President’s Message

Nursing Leadership Can Make Maine a Safe Patient Handling State

by Susan McLeod, BSN, RN, BC

Nurses have a professional and ethical responsibility to advocate for ourselves, our fellow nurses and healthcare providers in order to reduce injuries caused by manually lifting patients. When we reduce the risk of such injuries, we also improve our professional and personal lives.

We are well acquainted with the risks of manually lifting patients. Compared to other occupations, nursing personnel have, since 1999, been on the top-10 list of workers with the highest risk for musculoskeletal disorders (WMSD). In 2009, nurses ranked sixth overall for WMSD, and nurse aides and orderlies were ranked first! Since 1999, 10,000 to 13,000 registered nurses have been injured annually from patient-handling tasks. If RNs are ranked as the sixth highest for WMSD, then how many nurse aides and orderlies are injured each year? Across the nation, the costs of such injuries are astounding. In 2008, direct and indirect expenses related to back injuries were estimated at $7.4 billion; accounting for inflation, this cost has increased.

This situation is unacceptable. How sad, even ironic, that the very people helping and caring for the ill and injured are exposed to unsafe lifting practices every day. It shocks me that, comparatively, every other occupation in the country is doing a better job of protecting its workers from injuries caused by manually lifting patients. When we reduce the risk of manually lifting patients, we improve our professional and personal lives.

We need to come together, all nursing organizations as well as all nursing specialties and subspecialties to declare this year as the year in which a safe patient handling team is initiated in every healthcare facility or service in the state of Maine.

Since 2003, ANA has been advocating and working to protect nurses and other healthcare providers from lifting injuries. This effort started with a position statement, titled The Elimination of Manual Patient Handling to Prevent Work-related Musculoskeletal Disorders. It was meant to be the cornerstone of a multi-faceted ANA health and safety campaign. Since then, ANA has partnered with many other nursing and professional organizations, researchers, the U.S. Occupational Safety and Health Administration (OSHA), the National Institute of Occupational Safety and Health (NIOSH), and universities to develop guidance documents and tools to reduce injuries related to patient handling. In 2004, ANA launched a nursing school curriculum pilot project for safe patient handling in partnership with NIOSH. It was completed in 2007 and is now available in a tool kit on the ANA website along with safe patient handling resources for healthcare facilities. ANA is your resource to start your own safe patient handling program in your facility.

Safe patient handling needs to be a top priority of every healthcare facility across Maine. It should be reflected in facility budgets for program development, staff education, and equipment acquisition. Teams should be formed, comprised of at least 50 percent direct caregivers, and mandated to write policy and implement an evidence-based safe patient handling program. The program would include assessment, continued education, and equipment acquisition to prevent musculoskeletal injuries to all healthcare providers. Research shows that the investment in safe patient handling programs is recouped within three to four years. What administrator would not be happy with that?

Act now. Volunteer to be the leader of the project. Go to the ANA website and download the program. Work with your chief nursing officer, employee health nurse, insurance carrier and other healthcare providers and start a safe patient handling team in your facility.

Let’s save our friends, colleagues, and maybe ourselves from the pain and disability of patient-handling injuries.

ANA-ME President Susan McLeod, RN, BC is the Nurse Clinical Education Specialist for Maine General Medical Center, Augusta, ME.
Student Nurses Arrange for 10 Free Colonoscopies in Washington County

by Meg Haskell, BDN Staff
March 18, 2011
Reprinted with permission from the Bangor Daily News

MACHIAS, Maine—It doesn’t sound like much of a party, but for 10 Washington County women the promise of a free colonoscopy is definitely cause for celebration.

The opportunity comes on Saturday, March 26, courtesy of two ambitious nurses who appealed to local medical providers and other groups to donate their time, expertise and other resources to help raise public and professional awareness during Maine Colorectal Cancer Awareness Month.

National guidelines recommend a screening colonoscopy at age 50 and every five years after that. That’s considered optimal for identifying colon cancer at an early stage, when it is among the most treatable of all cancers.

“My doctor said I should have a colonoscopy back in January,” said 56-year-old Catherine Smith of Columbia. “I had to call up and cancel the appointment; I just couldn’t afford it,” she said. “I’m still paying off the last one I got when I was 51.”

Without health coverage, a colonoscopy is an out-of-pocket experience that is also out of reach for many people. The basic procedure—subject to various add-ons and complications—can cost anywhere from $1,130 at Mercy Hospital in Portland to $4,895 at tiny Charles A. Dean Memorial Hospital in Greenville, according to recent information compiled by the Maine Health Data Organization.

Smith’s small workplace doesn’t offer comprehensive health insurance—it’s too expensive for the employer and the workers alike. Like many Mainers, Smith has only “catastrophic” coverage which kicks in after she is diagnosed with a life-threatening condition. Other than that, she’s on her own.

Never mind that Smith’s mother died of colon cancer at the age of 54, and that cancer runs in her extended family. Never mind that Maine has among the highest rates of cancer diagnosis in the nation, according to the U.S. Centers for Disease Control and Prevention, or that Washington County has the highest rate of colon cancer deaths and—not coincidentally, perhaps—the lowest rate of colon cancer screening in the state. Or that the colon cancer rate for women in Maine has declined over the past decade—except in Washington County, where the rate has actually risen. Catherine Smith couldn’t afford a colonoscopy, and she wasn’t going to have one.

Tackling the problem at the local level

The statistics raised red flags for registered nurses Erin Flannery and Karen Labonte. The statistics raised red flags for registered nurses Erin Flannery and Karen Labonte. Student Nurses continued on page 3

Catherine Smith (far right), 56 of Columbia, ME pauses while recounting how her mother succumbed to colon cancer years ago. “My mother knew something was wrong and she waited way too long,” said Smith. Smith and nine other Washington County women, who are either underinsured or who have no health insurance, will receive free colonoscopies at the end of March. Erin Flannery, R.N. (far left), and Karen Labonte, R.N. (center) recently researched the frequency of colorectal cancer in Washington County and decided to enlist fellow medical professionals at Down East Community Hospital in Machias to provide free colon screenings for at-risk area women.
Flannery is the school nurse at Washington Academy, and Labonte is the chief nursing officer at Down East Community Hospital in Machias. Both women have been pursuing their bachelor’s degrees in nursing online through the University of Maine at Fort Kent and discovered the disturbing information while researching a paper for one of their courses. They decided to tackle the problem head-on, tapping local resources to raise local awareness and drive up local screening rates.

“I went online and found a group in Colorado that had a ‘colonoscopy party,’” said Flannery, describing a free colorectal screening event for low-income women. “They picked the women up at their homes in limousines and took them to a spa for pedicures afterwards.”

Spas and limousines being in limited supply in Washington County, Flannery and Labonte opted for a less froufrou approach.

They approached Down East Community Hospital, which promptly agreed to donate its endoscopy facilities, equipment and nursing staff for a one-day colonoscopy event for 10 patients. They secured the services of local colorectal specialist Dr. Aziz Massaad, along with a staff anesthesiologist and a nurse anesthetist. Dahl-Chase Diagnostic Services in Bangor agreed to biopsy any suspicious specimens found during the colonoscopies, for free. And a pharmaceutical distributor promised to round up the prep kits needed for the infamous overnight bowel purge that enables a clear look at the colon, which is typically 5 to 6 feet long in adults and must be squeaky-clean for the examination to be accurate.

All that was needed was to find some patients. The nurses contacted 10 primary care physicians in the area and asked each one to identify one uninsured or underinsured female patient who was overdue for a colonoscopy.

“Out of the clear blue sky, I got a call from one of the office nurses asking if I wanted to be involved,” Catherine Smith said.

She jumped at the chance. “My daughter really wants me to have this [colonoscopy] done,” Smith said. “She was only 10 years old when her grandmother passed away. My mother only lived a year and a half after she was diagnosed. She had symptoms for a long time, but she waited way too long to get treated.”

**Spotty progress in improving access to screening**

About a year ago, Maine was awarded a five-year federal grant of about $4 million to provide free colonoscopy screenings for uninsured and underinsured adults throughout the state. The programs are up and running at Maine Medical Center in Portland, Central Maine Medical Center in Lewiston, Maine General Health in Augusta and Eastern Maine Medical Center in Bangor, and so far have provided free exams to about 185 Maine residents.

Eleody Libby, executive director of the Washington County: One Community agency in Machias said it will be a fine day when the federal program sets up in rural facilities like Down East Community Hospital so Washington County residents don’t have to factor in a 90-minute drive to Bangor on top of an uncomfortable overnight prep and the anxiety of the scoping procedure itself.

Libby said public health programs funded by the 1998 tobacco settlement have been working to spread the word about colorectal cancer and the importance of routine colonoscopy. In Washington County, materials have been distributed to medical offices and other public locations, she said, and local public seminars and professional workshops have aimed to raise awareness as well. The upcoming one-day colonoscopy event will help educate the public, she said, even though there are many, many more women and men in the area who should undergo the screening.

Flannery and Labonte said they will personally deliver the colonoscopy prep kits to each participating woman’s home a few days before the screening. Picture the Publishers Clearinghouse Sweepstakes van—without the van, Ed McMahon, confetti, balloons and swooning housewives. Just the cheerful good wishes of some local providers and the sincere appreciation of 10 women who would otherwise probably not get screened for the potentially deadly disease of colon cancer.

For more information on the state’s Colorectal Cancer Control Program call 877-320-6800 or visit the website of the Maine Center for Disease Control and Prevention and click on “National Colorectal Cancer Awareness Month.”

Formerly a registered nurse in Maine and Massachusetts, Meg Haskell is health editor for Bangor Daily News. In October 2010, she was named Journalist of the Year by Maine Press Association.
Do YOU Have What It Takes To Be a Red Cross Nurse?

The American Red Cross is many things to many people: A helping hand in time of need, a respected resource for health and safety classes, a way for military families to stay connected during deployments, a safe and secure source for blood and blood products are but a few of the services provided by this agency. Most services are provided by volunteers, and few volunteers are more appreciated than Red Cross nurses. Whether assisting a client in an emergency shelter, facilitating medication replacement for someone whose home just burned down, teaching a CPR or First Aid class to a community group, or working with veterans and active-duty military families, the volunteer nurse is able to put her or his professional skills to good use. The American Red Cross in Maine is actively seeking additional nurse volunteers, especially those with daytime availability and flexible schedules who might be available to provide disaster services as needed on very short notice. In most cases, Red Cross volunteers are able to schedule activities around their home and work responsibilities; however, during a time of disaster, volunteers may be needed within a few hours to staff shelters or respond to affected individuals throughout the community. All Red Cross emergency shelters are staffed with health services volunteers around the clock, working in shifts.

In addition to providing health services during a disaster, Red Cross nurses also have the opportunity to teach community classes such as CPR/AED, first aid, babysitting, and specific health-related topics such as H1N1 or HIV/AIDS Awareness. Additionally, nurses represent the Red Cross at community events and health fairs. If working with veterans and military families is of interest to you, consider an opportunity to volunteer at the Veterans Administration Hospital in Togus or other such clinics, as well as perform resiliency training for military families about to be deployed.

Is your interest piqued? If so, contact your local Red Cross chapter and speak with the emergency services director. In Maine, they are Jason Shedlock (ShedlockJ@usa.redcross.org) in the Southern Maine chapter in Portland (http://www.southernmaine.redcross.org/), Paul Clark (redcrossemergencyservices@usacom-maine.net) in the Mid-Coast chapter in Topsham (http://www.midcoast.redcross.org/), and Gretchen O’Grady (ogradyg@pinetree.redcross.org) in the Pine Tree chapter in Bangor (http://www.pinetree.redcross.org/). By becoming a part of a local chapter, you become part of a larger national and international organization dedicated to helping others in their time of need following a disaster.

If you would like more general information, contact Karen Rea, RN, MN, Maine State Nurse Liaison Adviser, American Red Cross, at ReaKa@usa.redcross.org, or call 207-317-0316.

Karen Rea, RN-BC, MSN, serves on the board of directors of ANA-Maine. She is also the Maine State Nurse Liaison Adviser for the American Red Cross.

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Florence Nightingale Pledge

This modified “Hippocratic Oath” was composed in 1893 by Mrs. Lystra E. Greete and a Committee for the Farrand Training School for Nurses, Detroit, Michigan. It was called the Florence Nightingale Pledge as a token of esteem for the founder of modern nursing. This pledge, typically recited at nurse pinning ceremonies across the U.S. is being reprinted in honor of National Nurses Week.

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.

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National Nurses Week 2011

In honor of Nurses Week, May 6-12, 2011, a heartfelt thank you from the Board of Directors of ANA-Maine is extended to all nurses. We congratulate you all for the professional care and nursing service you provide every day in the state of Maine. The commitment and work you do in the care of patients and families is essential to the wellbeing of our communities. The support and care you give to one another adds to our collective strength as a profession. Thank you all for all you do!
Nurses at All Stages Learning to Tackle Personal Finances

by Irene Eaton-Bancroft, RN, MSN

“Do you mean it would be a good for me to buy a house at my age? I’m in my 20s! I can really do that?” Her radiant face and infectious laughter filled the otherwise nearly emptly amphitheater at Saint Joseph’s College. Expecting a crowd for our personal finance workshop, we had an audience of four. No matter, each person important, Marcy McGuire and I moved forward towards the reward. One life had been visibly empowered. Knowledge, which is power, kept its promise.

Then on to Brunswick. Marcy, Cindy Hounsell, and I conducted a training session during which a man out in the audience burst out with a question to Cindy: “Should I invest in ...?” Cautioned and redirected to review his financial situation in the light of what he had learned that evening and the information he would take home, he heard again, “Diversify! Look at the whole picture; review your resources to your advantage.” His relief and energy added hope to the larger group around the table.

A subsequent event was held at the University of Maine at Fort Kent with 85 students filling the room. Despite many youthful faces in the crowd, the age span and life experiences of the students affirmed the broad range in today’s nursing classrooms. Younger students were anxious to begin earning a salary to repay what they owed. Those with more life experience listened and shared their struggle as nontraditional students in today’s economy. Marcy and I presented to an attentive audience. Even the infant in his stroller let his young mother focus on what she came to hear. Student participation brought what for us were startling but informative comments.

A young woman asked, “How can you tell us we need to save and invest when we can’t even make ends meet now? I buy only what I really need, I don’t have credit card debt, but because of my circumstances as a student, I can’t dream of saving anything at this time!” Then a male student raised the question: “How can you continue to talk about 401(k)s when the company I worked for had a 401(k) and we lost everything!” We heard and learned about their strivings and struggles. The students provided powerful insights into their day-to-day financial realities. We had not in previous sessions experienced such direct, straightforward honesty.

A deep breath—on our part! “We hear your pain. These are tough times. You are doing all the right things. Right now, your education and the student loans you’re accruing, that stack of textbooks you carry around and absorb into your brain—these are the resources you’ll need in building your after-graduation bank account. We applaud you. What we offered today is intended to help you keep your financial house in order, develop or reinforce good habits in handling even pennies, nickels, and dimes. The information and handouts we offer are the tools to more readily reach the next level of financial stability. Use these tools. This financial information is the foundation upon which you will build tomorrow.”

Every time Marcy and I review the material and each time we present a workshop, we are more convinced than ever that even in this struggling economy our own financial lives would be more secure had we been equipped with similar information when we were young, aspiring nurses. Our future goal? We want to see personal financial management incorporated as an integral component of the undergraduate nursing curriculum. We owe it to everyone whom we will be calling “Nurse.”

Look for more news about our survey, and a big fall event to be held in southern Maine, on the ANA-MAINE website (http://www.ana-maine.org/) and in the summer issue of ANA-MAINE Journal.

Irene Eaton-Bancroft, RN, MSN is ANA-MAINE first vice president, and co-chair with Marcy McGuire, RN, MSN, of the Nurse Investor Education Project.

Legislative Committee Update: ANA-MAINE in Augusta

by Juliana L’Heureux

Nurses anticipated a busy Maine legislative session beginning in January 2011. The 125th state legislature convened its first session with health care anticipated to be an important public policy issue.

Members of the ANA-MAINE legislative committee currently are Irene Eaton-Bancroft, Karen Eisenhauser, Juliana L’Heureux (Chair), Nicole Guilfoyle, Susan McLeod, Ashley Moore, Paul Parker and Martha Vrana Brossett.

Legislative committee participation is open to ANA-MAINE members who are interested in participating in the legislative process. Working as a team, the committee determines how ANA-MAINE’s participation in selective policy initiatives can be useful when educating legislators. Additionally, the Legislative Committee will become familiar with Maine’s U.S. congressional delegation in Washington specifically for the purposes of supporting public policy positions consistent with those of the American Nurses Association.

Committee members participated in public policy training in Augusta at the end of February. Lisa Harvey McPherson, vice president of Eastern Maine Health Care, led the orientation describing Maine’s legislative processes.

Janet Haebler from ANA in Washington participated in the Augusta training via teleconference. She updated the committee about a White House teleconference call held on the morning of Feb. 28, during which the status of the healthcare reform law passed last year by Congress was discussed. Although ANA supports the law, the consensus of stakeholders participating in the teleconference was to maintain a measured approach on the political efforts to repeal all or parts of the law at this time.

Later in the training meeting, State Rep. Sharon Treat (D) of Hallowell spoke about the healthcare reform law (the Patient Protection and Affordable Care Act), as well as her work as a senior minority member of the Maine Joint Standing Committee on Insurance and Financial Services and the Joint Select Committee on Regulatory Fairness and Reform. Speaking from her experience as a lawyer, Treat explained the ruling by Judge Roger Vinson, a federal district court judge in Pensacola, FL, who ruled the health care law was unconstitutional, because Congress had enacted a requirement for Americans to obtain commercial insurance beginning in 2014. Treat said the judge had the authority to call for an injunction against the federal law, but he failed to do so.

Additionally, three legislative bills related to health care and nursing were discussed and positions taken:

• LD 466: An Act To Require Hospitals To Adopt Employee Illness and Injury Prevention Programs and To Provide Lift Teams and To Require Reduced Workers’ Compensation Insurance Rates for those Hospitals sponsored by Representative Michael Celli of Brewer. (Position: ANA-MAINE legislative committee agreed to oppose this bill because it required compliance measures already in place at healthcare facilities).

• LD 290: Resolve, Directing Updated Review and Evaluation of Maine’s Mental Health Parity Law sponsored by Rep. Mark Dion (D) of Portland. (Position: ANA-MAINE legislative committee agreed to support this bill because the board of directors voted in favor of supporting healthcare initiatives and coalitions working to improve consumer access to quality and affordable health care.)

• LD 398: An Act to Require Criminal History Record Information for Licensure of Nurses sponsored by Senator Christopher Rector (R) of Knox County. (Position: ANA-MAINE legislative committee agreed to support this bill, at this time, because states participating in the nursing compact are in compliance with this policy.) Information about the nursing compact is at: http://www.maine.gov/boardofnursing/Chapters/Chapters/Chapter%2011.pdf

Nurses interested in obtaining information about the work of the American Nurses Association in Washington, as well as issues tracked at the federal level are encouraged to sign up for the free Capitol Update e-newsletter. This e-newsletter is published 10 times a year and is available at the website: http://www.nursesworld.org/MainMenuCategories/ANAPoliticalPower/Federal/ CapitolUpdate.aspx

Upcoming events for the ANA-MAINE legislative committee includes a proposal to conduct future training and planning sessions.

On April 13, ANA-MAINE will host a reception table alongside other nursing organizations during annual Nurses Day at the legislature in the Hall of Flags.

Questions for the legislative committee are encouraged and can be sent via e-mail to Juliana.L’Heureux@anamaine.org

Among her many interests and passions, Juliana L’Heureux is the secretary for ANA-Maine.

May, June, July 2011

ANA Maine Journal
Please Ask for Help

by Mindy Armstrong, RNBC, MSN, CARN

Nurses who have problems with drugs, alcohol, or both are not the best judges of what they need. If you are such a nurse, please ask for help. Be aware that you can protect your health, your license, and your livelihood if you ask for help before you are confronted at your place of employment about your substance use. The reality is that once you have been reported to the Maine State Board of Nursing, been investigated, and had sanctions brought against you, the Board is mandated to report you to a national data bank. That information is then shared with the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services.

The OIG was mandated by Congress to protect the health and welfare of the nation’s poor and elderly. Under this program, certain individuals may be excluded from providing services to entities receiving Medicare funding. If you are a nurse sanctioned because of substance use, this exclusion means you may not work in any capacity in any agency or facility that receives Medicaid or Medicare funding.

The Social Security Act authorizes OIG to exclude individuals based on particular circumstances. The act does specify when the OIG must exclude and when it may exclude.

The OIG must exclude an individual or entity when convicted of:
- Medicare- or Medicaid-related crimes (misdemeanor or felony)
- Patient abuse or neglect (misdemeanor or felony)
- Felony healthcare fraud (not related to Medicare or Medicaid)
- Felony controlled-substance violations

The OIG may exclude based on:
- Convictions for misdemeanor healthcare fraud (not related to Medicare or Medicaid)
- Convictions for misdemeanor controlled-substance violations
- Disciplinary actions taken by licensing boards or other federal or state healthcare programs
- Quality of care issues related to denial of services, excessive/unnecessary services or substandard care
- Prohibited activities such as false claims, fraud, or kickbacks (with or without convictions)
- Default on health education assistance loans

Being excluded may be only one of the many consequences that can happen if you leave the decision of when you start treatment up to others. Remember, the primary aim and goal of the board of registered nursing is to protect public safety.

An educated, committed healthcare professional with a wealth of knowledge about pharmaceuticals and the risks associated with substance use is insufficient to protect you from the ravages of drug and or alcohol addiction. If you are having problems with drugs and alcohol, contact Maine Medical Professional Health Program (MPHP) at 207-623-9266.

Earlier effective intervention and treatment can preserve a nurse’s employment and healthcare benefits. We at MPHP understand that addiction is an illness that responds to treatment and support. Don’t wait until the choice is taken from you. Please call now if you need help.

Mindy Armstrong RN, MSN, CARN, is a Certified Registered Addictions RN with years of experience in psychiatric/mental health and Substance Abuse Nursing. Mindy has been involved in Maine with the treatment of professionals requiring substance abuse services. She is a full-time staff member of the Medical Professionals Health Program.

Save the Date:
ANA-MAINE Annual Meeting, Oct. 14

by Rebecca Quirk

Be sure to mark your calendar for the annual meeting and conference to be held this fall, on Friday, Oct. 14, from 7:30 a.m. to 4:30 p.m., at the Dana Center, Maine Medical Center, Portland. In addition to the annual business meeting, the educational session in the morning will be focused on the implementation of lawful medical marijuana as well as the confounding issue of substance use and abuse. Hospice care is the topic for the afternoon, in which a multi-cultural panel will address cultural knowledge and skills needed to attend to end-of-life care.

Each year at this event, a silent auction is held to raise funds for an ANA-MAINE undergraduate nursing scholarship program. Scholarships are presented at the Annual ANA-MAINE Awards dinner each spring. The items sold in the auction are donated and range from used paperback books to homemade pies and quilts, and extend all the way to lavish gift certificates.

If you have any items you would like to donate for this year’s auction, or if you have any questions about the annual meeting and conference, contact Rebecca Quirk (rebecca.quirk@anamaine.org). The ANA-MAINE website will also be kept up to date with further details about the events of the day.

Regardless of one’s membership status with ANA-MAINE, all nurses are encouraged and welcome to attend.

Rebecca Quirk is treasurer of ANA-MAINE.
Stigma: An Up-Close and Personal Look

by Paula Davies Scimeca, RN, MS

Although a good example may be the best sermon, I have learned much over the years from illustrations of what not to do. Therefore, my own less-than-stellar example of tolerance may serve as a better demonstration of the root cause of stigma than a case study depicting extraordinary compassion and kindness.

As a new nurse graduate in the mid 1970s, it wasn't long before I encountered a handful of colleagues with a substance use disorder (SUD), which became evident in the workplace. While some of these nurses had a problem with alcohol, several diverted medication from the facility where we were working. My ignorance and intolerance prompted me to harbor the harshest of criticism within my heart toward these co-workers. Though ashamed to admit it, I was among those who engaged in gossip regarding colleagues afflicted with addiction.

Someone more articulate than I am once indelibly impressed upon me that the word “stigma” is nothing more than discrimination, which masquerades in more socially acceptable clothing. In fact, according to Webster’s dictionary, stigma is a mark of shame or discredit, which originated from the ancient Greek and Roman practice of branding slaves with a hot iron as a sign of disgrace (Merriam-Webster, 1998).

As nurses, we understand the role shame and fear play in preventing one from seeking timely treatment for any condition viewed as embarrassing or unacceptable. Since our professional endeavors furnish us with infinite opportunities to care for the stigmatized in society, we bear witness to the less-than-optimal and sometimes disastrous consequences that can arise when people are not confident that they deserve our compassion, dignity and respect.

Examples of prejudice persist within our ranks. One nurse in continuous recovery for over 14 years reported being banned from an emergency room after returning to practice with a year in sobriety. She stated that “all the discrimination we hear about nurses receiving in monitoring programs isn’t always ‘newcomer paranoia’…” At the time, I was devastated that someone would be so spiteful” (Scimeca, 2010). Though years have passed since her experience, current examples of stigma are as close as your nearest online nursing forum, where posts condemning nurses who have SUDs, even toward those in recovery, are made regularly.

While certainly not alone in my past judgmental attitude toward peers with SUDs, I acknowledge that underneath this insensitivity was a profound lack of insight and knowledge about the disease of addiction. I was oblivious to the occupational hazard nurses are indeed exposed to as we prepare and administer what has become our chief tool of the trade: potent pharmaceutical products. So, too, was I unaware of the many personal risk factors many of us bring into the profession, which can predispose one to develop an alcohol or other drug addiction.

To the credit of our profession, we are becoming better educated regarding the issue of SUDs within our ranks. Much work is being done throughout the nation to augment and ensure that peer assistance is available to colleagues in need of help. Nonetheless, there remains a great need for expanding our comprehension of ethical standards regarding our attitude and conduct toward nurses who have the neurobiological disease of addiction. Hopefully, by improving our familiarity with the ANA Code of Ethics, we may make gains in dismantling any lingering stigma or intolerance.

At a time when it is estimated that as many as 20 percent of nurses have, or will develop, a substance use disorder during their lifetime (Monroe and Kenaga, 2010), we must strive for greater compassion toward this significant portion of our professional community. Whether our prejudice and intolerance take the form of an uncaring attitude we conceal well or profess openly in the public domain, we must improve our ethical competency, as adherence to one’s professional ethics are the truest hallmark by which to measure any professional.

The Preface to the American Nurses Association (ANA) (2010) Code of Ethics establishes the foundation of nursing practice. It obligates those who become nurses to not only adhere to the code’s provisions, but to “embrace them as a part of what it means to be a nurse.” While it reminds us that nursing ethics evolve over time, it notifies us that our code of ethics is the nonnegotiable ethical standard by which all nurses must conduct themselves.

Respect for human dignity, the first provision of the ANA Code of Ethics, underscores our principle recognition that the basis of all nursing practice is “respect for the inherent worth, dignity and human rights of every individual.” This provision goes on to declare that the worth of a person is not affected by any disease or disability. It proceeds to prohibit us from “any and all prejudicial actions, any form of harassment or threatening behavior, or disregard for the effect of one’s actions on others.”

The ANA House of Delegates added specific language in Provision 3.6 to address impaired practice. It obliges nurses to “extend compassion and caring to colleagues who are in recovery from illness or when illness interferes with job performance.” Furthermore, this provision specifically mandates “supporting the return to practice of the individual who has sought assistance and is ready to resume professional duties.”

While I was never responsible for a nurse in recovery being banned from the workplace, I admit with the deepest regret that my past prejudicial attitude and critical gossip did absolutely nothing to assist peers who developed a SUD—peers who were very deserving of my complete support and compassion. Surely, my previous attitude of intolerance and prejudice toward colleagues afflicted with the disease of addiction is the antithesis of what is unmistakably clear in our code of ethics—a failing I try my best to make amends for every day.

Even so, as I take full advantage of every opportunity to dismantle stigma toward peers with addictive disorders, it is my fervent hope that other nurses will examine their conduct and attitudes to ensure that it reflects both the letter and spirit of the ANA Code of Ethics.

Paula Davies Scimeca, RN, MS, obtained her baccalaureate degree in nursing from Adelphi University and her graduate degree from SUNY Stony Brook. Her career has spanned over three decades, with the first ten years spent in medical, surgical and critical care nursing. With over twenty years’ experience in addiction and psychiatric nursing, her focus has centered on addiction and recovery in nurses since 2003. The author of “Unbecoming A Nurse” and “From Unbecoming A Nurse to Overcoming Addiction,” she is an adjunct professor at Wagner College School of Nursing.

References


Continuing Education Calendar for Maine Nurses

- Although we attempt to be as accurate as possible, information concerning events is published as submitted. We do not assume responsibility for errors. If you have questions about any event, please call the event planner directly.

- If you wish to post an event on this calendar, the next submission deadline is June 24 for the Summer issue. Send items to publications@anamaine.org. Please use the format you see below: date, city, title, sponsor, fee and contact information. There is no charge to post an educational offering.

- Advertising: To place an ad or for information, contact sales@alpdb.com.

- ANA-Maine is the ANCC-COA accredited Approver Unit for Maine. Not all courses listed here provide ANCC-COA credit, but they are printed for your interest and convenience. For more CE information, please go to www.anamaine.org.

- To obtain information on becoming a ANCC-COA CE provider, please contact anamaine@gwi.net.

- USM/CCE indicates the class is offered through University of Southern Maine/Center for Continuing Education. For course descriptions, visit www.usm.maine.edu/cce or call 207-780-5900 or 800-787-0468 for a catalog. Most classes are held at the new Abromson Community Education Center in Portland, conveniently located just off I-295. Free parking nearby.

- CCSME indicates class is held by the Co-Occurring Collaborative Serving Maine.

- For PESI HealthCare seminars in Maine, visit http://www.pesihealthcare.com.

Are you passionate about nursing education? Do you have experience in adult learning and nursing education, as well as a baccalaureate or graduate degree in nursing? If so, ANA-Maine has a spot just for you on its Continuing Education Committee! ANA-Maine is an Accredited Approver of Nursing Continuing Education by the American Nurses Credentialing Center’s Commission on Accreditation (ANCC-COA). Make use of this wonderful opportunity to facilitate the ongoing education of your peers, and to become involved in your nursing organization. For more information, contact Dawn Wiers at 207-938-3826, or anamainece@gwi.net.

Opening for CE Program Reviewers

May 2011


18 Portland, USM/CCE. Natural Therapies: Botanical Medicine and Homeopathy. $135. 9 a.m.-4 p.m. For more information, visit www.usm.maine.edu/cce or call 207-780-5900 or 800-787-0468.

June 2011

9 Augusta, CCSME. The 3rd Annual Institute for Co-Ocurring Studies: Complexities of Trauma. 8:30 a.m.-4:30 p.m. University of Maine at Augusta, Jewett Hall. There is a fee to attend that will include a 6.5 contact hour certificate for nurses. For more information, call 207-878-6170 or e-mail Events@ccsme.org.

22 Portland, USM/CCE. Sports Psychology Institute. Meets Wednesday, June 22-24, 9:15 a.m.-3:30 p.m. (first day check-in 8 a.m.-9 a.m.); $475 for entire institute; $175 for an individual day. Price includes handouts, continental breakfast, lunch, and afternoon refreshments. Register online at www.usm.maine.edu/cce or by phone at 207-780-5900.

27 Bangor, PESI. Geriatric Pharmacology: Maximizing Safety & Effectiveness. $189. Call for additional discount information or visit http://www.pesihealthcare.com.

28 Portland, PESI. Geriatric Pharmacology: Maximizing Safety & Effectiveness. $189. Call for additional discount information or visit http://www.pesihealthcare.com.

July 2011

6 Portland, USM/CCE. Health Psychology Institute. Meets Wednesday, July 6-8, 9:15 a.m.-3:30 p.m. (first day check-in 8 a.m.-9 a.m.); $475 for entire institute; $175 for an individual day. Price includes handouts, continental breakfast, lunch, and afternoon refreshments. Register online at www.usm.maine.edu/cce or by phone at 207-780-5900.

13 Portland, USM/CCE. Adult Psychopathology Institute. Meets Wednesday, July 13-15, 9:15 a.m.-3:30 p.m. (first day check-in 8 a.m.-9 a.m.); $475; institute; attendance for an individual day costs $175. Price includes handouts, continental breakfast, lunch, and afternoon refreshments. Register online at www.usm.maine.edu/cce or by phone at 207-780-5900.

27 Portland, USM/CCE. Childhood Psychopathology Institute. Meets Wednesday, July 27-29, 9:15 a.m.-3:30 p.m. (first day check-in 8 a.m.-9 a.m.). $475; institute; attendance for an individual day costs $175. Price includes handouts, continental breakfast, lunch, and afternoon refreshments. Register online at www.usm.maine.edu/cce or by phone at 207-780-5900.

27 Online, USM/CCE. Childhood Psychopathology Online Course. Runs Wednesday, July 27-29, August 19; $395 for the online institute. Register online at www.usm.maine.edu/cce or by phone at 207-780-5900.
Over the last several years, we have all been hearing and reading about toxic chemicals that are in a variety of products we use every day. Bisphenol A (BPA), flame retardants (PBDEs), and phthalates are hazardous chemicals found in our foods, mattresses, baby pacifiers, and personal care products, respectively. The range of health risks they create include cancer, infertility, and a host of endocrine-related problems. States around the country are passing legislation to ban these and other toxic chemicals. The question we nurses should be asking is, “How come these toxic chemicals are allowed in our products in the first place?”

The main reason they have been “allowed” is because we have no rules saying they can’t be in our products. We are all familiar with the tight government oversight that guides the development of new pharmaceuticals. Drug companies must apply to the U.S. Food and Drug Administration (FDA) for approval practically from inception. From the onset, through clinical trials and final approval, there is continuous FDA oversight. But what oversight exists when a manufacturer wants to bring a new paint or cleaner, or for that matter, a cosmetic or baby lotion to market? The answer helps to explain why we have so many potentially toxic chemicals in the formulas for products used in everyday life. The answer is: Before a product comes to market, NO requirement exists for pre-market testing of the chemical ingredients in the product you and I purchase.

So, what’s the result of this “undersight?” Fragrances can trigger asthma, carcinogens are in our hand creams, and reproductive toxicants are in the insect sprays we use. Do the labels on these products warn us about these risks? No. Not required.

A bit of U.S. chemical history is useful here. At the beginning of the 20th century, women were concerned about the new-fangled packaged foods beginning to appear on store shelves. They asked the federal government for some assurances about the safety of these new products. In response to their concerns, the federal government set up a new process by which food product manufacturers had to send their packaged goods to a new federal agency kitchen where the product would be cooked according to the directions on the can, box, or sack. The food substance would then be fed to a group of healthy, 20ish-year-old men. If they got sick, the product could not be marketed. If they didn’t get sick, the product could go to market. This odd oversight for processed foods lasted about six years or so. Then they disbanded the process. But, as silly as the previous oversight was, it was not replaced with anything else. So, pre-market testing for food substances in the U.S. is not required.

We can continue to try to pass legislation state by state, chemical by chemical but we’ll be at it for a very, very long time. An estimated 80,000 registered chemicals exist for which there is at least one, peer-reviewed study indicating a risk of toxicity. If nurses take them on one-by-one, it will still leave us with a trail of health risks for the next century. Alternatively, we can support legislation that calls for pre-market testing and appropriate labeling and a mechanism to remove products and chemical processes that create significant, known health risks. What sounds like a no-brainer is actually a steep, uphill battle. The chemical industry spent over $50 million to defeat last year’s congressional version of a comprehensive chemical reform bill. We, in health care, don’t have that kind of war chest for a national campaign. But what do we have?

First of all, there are a lot of us—mothers, fathers, nurses, other health professionals—all have a stake in reducing toxic exposures. One in every 100 Americans is a registered nurse! We are the most trusted profession for conveying information about health and health risks, and we have incredible organizational structures—the ANA, state nurses associations, nursing subspecialty organizations, nursing organizations by race (i.e., National Black Nurses Association, National Association of Hispanic Nurses), and so on. We have nursing honor societies and sororities. Currently, we mobilize ourselves when professional practice issues are at stake or other nursing concerns need to be addressed. We educate policy makers and lobby in statehouses and in Washington to promote our causes. In the same way, we can harness this incredible power to help make our immediate environments—our homes, schools, daycare centers, and workplaces—healthier and safer places by engaging in a new campaign to reform chemical policies in this country.

We nurses are also a very civic-minded lot. We are active members of our faith-based organizations, our PTAs, as well as being den mothers and fathers and leaders in a myriad of local organizations. We have an amazing opportunity to talk with our friends and neighbors to help them understand that this is an issue that truly affects each and every one of us.

The Centers for Disease Control and Prevention (CDC) has been sampling urine and blood from a cross-section of Americans for the presence of toxic chemicals. Researchers have there been finding that we are awash in chemicals associated with cancer, birth defects, neurological disorders, learning disabilities, depression, and a broad range of other common and uncommon diseases. These chemicals should never be found in the human body. They are clearly trespassing.

An even more disturbing study by Environmental Working Group, which was subsequently corroborated by several peer-reviewed studies, indicates that the same range of chemicals found in adults can also be found in the umbilical cord blood of newborns. This final fact should sound a very loud alarm in every nurse’s head. Compelling evidence indicates our chemical policies are broken and comprehensive chemical policy reform is needed. Women should not be delivering newborns who have a body burden of toxic solvents, plasticizers, and pesticides. As nurses, we find this completely unacceptable.

I invite you to join me and other nurses who are working with the national campaign for safer chemicals (www.saferchemicals.org) by working with the Advocacy and Policy Work Group of the new Alliance of Nurses for Healthy Environments (www.Anene.org). In our daily work, we care for people when they are at their most vulnerable. We need to add another element to our professional practice—a concurrent engagement in an effort that is truly designed to prevent diseases.

Barbara Sattler, RN, DrPH, FAAN, is Professor, Director of the Environmental Health Education Center at the University of Maryland School of Nursing. She also serves as Chair of the Board of Directors for the Alliance of Nurses for Healthy Environments (ANHE).
Thoughts on Being a Nurse

by Tara Dinsmore, RN

What draws me to nursing? What do I want to do? Where will nursing take me? Given that a number of my family members are RNs and LPNs, the nursing profession has been intertwined with my life for many years. My own journey took me directly from high school to nursing school. However, where I started and what I wanted to do then have changed considerably.

As a typical graduate nurse, I began working in a hospital and loved it with all of the many challenges and new things to learn. Rarely in nursing is there an “easy” day, and I enjoyed the dynamics that each day brought.

After completing graduate school, I got a job in camp nursing. Each summer, within a year, my personal life changed dramatically and I felt called to go in a different direction. After a time of soul-searching, I made the decision to quit my full-time job and go to Bible school. What an adventure it has been.

My first big change was working at a local Christian summer camp for eight weeks at Fair Haven Camps. The camp serves mostly local Maine children, but campers from Maine’s foster home program also participate. My colleagues and I work hard and deal with everything from the physical to the emotional needs of the children.

During a tough yet enjoyable summer, I shared love and listened to campers who described an incredibly rough time in their lives that summer. Although I was not a counselor, I often left camp feeling enriched by the personal stories I heard and the opportunity to pray and offer encouragement.

The next step in my personal journey was attending Word of Life Bible Institute, one of the hardest and best changes I ever made. I found the program at the school to be rigorous, from classes to work to chapels to ministry, but truly, the program was life-changing for me. Even in that setting, my nursing skills provided me another opportunity: volunteering on a part-time basis for the school’s health center, which serves the students and staff living on campus.

I see patients by appointment during the day and emergencies when on-call at night. This nursing work means spending cold nights bundled up at flag football games and sunny weekends sitting by a skate park praying for no injuries but ready just the same. Along with my clinic colleagues, I attend to everything from broken bones and concussions to scabies and mononucleosis.

There’s no end to the surprises.

In terms of my schooling, I attend classes where I learn about faith, the Bible and ministry to others. Such ministry may not always be the work of the church. I have joined a number of church-sponsored community groups, including a Widow’s Circle that meets each month. The group conducted winter snow camps and summer camps geared specifically towards reaching children and teenagers. During the winter snow camps, I work as a nurse for the health center treating minor illnesses and injuries. All students work with the paid staff each weekend to make each winter camp happen. Through this endeavor, everyone comes to know the teenagers and to become invested in their lives. I’ve learned there’s a lot of joy in serving others and helping them to make their lives better.

The atmosphere of both camp nursing and the Bible institute have drawn me towards another year of adventures. Despite feeling out of my comfort zone almost every day, the past two years have been both the best and the most challenging years of my life, far beyond what I ever thought I would do. Yet I’m content and feel called to do this work. I’ll continue to serve every day, praying for God to bless me all the way.

For those of you looking for a change or a respite from your normal routine, give camp nursing a try. Numerous camps, both in Maine and across the nation, need nurses every summer. You can work for a day, a week, the whole summer, or a lifetime. You’ll never forget the experience and it might just have you coming back year after year. Take a step back from the rat-race of daily life and see how fulfilling it is to serve others.

Nursing has taken me to places I never dreamed and given me experiences I’ll never forget. What does the future hold? I don’t know, but I’m pretty sure nursing will play a part. Where will nursing take you?

Tara Dinsmore, RN, works per diem at Maine General Medical Center in Augusta on the telemetry unit. She also volunteers at Word of Life Bible Institute’s Health Center in Pottsville, NY.

by Anne Sluzenski, RNC

My mother was a nurse. I say “is” because, even though she retired from an acute care setting several years ago, she will never stop being a nurse. When I was younger, I used to tell people with pride, “My mom helps sick people get better.” I remember that meant, I just knew it was important work, and my mother did it well. She never told me anything about her job, but I have vivid memories of her coming home in the morning, with her previously pristine, white uniform covered in substances I did not even want to try to identify. She subscribed to magazines with pictures of the grossest things my 12-year-old brain could imagine. I did not know much about what a nurse really did, but I knew I never wanted to be one!

Twenty years later, after having three children, the strange substances on my mother’s uniform did not scare me as much. I had a much better idea, or so I thought, of what being a nurse was, and I decided I would be the one who helped people when they were sick. I enrolled in nursing school, and found out how much more there was to being a nurse. Suddenly my mother and I had a lot more to talk about. Our conversations became peppered with an array of medical acronyms that others did not understand.

We spoke in a type of shorthand that conveyed a complete story but with a brevity that illustrated how valuable our time was. Other members of our family felt left out, but they did not want to hear, or could not appreciate, the day-to-day details of our job. By becoming a nurse, I joined a society of professionals who are committed to treating every patient with respect. My mother showed me the best a nurse can be, and she taught me verbally, and by example, how to be that way in my own practice.

She talked to me about dramatic saves and frustrating outcomes, but most of all, about feeling quiet pride when she knew she had done her job well. She reminded me to remember the little things. The nurse who takes the time to listen, to give backrub, to promptly medicate, and who keeps promises is a nurse who is appreciated by the patient. The patient does not need to know that same nurse is assessing 20 different things while giving that backrub or having that short conversation.

Mom still gets calls from people asking her medical questions, and she loves that her knowledge is still valued. Being a nurse is such an intrinsic part of who she is, I could only imagine myself as anything else. I decided that I could make a difference in people’s lives and help improve the quantity and quality of time our loved ones have with us—irectly or indirectly—t the restrictions imposed by a halocervical spine stabilization device.

My knowledge and skills mean I need to make patients comfortable with the information, the procedures, and the medications they take so that when I am not there at home, the patient is knowledgeable about and able to manage the medication and other treatments needed to recover and heal.

I’ve learned the patient and family, especially people who are chronically ill, are the ultimate experts on their condition, their health, and their bodies. Although they may need the knowledge and guidance of a nurse, they know that the best nurses are fun to be with. From the Rancho scate for cognitive staging of traumatic brain injury patients, to the signs and symptoms of DVT, nurses teach patients what to expect as their condition improves, stabilizes, or deteriorates.

When my son was in NICU, the doctor assisted me in tying his gown. With that simple action, she became human to me, and when she told me my son would be all right, I believed her—for the first time. I try to remember this as I care for my own patients. Be human. Be knowledgeable, accountable, and professional. Slow down; get back to the basics of nursing care and remember how you would want to be treated if you were ill in a similar situation. When nurses assume they know better than the patient, the patient loses trust in the caregivers.

I have pride in my work, and I am proud of my patients when they succeed. I have confidence and make myself approachable so as to share my knowledge with both my patients and my fellow nurses. How could you go home at the end of every shift knowing I have given everything I could to help my patients, that they did well because of the energy I expended on their behalf. I am a good nurse because I know enough, do enough, and care enough.

Lyne Proctor, RN, is Clinical RN III at Maine Medical Center and an adjunct clinical instructor at Southern Maine Community College.
In October of 2010, I attended a presentation given by Dr. Ruth Nadelhaft on the anthology she edited, *Imagine What It’s Like*. This book, part of the literature and medicine project of the Maine Humanities Council, included stories and poems about people’s healthcare experiences. During the presentation, Dr. Nadelhaft read a piece from the book, *The Eleventh*, written by Henri Barbusse. She stood out in particular for me. Barbusse’s story was about a palatial home inhabited by rich aristocrats. Each month, these well-to-do people would take in 10 less fortunate people and for a month took excellent care of them. At the end of the month, the unfortunate beggars were released and 10 more vagabonds were allowed in to the sanctuary of this luxurious home. The main character of the story, a young man, worked at the home and, following his promotion, was required to admit the first 10 people standing at the gate. At first he thought it was great: Ten people would live in a style and be cared for in ways otherwise unimaginable to them. As time went on, however, the young man began to notice the 11th person, the person he must deny entrance. So haunted was he by the 11th person, he eventually asked to be placed in a different position.

This particular tale reminded me of a video presented in one of my nursing classes. A woman who did not have health insurance and could not pay for her hospital care was sent by cab and dropped off at a homeless shelter wearing nothing but a hospital johnny. Who decided she was the 11th person?

I, like the young man in Barbusse’s story, would feel horrible about turning anybody away; my conscience would not allow it. Part of being a caring and responsible nurse is finding a way to prevent the theoretical 11th person from being turned away. Everyone deserves to be cared for in a humane healthcare system.

Leah Sturzl will graduate with a BSN from UMFK in May 2011.

Presenting himself to the ER in pain, Mr. Smith’s ultrasound showed he had a thickened, inflamed gallbladder along with an episode of pancreatitis. His surgical history was extensive and included a hernia repair of the abdomen, a gallbladder along with an episode of pancreatitis. His ultrasound showed he had a thickened, inflamed gallbladder. When I met Mr. Smith at the start of my shift, he presented himself to the ER in pain. Mr. Smith’s ultrasound showed he had a thickened, inflamed gallbladder along with an episode of pancreatitis. His surgical history was extensive and included a hernia repair of the abdomen, a gallbladder along with an episode of pancreatitis. His ultrasound showed he had a thickened, inflamed gallbladder. When I met Mr. Smith at the start of my shift, he presented himself to the ER in pain.

Mr. Smith, nurses apply their knowledge, care, commitment, and competence to improve the patient’s wellbeing. This truly is nursing.

by Janice Scott, RN

“What, truly, is a nurse? Who is a nurse? And why be a nurse?” These are questions frequently asked of nurses and nursing students alike. At this point in my life and education, the answers to these questions have changed numerous times, and no doubt will continue to change throughout my career.

Originally, I thought a nurse was simply a “caregiver.” I set out on my own journey to become a caregiver, who in my mind was someone who gives care to others and is an aide, of sorts, to the physicians. I quickly realized I am much more than a caregiver. Because of my education, I have specialized knowledge that I use to help patients optimize their personal health.

As a nurse, I am privileged to be there at all the greatest moments and trials in a person’s life. As a nurse, I am present for births, disease, accidents, and at the end of life, I am there to guide the patient and the family through their fear of the unknown. It is an honor and a privilege to share in the pain and joy of those in my care. In my short nursing career, I have already worked in primary care, specialty and surgical practices, and in the acute care setting in the hospital.

Recently, while working in a primary care office, I encountered a patient who reminded me of why I became a nurse. The patient, Mrs. Jones, was concerned about a lump in her breast. After an abnormal mammogram, Mrs. Jones was referred to a surgeon’s office. I was working in that surgeon’s office the day that Mrs. Jones came in for a consult and breast biopsy. I held her hand throughout the ultrasound-guided fine needle aspiration breast biopsy. A couple of weeks later, I was there holding her hand after she was told she had breast cancer. I encountered Mrs. Jones again in the waiting area at the office of her primary care provider. Through tears and hugs, she thanked me for all I had done. By just making myself available to the patient and providing a comforting touch and a genuine smile, I had developed a trusting, therapeutic relationship with both Mrs. Jones and her daughter.

So when I am asked, “Who is a nurse?” or, “Why be a nurse?” my answer is, “I am a nurse because I choose to be an obstacle in the path of death and disease, a guide on a spiritual journey, and a kind face and kind person in a cruel reality.”

by Becky Ford, RN

As we skipped around the department to clean and restock supplies, a call came in from the ambulance service. It was on its way with a lady in her early 60s who, while shopping in a local department store, had a sudden onset of right-sided weakness, facial droop, and inability to speak. Bystanders in the store hailed an employee who quickly called 911. My mood and that of my colleagues quickly shifted to serious. Within minutes, we had notified our radiology technologist we were going to need a STAT head CT, the lab was notified to be in the department for STAT blood work, and the TPA was pulled from the pharmacy with the stroke protocol procedure on the physician’s desk. Time is brain.

The woman arrived. As she was wheeled around the corner on the ambulance stretcher to our critical care room, I could see the anxiety in her eyes. Everyone worked quickly to gain IV access and get her to the CAT scan department. We obtained the woman’s medical history, which consisted of an undiagnostic thyroid. The woman, who was having great trouble speaking, was unable to move her right arm or leg. The CAT scan results were received, and after careful consideration by the team of healthcare professionals who were completing the stroke protocol, this woman was deemed a candidate for the TPA.

Within 10 minutes of the medication being given, I was in the ambulance riding with the patient to a larger hospital where she could be monitored in ICU. Over the hour-long trip, this woman began to move her right arm and leg. Her facial droop slowly disappeared. By the time we arrived at our destination, she was talking to me without any problems. She was a widow who lived alone. She was so grateful to us for getting the TPA. As we dropped the patient off, she squeezed my hand and thanked me.

So many feelings washed over me. I knew this woman had just undergone life-altering treatment. Without the TPA, she may have not been able to walk again. As we walked back to our ambulance, I became teary. At that moment, I was so grateful to be a nurse and be part of something so wonderful.

by Raegan D. Ward, RN

It was just a regular summer Saturday morning in our emergency department. It was a hot day, temperatures already in the 80s, and it was only 9 a.m. The forecast was for the mercury to reach 100 that day. We had been having a quiet morning. Yes, the “Q” word, which as an ER nurse, you never say out loud because you are sure to get slammed with sick people, ambulances, and violent patients needing one-to-one care—all at the same time. Among ourselves, we were commenting on things like, “It’s so nice out today, and only truly sick people are going to come in today.”

As we skipped around the department to clean and restock supplies, a call came in from the ambulance service. It was on its way with a lady in her early 60s who, while shopping in a local department store, had a sudden onset of right-sided weakness, facial droop, and inability to speak. Bystanders in the store hailed an employee who quickly called 911. My mood and that of my colleagues quickly shifted to serious. Within minutes, we had notified our radiology technologist we were going to need a STAT head CT, the lab was notified to be in the department for STAT blood work, and the TPA was pulled from the pharmacy with the stroke protocol procedure on the physician’s desk. Time is brain.

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by Raegan D. Ward, RN, is a RN-BSN student at UMFK.
An Antibiotic Stewardship Program: Taking Action Against Multi-Drug Resistances

by Ann King, RN

An antibiotic stewardship program is a first step in reducing the growth of multi-drug resistances. To be effective, an antimicrobial program needs senior administrative support, information technology support, an infection preventionist, pharmacist, lead physician, microbiologist, and support from case management/quality management.

George Washington University has made assisting providers in the use of antibiotic therapy, right antibiotic for the right duration, IV to PO conversion, and tracking and reducing resistance. The committee should be a jumping-off point for information technology support, an infection preventionist, antimicrobial program needs senior administrative support, and providing the most compassionate, appropriate, and effective care.

A gap analysis can be helpful to identify the strengths and weaknesses of a clinical setting. Smaller facilities may not have all the specific staff needed, but resources are available through the U.S. Centers for Disease Control and prevention (CDC). The CDC provides free education to every facility and expert physician consultation is always available. Infection preventionists (IPs) have access to resources through the preventionists (IPs) have access to resources through the weaknesses of a clinical setting. Smaller facilities may not include standardized orders, de-escalation guidelines, and education and guideline development. This approach may help us to address some of the issues that are relevant to us.

The committee should be a jumping-off point for technology, staffing, educational needs and habit. Administrative and medical staff support will be needed to assist in working through these issues. Seek out the people in your organizations that share your vision to assist you.

Benefits of an antibiotic stewardship program include a decrease in the growth of multi-drug resistances, antimicrobial guidelines specific to the organizational antimicrobial use, and decreased costs related to patients’ length of stay.

Ann King, RN, is Infection Prevention Nurse at Cary Medical Center, in CARY, ME.

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Vaccinations for Adolescents and Adults

Adolescents and adults may question the need for and safety of vaccines, not realizing that vaccine-preventable diseases affect them, their families, friends, and household contacts. By strengthening patient-provider communication and implementing strategic outreach activities, nurses can ease the concerns of hesitant patients, so they feel confident about their decision to be immunized. Visit www.ANAImmunize.org and browse the Special Populations section to view outreach and targeted campaign toolkits.

Expanded recommendations for Tdap vaccine

The Advisory Committee on Immunization Practices (ACIP) voted to expand the use of Tdap vaccine, as summarized below:

- Adolescents ages 11 to 18 who've completed the recommended primary pertussis-containing vaccination series, and ages 19 to 64 should receive a single Tdap dose.
- Tdap can be given at any time regardless of time elapsed since the patient’s last tetanus- or diphtheria- toxoid-containing vaccine.
- Adults ages 65 and older who have or will have close contact with an infant less than 12 months old should receive a single Tdap dose.
- Children ages 7 to 10 years who didn't complete the primary series of pertussis-containing vaccine should receive a single Tdap dose.
- Those never vaccinated against tetanus, diphtheria, or pertussis or who have unknown vaccination status should receive a series of three vaccinations containing tetanus and diphtheria toxoids. The first of these three doses should be Tdap.

Updated meningococcal conjugate recommendations

Here's a summary of the updated recommendations for quadrivalent meningococcal conjugate vaccines in adolescents and persons at high risk for meningococcal disease:

- routine vaccination of adolescents, preferably at age 11 or 12, with a booster dose at age 16
- two-dose primary series given 2 months apart for persons ages 2 to 54 with persistent complement component deficiency and functional or anatomic asplenia, and for adolescents with HIV infection.

Vaccines protect yourself, your family, your patients, and your community. Don’t risk it. Be vaccinated!

For the 2011 recommended adult immunization schedule, go to www.cdc.gov/vaccines/recs/schedules/downloads/adult/adult-schedule.pdf.
ANA Safe Patient Handling

For almost two decades, the American Nurses Association (ANA) has been leading the fight on behalf of registered nurses, health care workers and patients to eliminate manual patient handling. The nation—now facing a serious nursing shortage—can no longer afford to lose the nurses who leave the profession annually due to musculoskeletal injuries and pain.

ANA will continue to be actively engaged on Capitol Hill representing the interests of America’s 3.1 million registered nurses. However, members of Congress need to hear from YOU! Join the fight for safe patient handling by becoming a member of ANA’s Safe Patient Handling Team.

What ANA is Doing to Promote SPH

Research, technology and legislation are changing the way healthcare facilities approach various aspects of workplace safety. Nurses require a safe work environment which includes moving patients without the risk of musculoskeletal disorder injuries which can lead to days away from work, burnout, nurse turnover and early retirement from nursing. It is becoming increasingly vital from both a legislative and workforce satisfaction point of view to implement safe patient handling programs in these facilities and to showcase the benefits of these programs to the nursing staff and local nursing and health care community.

ANA is working on both a local and federal level to promote safe patient handling, through the ANA Handle with Care® Campaign. Local efforts include helping states pass safe patient handling legislation as well as creating the ANA Handle with Care Recognition Program™ to highlight individual hospitals successfully implementing safe patient handling programs.

Federal efforts include advocating for nurses’ wellbeing and supporting helpful bills, such as “The Nurse and Health Care Worker Protection Act of 2009.”

ANA: Preventing Back injuries: Safe Patient Handling and Movement

ANA created this brochure to provide an overview of safe patient handling concepts and steps to creating an effective injury prevention program; including best practices for lifting patients, how to choose lifting devices, and the myths of ergonomics. (http://www.nursingworld.org/safepatienthandling/preventingbackinjuries)

OSHA Ergonomic Guidelines for Nursing Homes

OSHA issued an ergonomics guideline for the nursing home industry on March 13, 2003. (http://www.osha.gov/ergonomics/guidelines/nursinghome/)

Ergonomics/Handle With Care

The ANA Handle with Care® campaign seeks to mount a profession-wide effort to prevent back and other musculoskeletal injuries through greater education and training, and increased use of assistive equipment and patient-handling devices. The campaign also seeks to reshape nursing education, and federal and state ergonomics policy by highlighting the ways technology-oriented safe-patient handling benefits patients and the nursing workforce.

For more information and resources, visit ANA Safe Patient Handling website: http://anasafepatienthandling.org/default.aspx
NeJm study finds low RN staffing increases mortality


IOM Future of Nursing Report

The Future of Nursing: Leading Change, Advancing Health

The Institute of Medicine (IOM) calls on nurses to take a greater role in America's increasingly complex health care system. The IOM Consensus Report was released October 5, 2010.

ANA Immunize

The [Bringing Immunity to Every Community](http://www.anaimmunize.org/) initiative is a two-year cooperative agreement with the Centers for Disease Control and Prevention (CDC) to promote immunizations among nurses and their surrounding communities. Nurses have an important stake in helping to promote immunizations, both by being vaccinated to protect their families, contacts, and patient populations, but also by advocating for vaccination and striving to break down the barriers to a fully-vaccinated American population. As the country’s only full-service professional organization representing the country’s estimated 3.1 million registered nurses, the American Nurses Association and the American Nurses Foundation (ANA/ANF), has a long history of leading and participating in health promotion activities, and nursing itself is grounded in education and action to prevent disease and enhance wellness.