Dear dedicated and brave nursing professionals:

We are reaching out on behalf of the Arizona Nurses Association (AzNA) to let you know we are thinking about you, support you, and stand with you during this exceptionally challenging time.

The world is experiencing a historic public health crisis and nurses are stepping forward to do what they do best: care for patients and save lives. Many will never fully comprehend the level of hard work, selflessness, and sacrifice it takes to do what you do on a daily basis – let alone during a global pandemic. While none of us are in this for glory and attention, it is clear more Americans and Arizonans are recognizing every day that nurses like you are the beating heart of our healthcare system.

Our message to you is simple: keep doing what you do every day while being vigilant about your own health and safety. Your patients will always come first, but their health and well-being ultimately depends on yours. Take care of yourselves. Stay as well-rested as possible. Wash your hands a little bit longer. Eat healthier. Of course, follow all state and federal guidelines when caring for potential and confirmed COVID-19 patients.

As we all know, the PPE situation is problematic. Though there is a massive public-private effort underway to secure additional protective equipment, the Arizona Department of Health Services acknowledges the “current expectations for re-supply are low.” AzNA will continue to advocate for appropriate PPE usage guidelines so that Arizona nurses are able to do their jobs safely and effectively.

Thank you for all you do – and for making us proud.

Stay well,

Selina Bliss, RN
President
Arizona Nurses Association

Robin Schaeffer, RN
Executive Director
Arizona Nurses Association

NURSE PRIDE
Arizona's state school nursing programs create proud nurses with unique stories.

Donna H. is proud to display on her tag that she is a nurse in the great state of Arizona.

Charlie C. is an RN, CCRN and hopes you like the plate. Charlie celebrates certification all year with this plate.

Greg S. got this plate for his wife for her RN graduation 15 years ago. Every time she sees Az Nurse, she comments on how she should send in a picture. Greg sent in Shelly’s plate to hopefully surprise her again after all her years of being a fantastic nurse.

Arizona’s state school nursing programs create proud nurses with unique stories.

Do you have a nurse pride license plate you want to share? Send it to info@aznurse.org. You might be on our next front page!
Surgical Smoke is No Joke!
Let’s Clear the Air!

Tamara Uhler, RN and Alana Schmitt, RN

Would you smoke in the operating room? Of course not! Yet, every day up to 500,000 health care providers are exposed to surgical smoke, which is equivalent to smoking up to 27-30 cigarettes a day (Ball, 2012). Chronic exposure to surgical smoke can lead to an increased risk of respiratory illness, Parkinson’s disease, Alzheimer’s, collagen and cardiac disease, and lung, breast, and prostate cancers (Schultz, 2014).

Surgical smoke, or smoke plume, is a by-product of the electrocautery devices and lasers used in surgical procedures and cesarean sections. Surgical smoke contains harmful chemical compounds, such as benzene and formaldehyde, which are known to be strong carcinogens (York, 2018). Smoke evacuation systems are effective in limiting exposure to surgical smoke, but they have not been routinely used in the OR. While professional organizations have been aware of this issue, little has been done to mandate the use of smoke evacuation equipment (Dobbie, 2017).

As an experienced OR nurse, I became passionate about the health and safety of patients and staff exposed to surgical smoke. I accepted an opportunity to participate in an EBPresearch fellowship program offered by Banner Health. I began with the PICO question, P-in the operating room, it- does staff education about the dangers of surgical smoke, C-as compared to current awareness, O-renforces the staff’s willingness to use smoke evacuation equipment.

Through a literature review and talking with my peers, I identified several barriers within the clinical setting that could prevent the implementation of a smoke-free program: lack of information and education regarding the hazards of surgical smoke, physician and team members’ resistance to change, and the higher cost associated with smoke evacuation equipment.

I began by gathering a team who were also passionate about smoke evacuation. I found an influential surgeon and team members who were willing to help facilitate change. We worked with our supply vendors to choose a device that would be easy to use and was similar to the electrocautery device we were already using.

At a department staff meeting, we administered a pre-test to assess the OR staff’s knowledge about the dangers of surgical smoke. I was surprised to discover that most of our staff were not aware of the dangers of surgical smoke. We scheduled an in-service to discover that most of our staff were not aware of the dangers of surgical smoke. We were surprised by the result of the pre-test to assess the OR staff’s knowledge about the dangers of surgical smoke. We were surprised by the result of the pre-test.

To raise awareness, we distributed pens with our slogan “Surgical Smoke is No Joke. Let’s Clear the Air.” We placed posters on the walls throughout the operating room area discussing the dangers of surgical smoke and the chemicals contained in the smoke. Many of our surgeons were resistant to trying the new devices, but we persisted in trying to change practice.

Our data showed that by increasing awareness of the dangers of inhaling surgical smoke, we observed an increase in the use of smoke evacuation equipment. The pre and post-test scores increased from 67% to 87%. Chart audits revealed the use of smoke evacuation equipment increased from 12.5% to 41% after implementation.

Maintaining a smoke-free environment is a challenge. The surgeons and OR staff must be committed to providing a healthy environment for our staff and patients. Banner Health now has created a system task force to implement smoke evacuation equipment in all its facilities. Becoming a smoke-free environment is a possibility, it just takes hard work and a passion to drive change.

References:
Ball, K. (2012). Compliance with surgical smoke evacuation equipment. The pre and post-test scores increased from 67% to 87%. Chart audits revealed the use of smoke evacuation equipment increased from 12.5% to 41% after implementation. Ball, K. (2012). Compliance with surgical smoke evacuation equipment. The pre and post-test scores increased from 67% to 87%. Chart audits revealed the use of smoke evacuation equipment increased from 12.5% to 41% after implementation.


Submit your article or research for publication in A2NA’s quarterly print publication. The Arizona Nurse is mailed to all 89,000+ RNs in the state.

A2NA welcomes submission of nursing and health related news items and original articles. We encourage short summaries and brief abstracts for research or scholarly contributions with an emphasis on application.

To promote inclusion of submitted articles, please review the article guidelines available on the A2NA website at www.a2na.org.

An “article for reprint” may be considered if accompanied by written permission from the author and/or publisher as needed. Authors do not need to be A2NA members.

Submission of articles constitutes agreement to allow changes made by editorial staff and publishers. See article guidelines for more information.

Submit your article to info@aznurse.org.

April, May, June 2020

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What’s the Catch?

The other day, I was chatting with one of the nurses in the medical-surgical unit at our local hospital and asked her what she thought about AzNA offering the Success Pays Program for Arizona nurses. I was referring to my President’s Message from the October 2019 edition of the Arizona Nurse where we rolled out information on the Success Pays Program. Her response was that when she read about this program she thought it was too good to be true and wondered what the catch was?

This conversation made me realize in our day-to-day world, when so much is thrown at us, sometimes important opportunities can slip by.

Simply put, the Success Pays Program is a no-risk opportunity to earn a certification in the specialty of your choosing from the American Nurses Credentialing Center (ANCC). You can take the exam twice and only pay if you pass. As a bonus, to kick off the program in Arizona, the Sasmor Foundation is covering the cost for the first ten applicants who pass in 2020 and each year after. For those of you already certified by the ANCC, you can renew your certification for a reduced rate.

Go to the AzNA website and click on Membership to see the link for information on the Success Pays Program. Now that we are a couple of months into the year 2020, I am happy to report that 11 nurses have taken advantage of this program. Of the 11 nurses, six Arizona nurses have earned initial certification and to date, none have renewed their certifications through the Success Pays Program.

We just celebrated National Certified Nurses Day which is observed every March 19th. This day of recognition provides an opportunity for employers, certification boards, education facilities, and healthcare providers to celebrate and publicly acknowledge nurses who earn and maintain the highest credentials in their specialty. While our RN license allows us to practice, certifications affirm advanced knowledge, skill, and abilities to meet the challenges of nursing. I urge you to take advantage of this opportunity from AzNA to advance your nursing career by choosing certification. Then next year you can enjoy National Certified Nurses Day which honors and recognizes nurses and their significant achievements in the profession.

Personally, I was inspired to earn the Medical-Surgical Certification (RN-BC) by another nurse on our unit who had taken and passed the exam and proudly wore the initials of her certification on her name badge. Perhaps you will unknowingly inspire another nurse to achieve certification. Make it a priority in 2020 to take the next step in your career and get certified. The catch is you advance your career while promoting positive patient outcomes. It is a win-win situation for you, your employer, and the patients you care for!

Until next time,

Selina Bliss, Ph.D., RN, CNE, RN-BC, ANEF
Congratulations to the following nurses who have taken advantage of the Success Pays offering by ANCC to AzNA Members!

- Elizabeth Garrison, RN-BC; certified Nursing Professional Development
- Melania Kamler Flores, RN-BC; certified Nurse Executive
- Lori Williams, RN-BC; certified Informatics Nurse
- Lisa A. Palucci, RN-BC; certified Nurse Executive
- Robert William Adams, RN-BC; certified National Healthcare Disaster
- Terry Watson, RN-BC; certified Adult-Gerontology Acute Care Nurse Practitioner

AzNA partners with the American Nurses Credentialing Center (ANCC) using the Success Pays Program to support professional development of nurses, increase the number of certified nurses in the workforce, decrease test-taking anxiety and reduce financial burden for our members.

Take the exam up to two times and pay the reduced rate of $260 only if they pass the exam.

Save time, money and anxiety.

Certifications with ANCC can also be renewed through AzNA at a reduced price of $250.

Success Pays is offered to all AzNA Members. Not a member? Join today aznurse.org/JoinToday

Mindfulness
Learn scientifically proven skills to reduce stress in your life. This stress management course can show you how to immediately start applying your new mindfulness skills to your daily life.

Nutrition
This course covers the current state of nutrition practices, eating styles and diet trends. You can also elevate your knowledge of the connections between physical and mental well-being.

Sleep
This course will help you develop better sleep habits by studying your sleep health and learning sleep strategies that can improve the quality and consistency of your rest.

Physical Activity
This course provides evidence-based approaches to physical activity. Expert interviews and short tutorials are included, as well as knowledge checks and personal challenges.

Whole Person Well-being
Learn how well-being relates to the workplace, financial health practices, trauma, grief, self-care and even pets, and discover how caring for your time and energy can be practical and effective.

Learn more at: links.asu.edu/well-being
Nurses are running for office: why it is critical to have nursing represented in our COVID-19 pandemic.

As our community is feeling the effects of the COVID-19 virus outbreak, it is a time when nurses and frontline health providers are tasked the greatest. Yet, as in any crisis, nurses continue to step up and provide the leadership and expertise that we need to get through these difficult times. It is during these times, that we often look to government to make honest and rational decisions (nurses call these “evidence-based” decisions) that can help us manage and mitigate the effects of the COVID-19 pandemic.

Never before have the stakes been higher. That is why it is critical to have nursing represented in our state legislature! This fall, two Arizona Registered Nurses are running for office:
- LD 1 – Selina Bliss, RN
  https://sites.google.com/view/SelinaSBliss-Com
- LD 6 – Felicia French, RN
  https://www.frenchloraz.com/

The AzNA PAC is proud to early endorse these two candidates and asks for your help in getting them elected. Here’s what you can do:
- Vote
  Make sure you know the dates for the primary election (August 4, 2020) and the general election (November 3, 2020). Put them on your calendar and tell your friends and family!
- Support the nurse candidates’ campaigns no matter where you live!

The purpose of the AzNA PAC is to endorse candidates for the Arizona Legislature based upon the principles of the AzNA Public Policy Agenda.

PAC Chair - Colleen Hallberg, MSN, RN
(43hallerberg@gmail.com)

A Mother’s Love

Angela C. Brittain, RN

My mother died from cancer when I was 9 years old. I was so impacted by the nurses who provided her care and knew that this was my purpose. I have been a nurse for 22 years and will graduate in August with a Ph.D. I wish to transform healthcare through teaching/mentoring the next generation of nurses and advocating for environments that help them nurse well. Although my journey has not been an easy one, it has been joyful as I get to do what I truly love.

A mother’s love and affection pervade the expanse of time,
Reaching across the waters that separate the living from those now gone.
Her legacy persists in the hearts of those whom she loved,
Giving birth to a vision of what might yet be.

A daughter dismayed upon learning her mother’s plight,
For cancer, a dreaded foe had staked its claim on the one she loved.
But the strength of a vile enemy quickly stole bits of her away.

Treasured nurses rendered care to this beloved mother,
Giving full care, love, compassion, and skill
While the daughter watched with wondering eyes and open heart,
Filled with knowing that she too would someday give such care.

Now betwixt times past and present, though one’s spirit has taken flight,
A mother’s love intertwined with nurses’ devotion
Has made the way for a once young dreamer’s vision.
For she is now too, a nurse valiant and strong
Paying forward the everlasting care, love, compassion, and skill.
Ever onward, always forward, never doubting, full of joy.
Life’s purpose from the dawn of time - to love and be loved,
To gladly serve those in need.

All precious and worthy, regardless of color, code, or creed.

Angela C. Brittain, MSN, RN is a PhD candidate at the University of Arizona College of Nursing.
A Day in the Life of One Arizona Midwife

Maria Sienkiewicz Lennon, RN

It’s 7:00 am on a cold winter morning and snow flurries are flying around as the day dawns. Walking to the hospital in thin scrubs the freezing wind is a bit of a shock to the system. It’s nearly time to start the day shift as a Certified Nurse Midwife at Tuba City Regional Health Care Corporation (TCRHCC), a 70-bed hospital in very rural northern Arizona, located on the Navajo Nation.

Of the 10,483 advanced practice nurses in Arizona, Certified Nurse Midwives (CNMs) make up about 3% of the total. There are 283 of us. The largest majority live and work in the Phoenix metro area, but there are a fair number of us who live and work in rural areas far from tertiary care medical centers. CNMs care for women of all ages – from those entering womanhood to great-grandmothers; from all walks of life, all socio-economic groups. We are women’s health providers who care for women throughout the lifespan.

7:30 am: The CNM from night shift gives report on the patients on the unit. There is one patient in labor; one mother who gave birth an hour ago and is experiencing heavier than normal bleeding; three other postpartum patients, one of whom is experiencing difficulties breastfeeding a sleepy, late preterm baby; and a 28-week pregnant patient in triage who has just arrived and is complaining of severe back pain. I am precepting a second-year midwifery student today; she and I put our heads together and quickly make a plan to tackle the day.

The World Health Assembly has designated 2020 as the “Year of the Nurse and Midwife.” This is a year of celebrating what we do and examining the challenges we face. Certified Nurse Midwives work in various practice settings all over Arizona: private practices, hospital-based practices, birth centers, and home birth practices. We work as faculty in higher education teaching midwifery and medical students, in Federally-Qualified Health Clinics and for the government in tribally owned and Indian Health Service facilities. Our practices are as diverse as our individual personalities.

9:30 am: Rounds made; labs reviewed. The patient who was bleeding has improved but still bears close watching. Antibiotics were started on the 28-weeker who has a UTI. The mother with the late preterm infant needed quite a bit of support and assistance with breastfeeding. We communicated the plan to the pediatrician. Our laboring patient is a high-risk induction of a primigravida at 37 weeks due to pre-eclampsia with severe features. We checked in with the OBGYN who is on call.

Our practice is an evidence-based midwifery practice of seven Certified Nurse Midwives. It is somewhat unique in that we care for a mixture of both healthy, low-risk patients, and pregnant patients who have high-risk conditions such as gestational and type-2 diabetes, pre-eclampsia and other hypertensive disorders, and other co-morbidities. We work as a team with five ObGyn physicians who are available when needed for consultations, assistance, and surgery. Our cesarean births are done on the unit and the CNM working labor and delivery serves as First Assistant.

11:00 am: Two discharges completed. One patient lives two hours away on the other side of the Hopi reservation. We will coordinate with the Hopi Public Health Nurses to visit the mother and baby at home for the weight check since the patient and her family plan to participate in a cultural ceremony which requires that the mother and baby stay home for twenty days after the baby’s birth.

Tuba City Regional Health Care Corporation provides services to a 6000 square mile area and serves as a referral center for the western part of the Navajo and Hopi reservations. Native American tribes located and served here are the Navajo, Hopi, and Southern Paiute. Providing individualized, culturally sensitive care is a priority for the midwives in our practice.

12:00: Two midwives who have been in clinic all morning come over to the midwifery office on L&D to eat lunch and to discuss some of the day’s patients and to plan for those who may come in to give birth in the coming days. During our discussion, a physician at one of the outlying clinics 75 miles away from Tuba City, calls and has a patient in labor who needs to be transferred to our hospital for delivery.

1:30 pm: A mother and baby discharged from the hospital two days ago have returned for the baby’s scheduled weight check. I show the student midwife how to assess the four-day-old baby’s weight, level of jaundice, and observe breastfeeding for effectiveness. We teach the mother signs that breastfeeding is going well, when assistance is needed and set an appointment for her to return to Pediatric clinic for a two-week checkup.

TCRHCC is proud to be one of only six hospitals in Arizona designated as a Baby-Friendly hospital. The Baby-Friendly Hospital Initiative is a global program that was launched in 1991 by the World Health Organization and UNICEF to encourage and recognize hospitals that offer optimal evidence-based practices for infant feeding and mother/baby care.

3:05 pm: The helicopter arrives with the transfer. Our patient is a 39 yo G7 P4 at 39 4/7 weeks gestation, VSSA, normotensive, seven cms dilated, in active labor, and contracting every three minutes. Once she is admitted, the lights are turned down low and the mother labors in the room with her close family - including two of her daughters - in attendance. She progresses...
quickly and the student nurse midwife attends the birth under my close supervision. The baby is placed on the mother’s abdomen, gently dried, and after the umbilical cord stops pulsating, the father of the baby proudly cuts the cord. The baby is left undisturbed, skin-to-skin on the mother’s chest, until after the first breastfeeding. The nurses quietly take vital signs and assess both mother and baby as they rest after birth.

The number of CNM-attended births continues to rise. In 2017, we attended 351,968 births - 9.1% of total US births.

4:50 pm: The patient we are inducing for preeclampsia is uncomfortable and requesting an epidural for pain management. The Pitocin is infusing at 14 milliunits per minute, her contractions are every two minutes, the electronic fetal monitoring strip is Category 1, and her cervix is six centimeters. Anesthesia is on the way to see and evaluate our patient for pain management.

Many organizations in the United States and around the world are committed to reducing the steadily rising C-Section rates. In 2017, the national rate was 32%, the rate in Arizona was 27.5%. Nearly one-third of all babies are born via surgery! Our steadily rising C-Section rates. In 2017, the national around the world are committed to reducing the total US births.

We care for women throughout the lifespan, with a special emphasis on pregnancy, childbirth, reproductive health, and gynecology. We also provide a broad range of essential health services in local communities and throughout the state.

Tomorrow will be a day in the clinic – an 0800 to 1700 day. The schedule is packed with prenatal visits, NSTs and ultrasound for high risk women, collaborating with OB/GYN and perinatologists regarding care of high risk women, well-women visits, annual exams, and problem visits.

The American College of Nurse Midwives (ACNM), our professional organization, sets the scope of practice, the number of CNM-attended births continues to rise. In 2017, we attended 351,968 births - 9.1% of total US births.

Different Types of Midwives in Arizona

<table>
<thead>
<tr>
<th>Midwife Type</th>
<th>Education Required</th>
<th>National Exam</th>
<th>Licensed/Regulated</th>
<th>Professional Organization</th>
<th>Scope of Practice</th>
<th>Prescriptive Authority</th>
<th>Care Setting</th>
<th>Medical Physician Affiliation</th>
<th>Hospital Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Nurse Midwife (CNM)</td>
<td>Advanced Practice RN, Masters or Doctorate</td>
<td>Yes, American Midwifery Certification Board (AMCB)</td>
<td>State Board Nursing</td>
<td>American College of Nurse Midwives (ACNM)</td>
<td>Pregnancy Birth Newborn Gynecology Women’s Primary Care</td>
<td>Yes</td>
<td>Hospital Clinic Birth Center Home</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Certified Midwife (CM)</td>
<td>Masters or Doctorate</td>
<td>Yes (AMCB)</td>
<td>Not yet licensed in Arizona</td>
<td>ACNM</td>
<td>Pregnancy Birth Newborn Gynecology Women’s Primary Care</td>
<td>Yes</td>
<td>Hospital Clinic Birth Center Home</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Certified Professional Midwife (CPM)</td>
<td>High School or GED</td>
<td>Yes, North American Registry of Midwives (NARM)</td>
<td>Department of Health Services</td>
<td>Midwives Alliance of North America (MANA)</td>
<td>Pregnancy Birth Newborn</td>
<td>No</td>
<td>Birth Center Home</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Licensed Midwife (LM)</td>
<td>High School or GED</td>
<td>No</td>
<td>Department of Health Services</td>
<td>MANA</td>
<td>Pregnancy Birth Newborn</td>
<td>No</td>
<td>Birth Center Home</td>
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<td>No</td>
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<tr>
<td>Lay Midwife</td>
<td>None</td>
<td>No</td>
<td>Not licensed</td>
<td>None</td>
<td>Pregnancy Birth Newborn</td>
<td>No</td>
<td>Home</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Lila Kreibich Van Cuyk has lived and worked as a nurse in Arizona since 1995. What makes her unique is that she was in the first class admitted to the Walter Reed Army Institute of Nursing (WRAIN). WRAIN was developed by the Army as a baccalaureate program in nursing in cooperation with the University of Maryland to meet the demand for nurses due to the escalation of the Vietnam War. As members of the military, students received tuition and expenses, uniform allotment, and housing. Graduates of the WRAIN program were obliged to serve in the military or essential civilian or other federal government services for a specified period of time, usually the length of time they had been in training.

Prior to WRAIN, the Army developed two programs to meet the increased need for nurses due to war. During World War I, the Army created the Army School of Nursing. These nurses were educated in military hospitals but were not members of the military. In World War II, a different strategy was used. The Cadet Nurse Corps, supervised by the United States Public Health Service, focused on accelerated training of nurses to increase the numbers of nursing students to provide care in hospitals freeing graduate nurses for military service.

Of the 1000 individual applicants to the WRAIN program, 135 were selected, including 17-year-old, Lila Kreibich of La Crosse, Wisconsin. In high school, Lila was an exemplary student, consistently on the honor roll while participating in various clubs and organizations. Lila applied to the program because she wanted a college education which her parents could not afford. Lila began the WRAIN program in 1964 and was inducted into the Army prior to starting classes. Basic pre-nursing courses could be taken wherever the student was accepted. Private First Class Kreibich enrolled as a student at Saint Teresa College in Winona, Wisconsin. At the end of two years of coursework, she transferred to Walter Reed Medical Center in Washington, DC, and began nursing courses. The combined program lasted four years including three summers. Clinical rotations were largely at Walter Reed and included taking care of some of the 200-250 critically injured soldiers who were evacuated from Vietnam and arrived each week. The obstetrics and pediatric rotations occurred at other military hospitals where military dependents were treated. In addition to typical nursing classes, as members of the military, Lila and her classmates had experiences necessary for the Army which included physical training and setting up a field hospital. Upon completion of the program, the graduates were commissioned as Second Lieutenants in the United States Army. Following graduation, Lila and her classmates went to Ft. Sam Houston in San Antonio, Texas for basic training.

Soon after graduation, Lila married her husband who was stationed at the same base. She was promoted to First Lieutenant and worked in the nursery in the hospital at Fort Knox, Kentucky until she became pregnant. At that time, pregnancy resulted in an automatic discharge. First Lieutenant Van Cuyk was discharged in August of 1969. Her husband was discharged in September of 1970.

Lila and her family moved to Phoenix in 1995. She obtained a certificate in health management and worked in a variety of settings as a clinical manager in a local hospital, team leader in a hospice, MDS coordinator for the Arizona State Veteran’s Home, long-term care surveyor for the Arizona Department of Health, and in Quality Improvement for eight retirement centers. For the last five years of her work life, she was an Education Consultant for the Arizona State Board of Nursing. Lila retired in 2011.

WRAIN provided valuable knowledge and skills which launched a nursing career. Lila is grateful for the opportunity to become a nurse that the Army provided and from which the citizens of Arizona benefited.

Shannon E. Perry, RN, PhD, FAAN is a long-time AzNA member and is passionate about the history of nursing in our state and nation.

*Based on Perry, S.E., WRAIN, the Walter Reed Army Institute of Nursing: An Oral History, a Poster Presentation at the American Association for the History of Nursing Conference, Dallas, TX, September, 2019.
New & Returning AzNA Members
December 2019 – February 2020

Anthem
Karen Cox
Sherry Razoo

Avondale
Daisy Hernandez
Nicole Jojola

Buckeye
Brenda Correa
Tiffany Meintel

Casa Grande
Courtney Hill

Cave Creek
Elizabeth Sharpe

Chandler
Linda Alvarez
Anqi Chen
Elisa Martinez
Melissa Nicklaus
Jennifer Pace
Michelle Quinton
Ester Ruiz
Thomas Scarpellino
Nikki Scheffner
Rachel Wilkins

Cottonwood
Jason Litzinger
Gina Rinehart

El Mirage
Amy Todoran

Flagstaff
Shay Davis
Sarah Jaquith
Barbara Matook
Maureen McGarrity-Yoder
Rachel Minton

Gilbert
Nneka Aguwamba
Gloria Brooks
Sheree Dabrowski
Farheen Khan
Laura Mendonsa
Michelle Neal
Neerja Sethi
Amanda Stanford

Glendale
Kaylin Muscato
Kathy Nelson-Hawks
Catherine Samuel-Ojo
Shannon Santo
Ha Seung
Martin Smith

Golden Valley
Sheri Donald
Christie Yingling

Goodyear
Angela Davis-Taylor
Elaine Jewett
Sandra Maas
Kimberly Monti
Patricia Navarro

Kingman
Miranel Macaranas
Carrie Sparkman
Sarah Stacks

Lake Havasu City
Marie O’Haver
Susan J. Zarp

Laveen
Valery Ayafor
Nkendong
Annalyn Rasul
Shanik Wornack

Litchfield Park
Vickiyn Alvey
Helena Hoover
Yvonne Maeae
Caesar Rangel

Marana
Amy Carlson
James Frke
Jean Folariin
Karina Navarro

Marcopa
Brenda Butron
Erika Scott

Mesa
Tyler Aman
Cynthia Arredondo
Paramo
Vicky Castillo
Theresa Chmidling
Cathy Guinan
Holly Hanson
Donna Hornyak
Donald Huemiller
Rebecca McDowell
Lisa Price
Annie Seitz
Janine Sutter
Suzanne Walker
Janice Wentworth

New River
Michelle Figueroa
Sarah Giunta

Oro Valley
Brett Curran
Amanda Hatch
Antonia Landau
Michelle McNally

Paradise Valley
Shannon Myers

Parker
Amythest Osuna

Peoria
Shari Davis
Rosie Davis
Christa Goodwin
Meaghan Green
Amory Godwin
Grijaldo
Mindy Madoski
Melissa Pachak
Katherine White

Phoenix
Elena Aminov
Tiffany Benton
Amy Blanchard
Robin Burkell
Alana Callingham
Margaret Capozzi
Abbie Davis
Lettie Debber

Pima
Marjane Poindexter
Prescott
Jacqueline Hall

Pamela Lusk
Joseph Rodriguez

Queen Creek
Agneszka Pisia

Safford
Keisha Thompson

San Tan Valley
Mindy Beck
Rebecca Riley
Felicia Straughter

Scottsdale
Shannon Burney
Chelsea Cannon
Kaleigh Crozier
Samantha Holiday
Sheila Janisch
Alexa Kucharo
Alyssa Lehn
Michelle Mulady
Julie Mulroy
Natalia Sneathes
Donna Tew
Steve Thompson
Katie Walsh
Caitlin Woerner

Sierra Vista
Arleene Djordjevic

Snowflake
Deborah Huish

Springerville
Pam Lowry
St. Michaels
Lorraine Kelwood

Surprise
Bose Anifowose
Diane Punnell
Melinda To

Tempe
Maya Ogden
Lindsey Triemstra
Teresa Tuznik

Tohono
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Decode Delirium: Evidence Based Practice Findings

Maria Nnaji, RN
Karen MacDonald, RN (Mentor)
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Mary Rivero, RN

Patients 65 and older in the United States now comprise about 50% of surgical patients and due to their age, are at higher risk for post-operative delirium (PD). Delirium is a preventable disorder, but it is not well understood by medical professionals. There are three types of delirium: (1) Hyperactive (2) Hypoactive (3) Mixed. Hyperactive is displayed as heightened arousal such as climbing out of bed or pulling at catheters. Hypoactive is displayed as lethargy or lack of responsiveness. Mixed delirium is a vacillation between the two forms. Identification of delirium risk factors by the Perianesthesia nurse is imperative to preventing PD.

We asked the PICO question: “Among geriatric patients age 65 or older being admitted for surgical procedures, does the use of a preoperative delirium risk assessment tool compared to the standard use of clinical judgment result in the identification of patients at risk for postoperative delirium?” A review of the literature identified 25 common risk factors from which we developed a “Delirium Screening Tool” for use by perioperative nurses. This simple checklist and rating system enabled staff to subsequently intervene to reduce the likelihood of postoperative delirium. The tool selected was adopted because it provided the easiest transition for the current workflow of the bedside nurse. The screening tool requires the nurse to check off risk factors for the patient and if three or more risks are identified then a Confusion Assessment Method (CAM) would be conducted. The CAM is the best tool to assess for the presence of delirium. When we searched for the CAM tool in our current electronic medical record (EMR), the screening tool requires the nurse to check off risk factors for the patient and if three or more risks are identified then a Confusion Assessment Method (CAM) would be conducted. 

Delirium assessments were conducted in a 342-bed community hospital based in Arizona that has a large geriatric population, between October 2019 and December 21, 2019. As the nurses began using the tool, they expressed a heightened awareness of the risk factors for delirium and recognized the rationale for the interventions they currently practice, which have a more comprehensive role in preventive delirium in this vulnerable patient population (such as making hearing aids and glasses available postoperatively). These preventive strategies are nurse-driven and non-pharmacological in nature. Of the 129 patients assessed, 109 (84%) scored as moderate risk and 14 (11%) were high risk. These findings confirmed that our patient population was at risk for PD and the assessment tool did identify the patients at risk. The literature estimates that the cost of a single case of delirium is $16,000- $64,000/year, whereas preventive strategies are estimated at $6,000 for a single case per year.

Hypothetically speaking, if every one of the 109 patients that scored as moderate risk for delirium experienced an episode of PD, it would cost an organization approximately $1,744,000- $6,976,000/year, compared to implementing a multidisciplinary preventive approach of $654,000/year. This would be a cost savings of $1,090,000-$6,322,000 over the course of the year; all while decreasing mortality and providing exceptional patient care.

This project allowed us to engage our staff in the process of bringing EBP to the bedside to affect patient outcomes and improve our patient care. In the future, we hope to build on this foundation and begin collecting data from rapid responses, code grays, and stroke alerts to identify possible delirium cases with the use of this screening tool.

For nurses in other institutions across Arizona, we recommend the following for implementing a similar tool:

- Step 1: Identify your target patient population
- Step 2: Conduct a literature search using keywords such as Postoperative Delirium, screening tool, risk factors and target population i.e. (Pediatrics, geriatrics)
- Step 3: Analyze literature several times to get a deeper understanding of what information is needed for your tool
- Step 4: Create the tool that fits best into the bedside nurses’ workflow, and mimics questions or data that they are already collecting or should be collecting
- Step 5: Make sure to get buy-in from your leadership and physicians
- Step 6: Make sure to make it fun and engaging for staff

References available upon request

Maria Nnaji RN, MFA (Fellow); Karen MacDonald MSN, RN, CNOR (Mentor), Kris Gomez BSN, RN, Mary Rivero BSN, RN

Note: Partially funded by Banner Better Together Nursing Development Fund for EBP Fellows
Dementia Awareness in Hospital Settings

Angela M. Allen, RN

There is an estimate of 5.8 million Americans living with Alzheimer’s disease and other dementias. The annual number of cases of Alzheimer’s and other dementias is projected to double by 2050 (Alzheimer’s Disease Facts and Figures, 2019). It is estimated that 25% of older-aged hospitalized patients have some form of dementia (Maslow, 2006). These patients admitted into hospital settings have poorer outcomes as it relates to their length of stay, increased mortality and further institutionalization (Calnan et al., 2012). Furthermore, this group of patients requires more nursing hours of care and is more likely to have delayed discharge, which may result in a decline in health and an increase in hospital costs. One reason related to the poor outcomes is the lack of awareness, understanding, and attitude from hospital staff in providing appropriate care. The primary objective of this study was to assess the hospital staff’s knowledge and attitude of dementia.

Aim

A multidisciplinary team of hospital staff who participate in a 60-min educational dementia presentation will demonstrate an increase in awareness, understanding, and an improved attitude toward dementia patients in a hospital setting.

Method

Two hundred and seventy-three hospital staff in a large healthcare system participated in a quasi-experimental design program. The program evaluation was conducted to examine changes in their knowledge and attitude of dementia patients in an inpatient setting. A two-part valid and reliable instrument named Questionnaire in Palliative Care for Advanced Dementia (qPAD), originally developed in 2006 (Long et al., 2012), was used to measure staff’s knowledge and attitudes of persons with dementia.

In this study, the self-administered qPAD was issued before and after a 60-minute educational dementia presentation titled: Understanding Dementia and Communication Tips to Avoid and Manage Problem Behaviors. The analysis of this study consisted of descriptive statistics used to describe the participant’s role. Differences in overall knowledge scores before and after the dementia presentation were compared using a paired t-test. Differences in overall attitudes, based on the percentage of “agree” or “strongly agree” statements, were assessed using the Wilcoxon signed rank test for ordinal data.

Results

A total 273 participants were initially enrolled in the study. Of the 273, 260 participants (95%) completed the pre- and post-tests. They consisted of: 101 registered nurses (39%); 33 senior nurse managers (13%); 25 therapists (10%); 16 dieticians (6%); 8 advanced practice nurses (3%); 8 directors of professional practice (3%); 5 case managers (2%); 5 certified nursing assistants (2%); 4 behavioral health technicians (1%); 3 informaticists (1%); 2 social workers (1%); and 50 other (16%).

Knowledge and attitude of dementia awareness and understanding in the hospital setting:

The participants demonstrated an increase in the total qPAD knowledge test and attitude scale. Knowledge assessment was divided into four categories by content (behavior, caregiving, communication, and definition). There was a statistically significant increase in the overall percentage of answers in the knowledge assessment portion of 8.1% (78.2% to 86.3%, p<0.0001).

Attitude scale was divided into five categories by content (caregiver communication, knowledge impact, work experience, suggestions heard, and teammate discussion). There was a statistically significant increase in the responses in the attitude assessments portion of 7.1% (57.2% to 64.3%, p<0.0001).

Discussion

The participants demonstrated improved knowledge of dementia following a 60-minute educational dementia presentation. There was also a shift in attitude toward patients with dementia. These results are consistent with previous findings on the effects of pre and post-tests using the qPAD scale. This program has also allowed interdisciplinary teams to participate in other dementia-related programs offered by the health care system.

Conclusion

After completing the study to determine the effectiveness of a 60-minute dementia education presentation, the overall results demonstrated a need for dementia education. Recognizing this need may provide a better understanding of care for dementia patients in a hospital setting while decreasing the length of stay for hospitalization and the cost of care.

References available upon request

Angela M. Allen, PhD, CRRN

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Patient Position and Nutrition
Sylvia J. Galloway, RN

The population of hospitalized patients aged 65 years and older often experience less than optimal outcomes as a result of inadequate nutrition. A significant number of patients are not sitting in chairs for meals, which leads to impaired digestion and malnutrition. The purpose of this quality improvement project was to educate patients and staff on the benefits and detriments of position during mealtimes. A literature search was conducted, with few articles being found. As a result of this search, a deduction was made that the lack of literature proves more attention needs to be given to this matter. Patients and hospital staff were involved in order to focus on awareness and education within the hospital setting. Patients were encouraged to be proactive in their care and recovery. To determine the impact this has on nutritional intake, a select group of mealtime percentages at a rural hospital in the southwest was recorded and analyzed, utilizing a qualitative review of chart audits. Results served to provide awareness of the importance of the relationship between nutrition and position. The significance of this project included better patient outcomes, less need for skilled nursing facilities upon discharge, fewer hospital readmissions, and improved patient satisfaction.

Rationale
The intent of this quality improvement project was to improve nutritional intake. Two key factors contribute to patient recovery and rehabilitation: nutrition and functional mobility (Resnick & Gershowitz, 2013). The problem of patients becoming malnourished while in the hospital has been identified. The project included education for patients and staff in order to work collaboratively to encourage patients to sit in chairs for meals. Proper position facilitates eating and increases the percentage of meals consumed. As a result, patients experienced better outcomes.

Evidence
Nutritional status directly influences factors that contribute to functional disability (Cederholm et al., 2014). Functional disability may lead to malnourishment (Cederholm et al., 2014). Loss of lean body mass accelerates during bed-rest, putting the hospitalized patient at risk for malnutrition (Tappenden et al., 2013). Muscle and strength decreases by five percent a day when hospitalized patients are inactive (Resnick & Gershowitz, 2013). Patients are more likely to need skilled nursing facility placement after discharge when they are not properly nourished or assisted out of bed (PBS, 2016). Addressing the problem of hospital malnourishment has the potential to improve clinical outcomes and quality of care, at the same time reducing costs (Tappenden et al., 2013). Internal data within the rural hospital in the southwest for linking nutrition to patient position was unavailable.

PICO
In selected hospitalized patients aged 65 and older at a rural hospital in the southwest whose diagnosis and condition permits, (P) how does sitting upright in a chair for meals (I) compared to lying or sitting in a bed for meals (C) affect the percentage of meals consumed (O) within a period of one week (T)?

Problem Statement
A significant number of hospitalized patients aged 65 years and older are not sitting in chairs for meals. As a result, there is a decrease in meal consumption, leading to malnutrition, ineffective digestion, decreased functional mobility and an increase in hospital readmissions.

Significance to Nursing
Nursing is responsible for ensuring safety and providing care to patients. One element influencing health outcomes is nutritional status. Hospitalized patients generally eat less than 50 percent of their meals (Robert, Chaboyer, & Desbrow, 2015). Nutritional status is correlated with intake, which is directly under the control of nurses and interdisciplinary team members including subordinate staff. Positioning is one element that affects intake. Nursing can impact health outcomes by optimizing mealtime positioning. A significant number of hospitalized patients, whose diagnosis and condition permits, are not sitting in chairs for meals. When permitted, the most beneficial position for eating is an upright, sitting position.

PDSA Framework
Plan
• Design and facilitate an educational program at a rural hospital in the southwest that educates patients and staff on the importance of getting hospitalized patients aged 65 years and older out of bed for meals when diagnosis, condition, and willingness permits.
• This will produce statistical evidence that patients sitting in chairs for meals will experience greater percentages of nutritional intake.

Steps to execute
Surveys will be distributed to nursing staff at a rural hospital in the southwest to determine reasons patients are not getting out of bed for meals.
• Information gained from the survey will be used to improve modifiable barriers.
• Educational material for staff will be distributed at staff meetings and at shift huddles.
• Laminated cards educating the patient as to the importance of getting out of bed for meals will be included as part of the patient information packet in each hospital room. Nursing will review the cards with patients.

Do
• Reflective chart audits will compare percentages of meals consumed at breakfast, when most patients are in bed and at lunch when most patients are in chairs.
• Chart audits will occur over a period of one week.
• Key participants will make observations and identify barriers to getting patients out of bed for meals to determine if the plan should be modified.

Study
• Results of the chart audits will be analyzed to determine if meal consumption increases or does not increase when patients are assisted to chairs for meals.
• Meal percentages will be compared to the goal of a 25% increase in meal consumption per meal when sitting in a chair.
• Results will be recorded and a determination made as to what was learned and whether the goal was met.

Act
• After a study of the results, a conclusion will be made as to whether the project was a success and if it did not work, what can be modified to improve the results.
• At this time, a decision will be made to determine whether the plan is beneficial and should be expanded throughout the hospital inpatient units at a rural hospital in the southwest.

Goals
• By the conclusion of this project, 50% of the selected hospitalized patients aged 65 years and older at a rural hospital in the southwest whose diagnosis and condition permits will be assisted into a chair for meals.
• By the conclusion of this project, the selected hospitalized patients aged 65 years and older at a rural hospital in the southwest whose diagnosis and condition permits will increase their nutritional intake percentage by 25% per meal over the course of one week, evidenced by data collection analysis.

Conclusion
The plan included meeting with stakeholders and addressing possible barriers. Education materials were designed including laminated cards in patient rooms, which identified the benefits of spending less time in bed. Interdisciplinary team members worked together to ensure that selected patients were assisted out of bed for lunch. Breakfast was utilized as a comparison variable. The focus was to compare meal percentages eaten in bed and in chairs. The expectation was that meal percentages of patients who are sitting in chairs for meals would increase. Percentages were collected and analyzed with the assistance of the dietary department. With the implementation of this project, success was determined based on an increase of patients sitting in chairs for meals and subsequent increase in nutritional intake.

References available upon request
Sylvia J. Galloway, MSN, RN

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Test-Enhanced Stroke Teaching (T.E.S.T.): Evidence Based Practice Finding

Beth Stevenson, RN

**Introduction:** Stroke is the fifth leading cause of death and the leading cause of serious long-term disability in the United States. The risk of stroke occurrence and recurrence is influenced by a patient’s ability to change their modifiable risk factors. This ability to make change is affected by a patient’s ability to understand, initiate, and adhere to health care instructions, as well as the ability to be actively involved in learning, and have the information clarified and reinforced. Currently, teach-back is the preferred method to deliver stroke teaching; however, it is unknown if it is the best method. Test-enhanced learning utilizes the testing effect phenomenon, which is the idea that having to take a test enhances learning and knowledge retention. This evidence-based project examined whether test-enhanced stroke teaching improved retention of stroke knowledge when compared to standard teaching in the acute stroke inpatient population of a community hospital in Arizona.

**Methods:** All patients involved in this evidence-based project had their stroke knowledge retention evaluated by receiving a quiz at discharge. Quiz questions covered signs & symptoms, risk factors, and when to seek medical attention. Baseline data were collected on 10 patients with a diagnosis of acute stroke or transient ischemic attack (TIA) who received standard stroke teaching. This teaching consisted of receiving a stroke information book and teach-back education done by the bedside RN. The nursing staff then received instructions to continue to provide standard teaching but also instruct the patient that they will be quizzed on the information at discharge. This test-enhanced teaching method was evaluated in eight patients.

**Results:** Patients that received test enhanced stroke teaching performed better on the knowledge retention test when compared to patients that received standard teaching (85% vs 78.4%).

**Conclusion:** Test-enhanced teaching may be a more beneficial teaching method to deliver stroke education. The test questions were a good method to address knowledge deficits and correct misinformation in real-time. Although this method may be more beneficial for knowledge retention, it is only practical in a clinical setting if the bedside RN is able to administer the quiz questions. A more practical approach may be to incorporate the quiz questions in a teach-back structure. Nurses could readily incorporate a statement letting patients know that before they are discharged, they will be quizzed to be sure the nurse taught what they need to know. Such a quiz before discharge would then enable the nurse to further assess understanding and clarify any confusion or misinformation.

References available upon request
Beth Stevenson MS, RN, CCRC

Note: Partially funded by Banner Better Together Nursing Development Fund for EBP Fellows
The unforgettable bell alarm, the incessant ringing of the phone, a faint bed alarm with the associated sinking feeling of a possible patient fall, the new admitt, 234 needs her pain medication, 235 needs you to recall her blood cells, and in 236, a mother is lamenting over her son’s unexpected and irreversible illness; sound familiar? It’s no surprise that nurses frequently feel depleted, stressed out, and emotionally taxed, perpetuating a global peril to the health and wellbeing of nurses and threaten the collective enthusiasm of the nursing workforce. Although commonly linked contemporaneously, burnout and compassion fatigue, diverge in the unfavorable consequences of burnout and compassion fatigue, one must first understand the nuances of burnout and compassion fatigue and take prompt action to promote impactful vitality and overall wellbeing. Can mindful meditation enhance wellbeing and mitigate burnout?

Although commonly linked contemporaneously, burnout and compassion fatigue, diverge in various fashions (Gentry, 2018). Burnout is physical symptoms that arise among nurses who report their practice settings as demanding, stressful, and overwhelming (Gentry, 2018). Burnout does not occur instantly; instead, it is a zenith of expansive periods of susceptibility to stress (Gentry, 2018). Typical physical manifestations associated with burnout are exhaustion, adverse experiences, and sometimes a dearth of concern for the patients they interact with regularly (Gentry, 2018). Compassion fatigue can lend itself to unfavorable periods of susceptibility to stress (Gentry, 2018). Compassion fatigue can be defined as an act of political warfare” (Davidson, J. E., Proudfoot, J., Lee, K., & Zisook, S. (2019). Nurse suicide in the United States: Analysis of the Center for Disease Control 2014 National Violent Death Reporting System dataset. Archives of Psychiatric Nursing.

Mindfulness-based stress reduction (MBSR) is an individual-focused approach concurrent with a systems-level approach. Practices like exercise, prayer, meditation, spending time with loved ones and good sleep hygiene are all excellent forms of individual self-care and resilience building. Leaders with a personal interest in mindfulness involved in examining our work cultures to find ways to improve on staffing, time off for our colleagues, decreasing the burden of the EHR and improving patient flow. And both of us, clinicians and administrators, can rely on the wisdom of mentors who have been in this field for decades and have learned the critical and challenging lessons of life.

When I worked in emergency departments, full-time as a clinical staff nurse, I was only able to survive the stress by learning from nurses who stayed by my side, answered my questions and gave me support. This camaraderie keeps us all going. My new friend and mentor Florence Lansana, who is a nurse leader here at Emory, has reminded me that to be resilient, we should first remember why we chose to become a nurse—go back to that moment in time, when the passion for helping people, and nurses and physicians across the U.S.—tells us that the systems in which we work do not inherently provide the human support we need to be our best selves and to do our jobs well (Liu et al., 2018). Consider those times that you’ve really needed to take a break, but your unit was short-staffed, or you didn’t feel safe leaving your patient in the hands of someone else. Consider all of the 30-minute lunches that you’ve sacrificed because you were just too busy. I’ve been there many times—and it’s exhausting. Evidence tells us that this kind of non-stop workload, in addition to new technology requirements (think of all the clicking you have to do in the Electronic Health Record), and our ever-increasing ability to keep patients alive (though perhaps to the detriment of their own well-being) can combine to lead towards our own deleterious health outcomes, and saddles of, in some cases, the deaths or suicides of nurses (Davidson et al., 2019). Burnout is nothing new to nurses, nor is stress. But we need to do—and we can—change some things to better support ourselves and each other.


References:
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REFERENCES:

*Daily recommendations - The 2010 Dietary Guidelines for Americans recommends 3 daily servings of low-fat or fat-free milk and milk products for those 9 years and older, 2.5 for those 4-8 years, and 2 for those 2-3 years.

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