings!

Selfies, of course!

NDNA with WVNA

NDNA President, Tessa Johnson – have to stop by the White House when in DC!

Interrupted vs. Continuous Enteral Feedings

Peter Breda, Michaela Feist, and Mackenzie Irwin, University of Mary BSN Students; Kathy Roth, PhD, RN, Assistant Professor of Nursing

Clinical Question:

In patients with tube feedings, what is the effect of continuous tube feedings when compared with interrupted feedings on the risk of aspiration?

Synthesis of Evidence:

In many critically ill cases involving patients who are immobile and are unable to eat, enteral feedings and frequent turning are required to maintain proper nutrition and prevent impaired skin integrity. "Critically ill patients have an increased risk for aspirating oropharyngeal secretions and regurgitated gastric contents. For those who are tube-fed, aspiration of gastric contents is of greater concern" (Critical Care Nurse, 2012, para. 1). Since aspiration of gastric contents is concerning, tube-feedings have been paused in order to prevent the patient from aspirating during turning, thus having the patient not meet nutritional requirements. A review of literature was performed regarding interrupted versus continuous enteral feedings on the risk of aspiration. A total of six articles were reviewed highlighting the following information regarding the topic:

- Article one studied undernourishment of patients who rely on enteral tube feedings due to interruptions in the infusion process, and concluded patients received an average of 64% of their recommended intake (Elpern et al., 2004). Average length of interruptions accounted for 5.23 hours per patient day. Interruptions involved mainly tests and procedures accounting for 35.7% of the interruptions. Feedings were stopped more as a precautionary measure and time of fasting necessary before procedures is unknown (Elpern et al., 2004).
- Article two studied aspiration in 23 patients with tube feedings and concluded that aspiration occurred in four different patients, two when enteral feedings were withheld and two when entering feedings were continued during repositioning (DiLibero et al., 2015). This study revealed no significant difference between the incidence of aspiration during repositioning when enteral feedings were withheld and the incidence of aspiration during repositioning when enteral feedings were continued.
- Article three studied aspiration in relation to gastric residual volume in 107 patients, and concluded that intermittent feedings had slightly fewer incidences leading to aspiration pneumonia when compared with continuous feedings (Chen et al., 2006). The study discussed the importance of checking gastric residual volumes concerning aspiration in ventilated critically ill patients, as intermittent feedings might not provide adequate nutrition.
- Article four described interviews with critical care nurses on their enteral feeding practices (Emmons, 2014). All 11 participants agreed enteral nutrition is vital to critically ill patients and improves patient outcomes in the ICU. Enteral feeding has many benefits such as wound healing, increasing muscle mass, and ability to wean from the ventilator. Participants also reported the time of enteral feedings is often delayed beyond 24 hours after admission. The most discussed issue among the participants related to the lack of standardized procedures and knowledge regarding gastric residual volume (Emmons, 2014).
- Article five evaluated the occurrence of regurgitation and aspiration in patients with severe strokes being infused with different volumes of enteral nutrition (Chen et al., 2015). Patients in the treatment group received enteral nutrition with an initial rate of the total volume and the infusion rate adjusted based on the gastric residual volume assessed every four hours. Patients in the control group received enteral nutrition without the residual being monitored and needed to reach the target infusion volume within 72 hours. They concluded that the treatment group (n=126) had eight cases of regurgitation and 10 cases of aspiration and the control group (n=80) had 15 cases of regurgitation and 14 cases of aspiration; four patients were removed from the study due to complications. To reduce the incidence of respiratory complications, patients should receive enteral nutrition on a feeding pump continuously for 20 hours and adjust the infusion rate based on the gastric residual volume to reduce the risk of aspiration (Chen et al., 2015).
- Article six studied the patient positions and frequency of turning in ICU patients (Goldhill et al., 2008). They concluded out of the 393 patients observed, only 42% of patients were repositioned within a two hour period, other reposition frequency depended on the ICU nurses. 46.1% were positioned prone, 28.4% were positioned left, 25.5% were positioned right, and 97.4% of patients had their heads elevated. The determinant of the frequency of turning appeared to be the policy and the individual nurse in the intensive care unit (Goldhill et al., 2008).

Bottom Line:

In conclusion, each study reviewed stressed the importance of monitoring the gastric residual volume and the need for continuous enteral nutrition, but there was no evidence found that repositioning the patient during continuous versus interrupted feedings would cause the patient to aspirate either on their gastric residual or oropharyngeal secretions more than the other. Evidence showed that for the patients to have a better outcome the feedings needed to be continuously given but repositioning of the patient depended on the policy of the intensive care unit. Overall, the patients participating in the case studies aspirated due the amount of gastric residual volume in their stomachs, not by being repositioned.

Implications for Nursing Practice:

Nutrition is vital in critically ill patients to improve outcomes, decrease length of patient stay, and decrease time on the ventilator. Enteral nutrition needs to be initiated within 24 hours to sustain the necessary nutrition in ICU patients. Healthcare facilities need to have current evidence-based practice standardized guidelines to follow for enteral nutrition such as time of placement, when to advance feedings, when to hold feedings, checking gastric residual volumes, and time necessary to interrupt for procedures. Healthcare facilities should implement a practice guideline related to continuing feedings in critically ill patients and monitor the trends to compare the percentages with the previous standard of practice of interrupted feedings.

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NDCF Nursing Scholarship...continued from page 7

contribution was meaningful to the family as it represented the nurse's life and contributions to the profession of nursing. I would love to see the fund go over $100,000. That was a goal of Betty Maher's, and now one of mine.

What are your thoughts on how the proceeds should be spent? One, two, three or four Scholarship/Loans each year? An educational offering with a qualified speaker? Anything that fits within the parameters. The original agreement states

> **"funds shall be used for educational experiences within NDNA to include, but not be limited to, grants for educational experiences, either at formal educational institutions or in seminar workshop programs."**

The board's advisory committee will be meeting after the first of January to begin establishing criteria for disbursement. Members of the advisory committee will include the President-elect, and a former board member. Recommendations will be submitted to the Board of Directors for their approval and hopefully either scholarships or educational offerings can be awarded in 2020. That's quite fitting as remember 2020 is "**The Year of the Nurse**" and the 200th anniversary of Florence Nightingale's birthday.

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

The North Dakota Board of Nursing (NDBON), the North Dakota Nurses Association (NDNA) and North Dakota Center for Nursing (NDCFN) collaborated to provide this comparison of the three nursing entities. Each of these entities has a unique mission and description, which makes them very different from one another. This comparison is updated and published annually and is available on the respective websites.

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:*** *The Mission of NDNA is to advance the nursing profession by promoting professional development of nurses, fostering high standards of nursing practice, promoting the safety and well-being of nurses in the workplace, and by advocating on health care issues affecting nurses and the public.*	***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* Dr. Kevin Buettner, APRN member, Grand Forks: Treasurer Jamie Hammer, RN member, Minot Janelle Holth, RN member, Grand Forks Mary Beth Johnson, RN member, Bismarck Wendi Johnston, LPN member, Kathryn Julie Dragseth, LPN member, Watford City Cheryl Froehlich, Public member, Mandan	***Board of Directors:*** *President* - Tessa Johnson, MSN, RN, CDP 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 Corrie Lund, BSN, RN-Compliance Investigator-clund@ndbon.org Michael Frovarp, Accounting/Licensure Specialist - mfrovarp@ndbon.org Gail Rossman, Technology Specialist II - grossman@ndbon.org Kathy Zahn, Administrative Assistant III kzahn@ndbon.org Karen Hahn, Administrative Assistant/Licensing Specialist khahn@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

ND Nurse: Resilience Series 1 of 7

Melanie Schock, MS, RN, CNE, DNP-student
NDNA President-Elect

An elaborate healthcare system with patients having complex care needs is recognized as today's norm. Entry-level nurses and those longstanding within the profession are expected to navigate the system and respond appropriately. Building resilience begins within the academic setting and the workplace aims to sustain and/or improve resilience. Further, ALL nurses are in a prime environment to benefit from the enrichment of resilience. The trajectory of resilience has positive impacts for not only nurses, but also the patients that we serve. Nurses can also reap benefits of resiliency beyond the walls of one's professional landscape, but also personally. This article presents the first of a series of seven topics surrounding resilience: 1) Introduction as a Concept; 2) For Nursing Students and Educators; 3) For New Nurses; 4) For All Nurses and Special Practice Settings; 5) For Patient Populations; 6) In Our Personal Lives; and 7) Strategies to Improve/ Increase.

Resilience is not easily understood and is challenging to qualify and quantify; however, resilience is a vital attribute to own. The concept of resilience surfaced in the 1970s as pediatric psychologists followed children who had lived through traumatic home situations. Despite the chaos and tragedies of childhood, the researchers found that some children were able to live healthy adult lives (Turner, 2014). Answering the question, 'What human trait or characteristic enables people to thrive in the aftermath of misfortune or adversity?' is what eventually led to the term *resilience* (Turner, 2014).

Since the 1990s, resilience has been defined in many ways and depends on the context where the term is applied. A common defining thread involves the abilities and characteristics that allow an individual to cope successfully and function above the norm (Tusaie & Dyer as cited in Moran, 2012). These abilities and characteristics occur despite significant stress and adversity, along with having the ability to bounce back, adjust, and keep equilibrium (Jackson, Firko, & Edenborough as cited in Moran, 2012). Further understanding the concept of resiliency is a multifaceted undertaking. A first step towards this understanding is to investigate the characteristics of resiliency.

Many variables explain resilience in the context of nursing. Gillespie, Chaboyer, Wallis, and Grimbeek (2007) conducted a correlational study to develop and test a model for resilience. These authors discovered that five variables explained resilience in 772 Australian operating room (OR) nurses: hope, self-efficacy, coping, control, and competence. Hope and resilience had a highly significant statistical association. A supportive workplace can reduce the effects of potential stressors and enhance hope as an intrinsic factor. Strong associations were discovered between resilience and self-efficacy. Self-efficacy is the ability to use a repertoire of problem-solving skills to deal with change (Tusaie & Dyer as cited in Gillespie et al., 2007). Coping and control both had moderate statistical associations with resilience. Coping is a problem-focused approach that involves strategies such as mitigating the stressor, denial, or distancing (Lazarus as cited in Gillespie et al., 2007). Maintaining control augments resilience through situational adaptation (Bandura as cited in Gillespie et al., 2007). Control, as an explanatory variable of resilience, can minimize the effects of a stressful environment. Last, competence showed a modest association with resilience. Skillful nurses were more likely to show control in problematic clinical situations.

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A Guide to Displaying Nursing Credentials

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Kathryn Handy, DNP, RN, CNE

In today's complex health care system, a competent nursing workforce possessing the knowledge and skills to provide safe, high quality care, is essential. In 2010, the Institute of Medicine (IOM) released the landmark report, *The Future of Nursing: Leading Change, Advancing Health*, on the nursing profession and identified the need for nurses to take on leadership roles in all settings to meet the ever increasing demands of our changing health care system. Nurse academicians and clinicians continue to heed this call, advancing education and engaging in a wide range of professional development activities that support the evidence-based recommendations of the IOM. Credentialing and certifications validate the skills, knowledge, and abilities nurses need to succeed and create change in this ever-changing profession.

Utilizing a standard process of credentialing nurses ensures that nurses, healthcare providers, consumers, and other relevant entities understand the significance and value of credentials. To avoid confusion, there is a specific procedure for displaying credentials in a uniform manner. The American Nurses Credentialing Center (ANCC) provides a step-by-step guide to understanding and displaying your nursing credentials (ANCC, 2013).

Every day we see the multiple streams of initials within a nurse's signature. There is a vast array of credentials to note. Educational degrees include doctoral degrees (PhD, DrPH, DNS, EdD, DNP), master's degrees (MSN, MS, MA), bachelor's degrees (BS, BSN, BA), and associate degrees (AD, ADN). Licensure credentials include RN and LPN. State designations or requirements recognize the authority to practice at a more advanced level in that state and include Advanced Practice Registered Nurse (APRN), Nurse Practitioner (NP), and Clinical Nurse Specialist (CNS). National certification, which is awarded through accredited certifying bodies such as the ANCC, the National League for Nursing (NLN), or the American Organization for Nursing Leadership (AONL), includes Family Nurse Practitioner-Board Certified (FNP-BC), Certified Nurse Educator (CNE), and Certified in Executive Nursing Practice (CENP) respectively. Awards and honors that recognize outstanding achievements in nursing include those such as Fellow of the American Academy of Nursing (FAAN) and Fellow of Critical Care Medicine (FCCM). Other possible recognitions include non-nursing certifications that recognize additional skills, such as the EMT-Basic/EMT, awarded by the National Registry of Emergency Medical Technicians. As nursing continues to advance as a profession, the use of credentials to designate and to identify the levels of attained education, licensure, certification and achievement as a professional is essential.

Displaying credentials correctly is vital. The preferred order of displaying one's credentials is the following: (a) highest degree earned; (b) licensure; (c) state designations or requirements; (d) national certifications; (e) awards and honors; and (f) other recognitions. Why is this so important? The order is placed in regard to degree permanence. One's educational degree is placed first as it cannot be taken away except under extreme circumstances. Next, the licensure credentials and the state designations or requirements, which are required for practice. These are generally time limited and need to be maintained through renewals and continuing education. Then finally, the awards, honors, and other recognitions which are voluntary and not required for practice (ANCC, 2013)

This seems easy enough, right? It may be helpful to add a few points of clarification here. You might ask, do I have to place all my credentials on everything I sign or include in professional speaking and writing endeavors? With legal documents, such as prescriptions and documentation within the medical record, you must use the credentials required by your particular state for your area of practice. In professional endeavors such as speaking, writing for publications, or providing testimony before a legislative body, you should use all your relevant credentials. Please note that journals sometimes order credentials differently, so it is appropriate to conform to their specific style. Or perhaps, what if I have multiple credentials of the same type? In this case you would list the highest education degree first and if your second degree is in another relevant field, you may choose to list it as well. For example, a nurse executive might choose Nancy Gordon, MBA, MSN, RN. Note here that the highest non-nursing degree is listed first followed by the highest nursing degree. A nurse who has a master's in a non-nursing field might choose Anne Peterson, MEd, BSN, RN. Remember though, if you have a doctorate and a master's degree, omit your baccalaureate degree. If you have multiple nursing certifications, they may be listed in the order you prefer. Do consider listing them in order of relevance to your practice or in the order they were obtained, with the most recent first. Always list non-nursing certifications last.

Properly displaying credentials enables nurses to demonstrate their specialty expertise, professionalism, and validate their knowledge to employers, patients, colleagues, and students. Through education and professional development, we enrich ourselves, the future nursing workforce, ensure the provision of safe, high quality, patient-centered care, empower the nursing profession, and have the ability to promote change. Wear your credentials proud. Be proud of your accomplishments; acknowledge them and allow others to acknowledge them.

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The Effectiveness of Syringe Exchange Programs on Reducing Cost and Communicable Diseases

By: Haylie Leier, Julia Johnson, and Sage Walz, University of Mary BSN Students; Kathy Roth, PhD, RN, Assistant Professor of Nursing

Introduction:

Syringe exchange programs (SEP) are defined as "community-based programs that provide access to sterile needles and syringes free of cost and facilitate safe disposal of used needles and syringes" (Centers for Disease Control and Prevention [CDC] 2018, para. 2). SEP arose from a need to stop the transmission of communicable diseases such as HIV and hepatitis, that were being spread from the use of shared needles between people who inject drugs (PWID). Currently the goal of SEP is to provide comprehensive care that helps to stop the spread of disease, reduce risks of infection, provide education "on safer injection practices and wound care; overdose prevention; referral to substance use disorder treatment programs… and counseling and testing for HIV and hepatitis C" (CDC, 2018, para. 2). Intravenous drug use has been shown to be one of the most common routes of transmission for hepatitis C.

Clinical Question:

In people who inject drugs what is the effect of Syringe Exchange Programs compared to other treatments on decreasing cost and communicable diseases?

Synthesis of Evidence:

To find results of the effectiveness of SEP, there were 30 articles reviewed including from the Cochrane Library. Many factors were analyzed to determine the effectiveness of SEP. The studies discussed results of financial management, which style of SEP to implement, and what other treatment programs to implement with SEP for PWID such as opioid substitution therapy.

- Nguyen, Weir, Jarlais, Pinkerton and Holtgrave (2014) present a clinical study to examine if a calculated hypothetical increase in SEP would be a cost-effective solution to decrease the spread of HIV, using Pinkerton's Model. The results of the Pinkerton model show that if the model parameter estimates, "an additional $10 million investment for syringe programs... would avert 194 HIV infections and result in treatment cost savings of $75.8 million" (Nguyen et al., 2014, p. 10). Additionally, a "$50 million increase in funding would avert 816 infections and save $319.1 million in treatment costs" (Nguyen et al., 2014, p. 10).
- Results from the Louisville Metro Syringe Exchange Program (LMSEP) study determined twice as many syringes were distributed than collected (Persad, Saad, & Schulte, 2017). If a one-to-one SEP was implemented, there would be an increased chance of PWID to reuse syringes. LMSEP study has proven that needs-based SEP decreases the likelihood of PWID reusing syringes and transmitting communicable diseases.
- There is good evidence to believe that opioid substitution therapy can reduce the percentage of people who contract hepatitis C by 50% (Platt, et al., 2017). They do this by providing counseling, and administering and giving clients medications to reduce the draw of addictive substances. This in return reduces the amount of injected drug use overall for the client and gives them access to systems that can help eliminate the problem in the PWID lives (Platt, et al., 2017).
- According to Platt et al. (2017), in programs that offer opioid substitution therapy (OST), when coupled with needle exchange programs (NEP) it further reduces the instances of hepatitis C virus acquisition. "OST is associated with a reduction in the risk of HCV acquisition, which is strengthened in studies that assess the combination of OST and NEP" (Platt, et al., 2017, p. 6) granting a possibility of up to 80% reduction.

Bottom Line:

Syringe Exchange Programs are effective in reducing the incidence of communicable diseases such as hepatitis C and HIV within the community they are implemented in, as well as decreasing annual treatment costs. Opioid substitution therapy in conjunction with syringe exchange programs is proven to be a successful intervention as well as the implementation of needs-based syringe programs in reducing the spread of communicable disease.

Nursing Implications:

According to Beletsky, Macalino, and Burris (2005), "The importance of police in the effective implementation of syringe access policies combined with the occupational risk in handling needles highlight the need for greater efforts to understand police attitudes and behavior in relation to harm reduction and drug control policy more generally" (p. 5). To implement these services into a community the nurse needs to be aware of those who are on the front line dealing with PWID. Collaborating with the local governmental agencies to provide a detailed description and rationale for implementing a SEP and acknowledging the questions and fears that may arise will provide the best chance for healthy implementation into the community of SEP. Nurses should be aware of the communities that they serve and know what resources are available to help those with intravenous drug addiction. Nurses should be at the forefront of education on ways to prevent the spread of communicable disease such as HIV and hepatitis C through safe syringe handling practices, proper hygiene, and the safe disposal of syringes.

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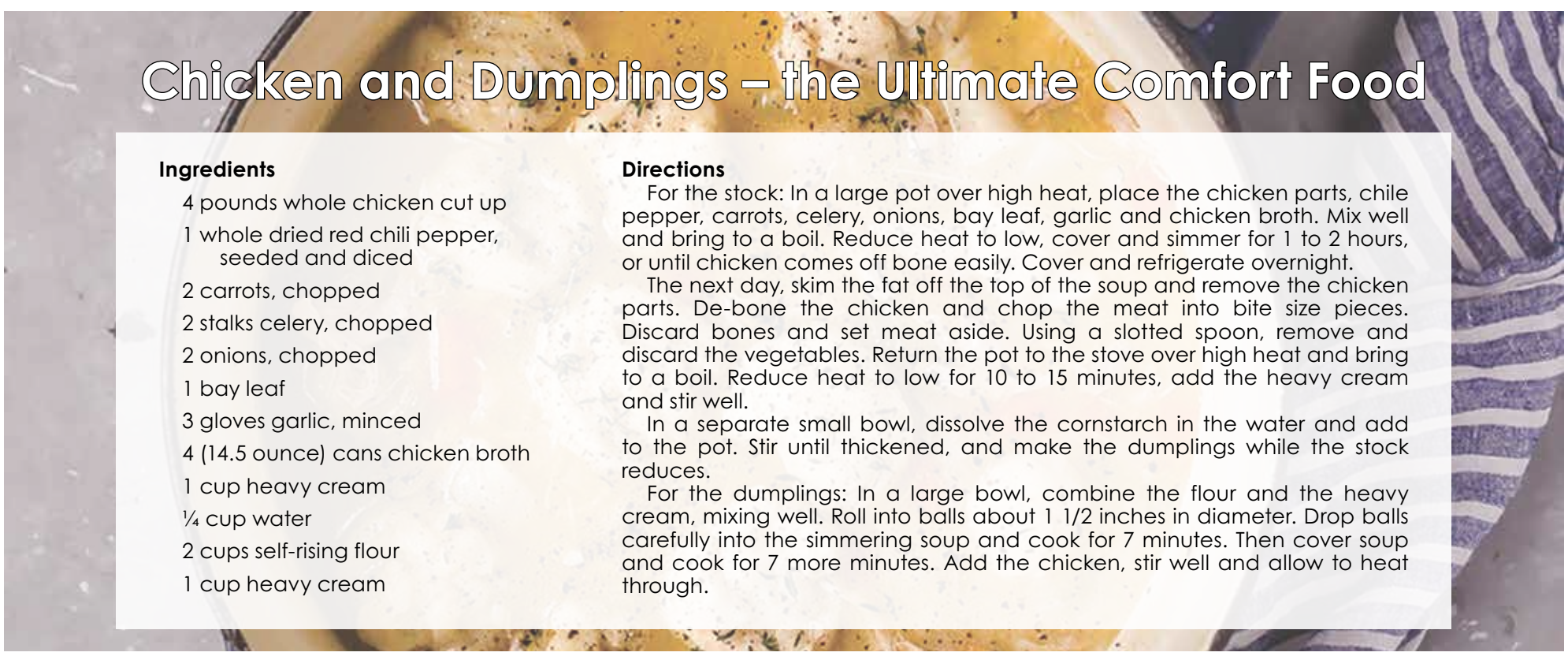
Recipe



Chicken and Dumplings – the Ultimate Comfort Food

Ingredients

- 4 pounds whole chicken cut up
- 1 whole dried red chili pepper, seeded and diced
- 2 carrots, chopped
- 2 stalks celery, chopped
- 2 onions, chopped
- 1 bay leaf
- 3 gloves garlic, minced
- 4 (14.5 ounce) cans chicken broth
- 1 cup heavy cream
- ¼ cup water
- 2 cups self-rising flour
- 1 cup heavy cream

Directions

For the stock: In a large pot over high heat, place the chicken parts, chile pepper, carrots, celery, onions, bay leaf, garlic and chicken broth. Mix well and bring to a boil. Reduce heat to low, cover and simmer for 1 to 2 hours, or until chicken comes off bone easily. Cover and refrigerate overnight.

The next day, skim the fat off the top of the soup and remove the chicken parts. De-bone the chicken and chop the meat into bite size pieces. Discard bones and set meat aside. Using a slotted spoon, remove and discard the vegetables. Return the pot to the stove over high heat and bring to a boil. Reduce heat to low for 10 to 15 minutes, add the heavy cream and stir well.

In a separate small bowl, dissolve the cornstarch in the water and add to the pot. Stir until thickened, and make the dumplings while the stock reduces.

For the dumplings: In a large bowl, combine the flour and the heavy cream, mixing well. Roll into balls about 1 1/2 inches in diameter. Drop balls carefully into the simmering soup and cook for 7 minutes. Then cover soup and cook for 7 more minutes. Add the chicken, stir well and allow to heat through.

Celebrating Nurse Wellness at Magnet® Conference

Holly Carpenter, BSN, RN, and Lois Gould, MS, PMP

Opportunities abound for engaging in self-care.

WHAT HAPPENS when you bring 10,500+ nurses together, mix in some magic from Universal's Islands of Adventure™ theme park, add plenty of wellness offerings from ANA Enterprise's Healthy Nurse, Healthy Nation™ (HNHN), incorporate exemplary nursing practice presentations and posters, and sprinkle with innovation and awards? Another successful ANCC National Magnet Conference® of course.

HNHN was proud to be a part of this year's Magnet® conference. With a large booth, healthy breakfast, raffle, gifts, new challenges, and a "hot off the press" year 2 highlights report, HNHN had a strong showing.

The HNHN breakfast, powered by support from Humana, featured micro-presentations from our Champion partners. Speakers from Humana, North Shore University Hospital, Ochsner Health System, Vanderbilt University Medical Center, and MD Anderson Cancer Center shared how their organizations participate in HNHN and other nurse wellness offerings.

The HNHN booth offered easy access for attendees to participate by:

- texting to join challenges (text healthynurse to 52-886)
- signing up to receive a monthly e-newsletter
- joining the HNHN Connect community at hnhn.org.

Hundreds of nurses joined HNHN's latest challenge, Embracing Caregivers, powered by support from EMD Serono. A fun raffle prize ($500 spa gift card) was awarded to one lucky winner.

This year's conference encouraged nurses to care for themselves and improve their own wellness and safety. For example, a quiet room for prayer or meditation was available where attendees could unplug, relax, and focus on themselves, their spirituality, and their emotional health. Modeling the behavior we want to encourage, water coolers for proper hydration were located throughout the conference center.

Many conference sessions spotlighted various aspects of nurse health, safety, or wellness, running the gamut from workplace violence prevention to food as medicine to transformational leadership. A poignant montage honored nurses who have served in the military.

The program included nurse innovation, powered by support from BD. Lydel Wright, MSN, RN, chief executive officer of SafeWatch, LLC and Texas Nurses Association member, spoke about his journey and creating his company. Antonette Montalvo, MSN, RN, PNP-BC, visionary nurse and community health consultant, encouraged audience members to be creative and resilient when faced with obstacles.

If the immense expanse of the Orange County Convention Center didn't offer enough walking opportunities, the welcome party at Universal's Islands of Adventure certainly did. Attendees had access to attractions, restaurants, and shops, as well as several joyful dance venues.

Attendees were invited to explore their artistic side by painting, decorating, and bedazzling super-size posters, hats, koozies, cups, and bandanas. From the opening program's speakers, operatic singing, and orchestral music to the closing inspirational message from Leon Logothetis, author of The Kindness Diaries, there truly was something for everyone's well-being. One of HNHN's Champion partners, OSF HealthCare Saint Francis Medical Center, won the 2019 ANCC Magnet Prize® for developing various food desert mitigation innovations, including a community garden.

Did you miss the conference this year? Join HNHN and thousands of your nursing colleagues in Atlanta, GA, October 7-9, 2020!

The authors work at the American Nurses Association. Holly Carpenter is senior policy advisor in the Nursing Practice and Work Environment and Innovation departments. Lois Gould is program manager in Nursing Practice and Innovation.

Dr. Mary Wakefield Named Living Legend by the American Academy of Nursing

Mary Wakefield, Visiting Scholar of Healthcare Policy at the UND College of Nursing & Professional Disciplines, has been named one of five "Living Legends" by the American Academy of Nursing. The award is the Academy's highest honor. She received the award in October for her commitment to transforming health care.

Wakefield was born in Devils Lake, North Dakota in 1954. She completed a Bachelor of Science in Nursing from the University of Mary in Bismarck, North Dakota in 1976, and completed a Master of Science degree in 1978 and a PhD in 1985, in nursing at the University of Texas at Austin.

Wakefield worked as a full or part-time nurse, primarily in rural nursing homes and intensive care, from 1976 to 1985, and taught nursing from 1977 to 1987 at the University of North Dakota.

A renowned advocate, leader and trailblazer, Dr. Wakefield's impact on health policy, especially for rural areas, has strengthened the healthcare workforce, increased health equity and improved the well-being of vulnerable populations.

Wakefield served as the Acting Deputy Secretary of the U.S. Department of Health and Human Services (HHS) under President Barak Obama, from March 2015 through January 2017, and as Administrator of the Health Resources and Services Administration (HRSA) from March 2009 through April 2015. She previously served as associate dean for rural health at the School of Medicine and Health Sciences at UND, where she also directed the Rural Assistance Center, now the Rural Health Information Hub. She taught nursing at UND from 1977 to 1987.

Her career has produced tremendous impact on health policy through her role in several high-profile positions within the federal government, said the Academy. During her tenure as Administrator of HRSA and as Acting Deputy Secretary of HHS, Wakefield led key health policy initiatives with a particular focus on health programs for rural populations. Wakefield is also a member of the Institute of Medicine and a fellow in the American Academy of Nursing.

She has served on a large number of public and not for profit boards and committees focused on bringing expertise in nursing, access to care, and health care quality and finance. She also serves as a Visiting Distinguished Professor at Georgetown University and the University of Texas at Austin, as well as serving as co-chair of the National Academy of Medicine's Consensus Study on the Future of Nursing 2020-2030.

Dr. Wakefield has been active with NDNA, including writing articles for the *North Dakota Nurse*.

ANA CEO Loressa Cole Named to Modern Healthcare's 100 Most Influential People in Healthcare

ANA Enterprise Chief Executive Officer Loressa Cole, DNP, MBA, RN, FACHE, NEA-BC, has been named one of Modern Healthcare's "100 Most Influential People in Healthcare." This awards and recognition program honors individuals in health care who are deemed by their peers and an expert panel to be the most influential individuals in the field.

Modern Healthcare also honored Dr. Cole on their 50 Most Influential Clinical Executives list earlier this year. An accomplished health care leader, Dr. Cole was appointed as the ANA Enterprise CEO in 2018 and is active in many professional organizations. Previously, Dr. Cole served as the ANCC Executive Director and Executive Vice President, President of the Virginia Nurses Association and currently as a member of the American Organization of Nurse Executives, the Virginia Organization of Nurse Executives, and the American College of Healthcare Executives.

The "100 Most Influential People in Healthcare" honorees come from all sectors of health care, including hospitals, health systems, insurance, government, vendors and suppliers, policy, trade and professional organizations. Dr. Cole and fellow honorees are highlighted in the December 9 print edition of Modern Healthcare and online at ModernHealthcare.com.

Responsible Use of Social...continued from page 9

regulations, employer policies, and the *American Nurses Association Code of Ethics with Interpretive Statements*. If you think something you are about to post may not be appropriate, most likely it is and you should delete the post.

Social media is a great resource in our world today, but remember what you post will become permanent and may follow you for years. Always remain professional, confidential and mindful of the posts you make. Let's make our social media posts positive, educational and something we will never regret!

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Effectiveness of Intradermal Lidocaine in Relieving IV Insertion Pain

By: Shariah Johnson, Michelle Marti, & Bailey Orvis, University of Mary BSN Students; Kathy Roth, PhD, RN, Assistant Professor of Nursing

Clinical Question:

In adult hospital patients, what is the effect of intradermal lidocaine prior to IV catheterization when compared to no anesthetic administration on patient pain levels?

Synthesis of Evidence:

The literature that was examined demonstrates that using lidocaine prior to IV catheterization can significantly reduce pain. The first study that was examined was "Use of Subcutaneous Local Anesthetic in Venous Catheters Channeling for Reducing Pain" (Santana, 2015). This article was determining whether or not lidocaine prior to intravenous cannulation or 0.9% normal saline is more effective in decreasing pain. Patients gave consent to the study and were aware they wouldn't know which medication was being given. The study found that 2% lidocaine was more effective in reducing overall pain (Santana, 2015). Another study that was examined discussed using lidocaine, EMLA cream, and normal saline. This study aimed to find the most effective anesthetic for starting intravenous catheters as well as compare pain (Bond et al.,2016). The study concluded that lidocaine was more effective over EMLA cream and normal saline. The third study looked at the use of intradermal lidocaine as an anesthetic versus the use of normal saline. "Local Anesthesia Before IV Catheterization," is a study that worked with pre-surgical patients to determine the efficacy of lidocaine versus normal saline as an anesthetic prior to having an IV inserted in the pre-surgical setting (Burke et al., 2011). This case concluded that intradermal lidocaine is superior to normal saline in providing local anesthesia and should be the medication of choice of IV catheterization pretreatment (Burke et al., 2011). A study involving jet injected lidocaine was also reviewed (Jain et al., 2017). The team collected biweekly data on all IV starts in the emergency department barring any data from patients triaged as level 1. This led to the determination that the same number of IV's were placed on the first attempt with the jet injection and without, however the patients who received the jet injection of lidocaine did not feel pain when the IV was inserted (Jain et al., 2017). The fifth study was titled "A Comparison of the Pain Perceived During Intravenous Catheter Insertion After Injection with Various Local Anesthetics." This study was done by several certified nurse anesthetists Ryan Beck, Frank Zbierajewski and Melissa Barber, along with doctors of medicine Milo Engoren and Robert Thomas (2011). It compared the efficacy of intradermal pain reduction of 1% lidocaine, 1% lidocaine with sodium bicarbonate, 2% chloroprocaine and 0.5 % bupivacaine (Beck et al., 2011). In conclusion, the patients who felt pain upon lidocaine injection also stated they felt pain upon the IV needle insertion. This is due to a persons' unchanged perception of pain from one needle poke to another. The use of lidocaine and other intradermal anesthetics were proven to be effective due to the average pain ratings of the subjects being low. The last study that was examined, in order to analyze the efficacy of intradermal lidocaine was named "Exposure-based Interventions for the management of individuals with high levels of needle fear across the lifespan: a clinical practice guideline and call for further research" (Mcmurty et al., 2016). This study concluded that "...children, their parents, as well as adults suffering from high levels of needle fear value a reduction in their fear" (Mcmurty et al., 2016, p. 226).

Nursing Implications:

What does this mean for nurses and hospitals? To implement this practice further, studies need to be done to decipher exactly what amount of lidocaine is most effective in decreasing pain for IV cannulation. Further studies need to be conducted to compare intradermal lidocaine versus no anesthetic. Will pain be the same as one poke without lidocaine or is the injection of lidocaine prior the most effective way to give patients a painless experience. Once these are determined, education and gaining support from faculty will be key to implementing this new practice.

Bottom Line:

The use of local anesthesia helps reduce patient distress at the time of the procedure, serves to facilitate needle insertion, and helps improve patient satisfaction and hospital experience (Beck et al., 2011). Medical staff should induce as much comfort as possible for the patient enduring needle insertion.

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Growth Suppression: Plausible by Use of Inhaled Corticosteroids in Adolescents?

Kylie Alto, Makayla Crable, Shelby Giesler, University of Mary BSN Students, Kathy Roth, PhD, RN, Assistant Professor of Nursing

Clinical Question:

In preadolescents with mild to moderate asthma do inhaled corticosteroids (ICS) suppress normal growth, as compared to treatment without corticosteroids?

Synthesis of Evidence:

Cochrane released two studies in 2014 related to corticosteroid use in prepubescent children with asthma and its effects on growth. One is titled "Inhaled corticosteroids in children with persistent asthma: dose-response effects on growth" which looks at low versus high dosing of ICS and their effect on the growth velocity in prepubescent children (Pruteanu et al., 2014). This article found a small, but statistically significant, difference in growth over the timespan of one year when comparing doses of ICS. The lower doses of ICS are preferred, but the review strongly recommends continued research to provide better data (Pruteanu et al., 2014).

The second article Cochrane released is "Do inhaled corticosteroids reduce growth in children with persistent asthma" which assessed the functionality of ICS usage on adolescents with mild to moderate asthma (Zhang et al., 2014). The findings of this study suggest that regular use of ICS, or a low-medium daily dose does have an association with reduction in linear growth averaging 0.48 centimeters a year along with a change of 0.61 centimeters in baseline height during the one-year treatment duration. The effects of ICS in prepubescents does ultimately cause some growth suppression, however, it is suggested that the growth size has a strong correlation with the ICS molecule (medication inhaled) rather that the device or dose in the low-medium dose range (Zhang et al., 2014).

The research article "The effects of inhaled corticosteroids on growth in children" showed how growth suppression in children is dependent on dose, device used to take the medications, and the medication itself (Phillip, 2014). The author makes a point to state that in order to minimize possible growth suppression in children of school age, health care providers should give a low dose with the proper device to ensure the child receives the medication effectively. Overall, most studies have found that Budesonide will cause some form of growth suppression in school age children who have asthma. However, it is emphasized many times that more studies are needed to conclude this fact (Phillip, 2014).

Implications for Nursing Practice:

It is difficult to make a clear clinical recommendation due to lack of in depth research specific to the long term effects of ICS and growth. This leads to the recommendations being general, but with an outcry for continued research to give more in depth accurate information. Moving forward it is important that we not only encourage continued research, but simply provide information to medical professionals on the current standards recommended. Along with educating medical professionals, it is important to uphold standards of education for the parents/guardians. Some of the things that are important to teach the parents/guardians are: proper dosages, how to use an inhaler, good oral hygiene, therapeutic effects of ICS, adverse effects of ICS, and the importance of follow up visits that monitor height, weight, and body mass trends.

Bottom Line:

Through this research, healthcare workers should recommend that ICS use be monitored continuously in prepubescent children. Dose and type of medication should be carefully considered before administering. Overall studies show that ICS use in children does more help than harm. With that being said, healthcare providers should be constantly looking for ways to better treatment and lessen possible side effects.

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Heparin vs. Normal Saline: Preventing Occlusions in Central Line Catheters

Elijah Arras, Corbin Horner, Jeremy Johnson, & Zachary Lang, University of Mary BSN Students; Kathy Roth, PhD, RN, Assistant Professor of Nursing

Clinical Question:

In hospitalized patients with central lines, does heparin demonstrate any advantage over normal saline in the maintenance of central lines by measures of prevention of occlusions and prolongation of the life of the catheter?

Review of Literature:

Through the review of the literature concerning heparin and saline based flush solutions, it has been concluded that there is no significant evidence supporting the use of heparin over saline for flushing intravenous catheters. Much of the literature supported the exclusion of heparin due to the possible complications this medication carries when compared to normal saline. An article questioned many aspects of the use of heparin when locking central venous catheters (CVCs). Some of these sources site potential adverse reactions, such as thrombocytopenia, heparin-induced thrombocytopenia, allergic reactions and facial erythema (Brito et al., 2018). Cost is another factor that was examined with most of the studies because using a solution such as saline could save medical facilities a large amount of funds to allocate to other areas of medicine. In the study done by Homo and Lima (2018), they found that in the overall maintenance of central lines it costs $0.90 U.S. less with 0.9% sodium chloride than with heparin. Additionally, it was found that heparin locked CVC's leak approximately 0.65mL of heparin which can inadvertently bolus patients which is associated with increased activated partial thromboplastin time (APTT) (Pepper et al., 2007). "With a heparin line lock concentration of 5000U/mL, approximately 3250 U of heparin may be delivered to the patient as a result." (Pepper et al., 2007, p. 433). This is a significant finding as elevated APTT values greatly contribute to the risk of bleeding.

Nursing Implications:

Given the low quality of evidence suggesting the use of heparin when maintaining patency of central venous catheters, the safety components surrounding the use of heparin in certain patient populations, and cost of heparin locking, it is our recommendation that normal saline continue to be used to lock central venous catheters. If a hospital were to need to change their practice to flushing central venous catheters with normal saline, the information provided above would need to be presented to administration. This would allow for a policy to be implemented within the hospital. Once the policy has been implemented education for each department is essential to ensuring the policy is followed. Education can take place in the form of seminars, continuing education hours, flyers around the unit, emails, posted policy guidelines, and word of mouth from nurse to nurse. The implications of the new policy create minimal changes for nurses, as flushing occurs one way or another for CVCs. Evaluation of this newly implemented policy can be completed through chart audits to determine if the central venous catheters remain patent, the unit costs are decreased, and patients are seeing less adverse effects from heparin.

Bottom Line:

The results have not produced the necessary evidence to use heparin as a safe and cost-effective alternative to normal saline, the safety implications of heparin use pose potentially life-threatening adverse effects. Furthermore, heparin use is subjective in the amount used to improve patency, requiring more research for changes to be made. At this time, the evidence continues to demonstrate that locking central venous catheters with normal saline is effective at maintaining patency, lowering hospital costs, and improving patient safety.

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Supervised vs. Unsupervised Media Effects in Children

Rachael Buechler, Bryce Eckman, & Connie Meziere, University of Mary BSN Students;
Kathy Roth, PhD, RN, Assistant Professor of Nursing

Clinical Question:

In school aged children what is the effect of parental supervised media when compared with unsupervised media on behaviors, lifestyle, and development?

Synthesis of Evidence:

"The internet, the most important communication tool of our time, has rapidly spread throughout the world since its inception and has deeply shaken areas" (Sözbilir & Dursun, 2018, para 1). Social media includes the use of visual and audiovisual mechanisms being used at the same time. This includes sites such as Facebook, Instagram, snapchat, etc. With this new style of media and the increased capabilities of smart phones, it appears that users are starting to use smartphones almost as often as their own clothing items. With the age of receiving a cell phone decreasing, to as young as six years of age, school-aged children are granted access to all kinds of social media at the press of a button, not knowing all the unsupervised harmful things the internet/social media can contain.

For many, media and technology has become the single most important thing in children's daily lives. Behavioral changes seen with the use of unsupervised social media on school aged children include risk taking behaviors, desensitization, aggression, mental health issues, and impaired school performances. It has become a part of their lifestyle and their daily routine, but its impact can be based on whether supervision is present or absent. When supervised, media can positively impact children's lifestyle choice because it fosters open communication between the supervising adult and the child. Certain advertising features present on television or social media accounts may influence lifestyle behaviors, such as obesity. The Foundation Acta Paediatrica published a study, which explored media preferences and use among children, as well as obtained information about parental supervision (Kostyrka-Allchorne et al., 2017). The study found that television remains the favorite source of media, and parents do monitor the content of media that their children are exposed to. Kostyrka-Allchrone et al. (2017) found 'Active' supervision requires parents to discuss media content with children… 'restrictive' supervision imposes rules relevant to the amount of content or exposure.

Many parents might have their child play on the tablet or watch a television show while performing housework. Adults may see the need to limit media content, but there has become a rising problem of limiting the amount of time spent on media content: "Reducing television viewing decreased energy and fat intake in lean adolescents" (Epstein et al., 2008, p. 2). Supervised media is an important influencer for decreased body mass index in children because the adult is active and restrictive in supervising the amount of time spent on tablets, TVs, and videogames (Epstein et al., 2008).

When there is a lack of supervision, there is a lack of discipline in lifestyle choices. Children's dietary intake might increase while viewing TV or might be influenced by the food commercials that are running: "foods commonly advertised, such as sweet baked snacks, candy, fast food entrées, salty snacks, and sugar-sweetened beverages, mediated the relationship between television viewing and changes in total energy intake" (Ford, Ward, & White, 2012, p. 5). Within the study, adverse dietary outcomes were seen with as little as one hour of daily television exposure. These results are consistent with the recommendations made by the American Academy of Pediatrics (AAP), "which has called for a reduction in television viewing in children as one strategy to prevent childhood obesity...the AAP recommends that children two and older limit total media time to 1-2 hours daily" (Ford et al., 2012, p. 2).

The American Academy of Pediatrics "discourage the use of media by children under the age of two" (Kabali et al., 2015, p. 1045). This is due to the extensive development that occurs in young children, and media usage is increasing in younger children. A young child's early adoption of media can impact a child's development and literacy. When a parent is involved in the supervision of media for a young child it can enhance the impact of educational shows and games. Often times, adults are engaged in their child's media exposure in order to protect them from inappropriate content, but it can also be a great way for the parent to take an interest in the child's development and literacy skills. Kabali et al. (2015) conducted a study that examined a young child's (aged six months to four years) exposure to and use of mobile media devices. It was found that many parents were allowing their children to utilize technology for reasons such as to keep them preoccupied while performing chores, keep them calm, or to assist them at bedtime. This is why it is essential that media is supervised by the adult, and utilized to benefit the child, rather than used as a "digital pacifiers to placate or distract children" (Kabali et al., 2015, p. 1047).

When exposed to media unsupervised in early childhood, there can be developmental issues, such as deficits in attention and language delays. A study published in the *Journal of Development and Behavioral Pediatrics* looked at excessive screen media exposure in children and its association with self-regulation difficulties, such as a child's ability to delay gratification and ability to wait. They found that an increase in self-regulatory behaviors were linked to a "lower risk of substance abuse, social competency, and higher cognitive abilities" (Munzer et al., 2018).

Bottom Line:

There are many studies that explain how the era of technology is becoming an issue when looking at the impact it has on our youth's safety and development. When supervised, children can be protected from the dangers that media poses. When unsupervised, children are experiencing the detrimental effects, such as increased behavioral problems, increased risk for unhealthy lifestyle behaviors, and decreased development in literacy and cognitive thinking. When an adult is involved in a child's media exposure, it makes it an opportunity for learning and growth, rather than leading to risky or detrimental health behaviors.

Nursing Implications:

Nurses have the ability to improve support for parents or caregivers by providing pertinent information related to improvements in self-esteem for personal health behaviors of school-age children. The recommendations for this epidemic revolve around safety measures that still allow privacy to the child. The American Academy of Pediatrics (AAP) provides guidelines that help parents guide their children and their use of social media versus spying on them and leaving them with no privacy (Miller, 2011). Some of the recommendations include discussing with their children about bullying situations, potential sexual predators, exploiting personal information on social media, and dangerous relationship opportunities that can arise from the use of social media (Miller, 2011). Developing linkages with supportive community based resources, and focusing on improving behaviors and quality of life may lead to better results and improved behavior patterns. Steps that can be taken to overcome barriers and identify linkages may include: PTA meetings for parents within the schools to help bring awareness to the problem, school nurses or counselors can provide teaching sessions to the students in a school setting, and begin to incorporate education about social media awareness in after school programs. Future research examining health-promoting behaviors in children needs additional factors related to how children make decisions about dietary intake, physical activity, and help avoid risky behavior (Chenchob, 2013).

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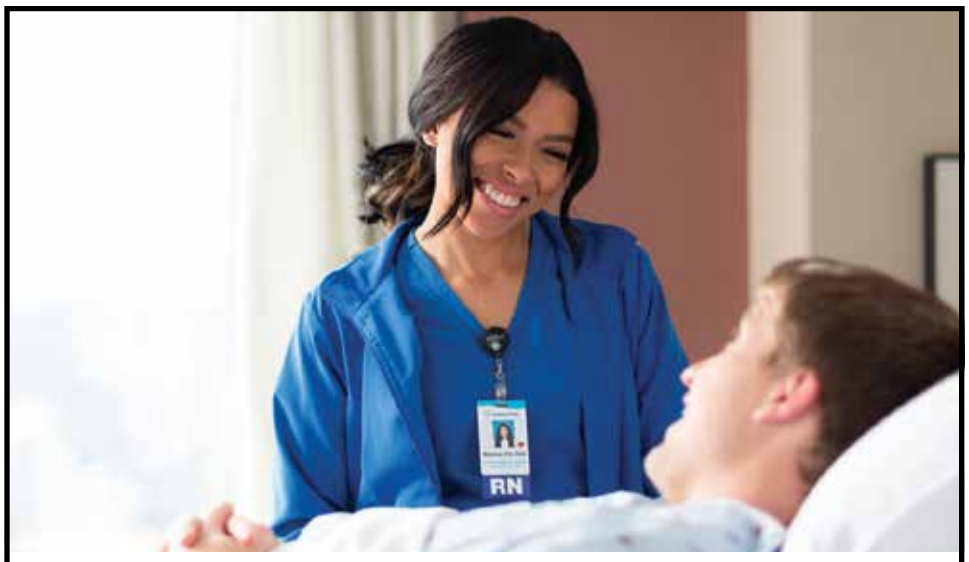

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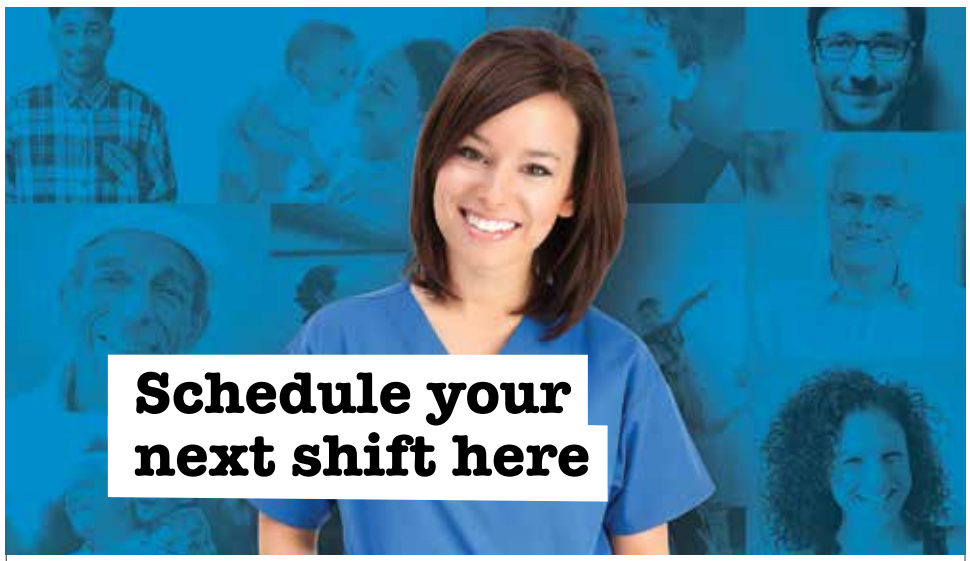

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