Nearly all of us are aware of nurses with back pain—or we may suffer from it ourselves. What we may not realize is how enormous the problem is. This issue of the UNA Newsletter is dedicated to educating Utah nurses about the risks they and their co-workers face in performing routine patient care. We’ll also give you information about what you can do to help: you and your co-workers.

“My name is Elizabeth White. I am an RN who graduated in 1976 from the BYU College of Nursing. In December, 2003, I was working in the Surgical ICU at Arrowhead Regional Medical Center, the San Bernardino, California county hospital. My assignment that night was a 374 lb patient who was on a ventilator and also on spinal precautions. I was able to get help to turn and bathe him only once that shift. However, because he was on spinal precautions his mattress was flat, but had to be in reverse Trendelenberg because of the vent. He slid down to the foot of the bed, of course. Only one other staff member was available to help pull him away from the foot of the bed. By the end of the shift, I was in so much pain I could hardly walk. I ended up leaving clinical nursing: nearly six (6) years later I still have pain on a daily basis.”

Last year, over 71,000 nurses suffered a back injury—but these are only the injuries that can be directly traced to work. 48% of nurses complain of chronic back pain, but only 35% have reported a work related injury.i Many of the injuries will simply be endured by nurses and health care givers, with no recourse to any compensation. The cumulative weight lifted by a health caregiver in one typical eight hour shift is 1.8 TONS.ii Back injuries are incremental and pain often presents in unrelated circumstances.

Cost of the problem

Nurses back injuries cost an estimated $16 billion annually in workers compensation benefits. Medical treatment, lost workdays, “light duty” and employee turnover cost the industry an additional $10 billion.iii Bureau of Labor Statistics show an inexcusable situation. Fig. 1 is a 2007 Bureau of Labor Statistics chart of the industries with the highest numbers of worker injuries.iv The top category: hospitals. In addition, the fourth and fifth categories are also of health care workers. In total, over 505,000 health care workers were injured. We know that a large percentage of these injuries are due to patient handling.

Healthcare worker injuries were three times the number of any other industry. Also, the RATES of injury are six times the rates of construction workers and dock workers. Why are we not angry? Perhaps it is because we are used to it, and figure that it can’t be any other way. After all, patients must be cared for, right?

THE CAUSES OF NURSING BACK INJURY, or, YOU MUST NOT BE USING GOOD BODY MECHANICS

Hospitals and nursing homes are well aware of the risks of back injury resulting from patient care. Virtually all of us have had numerous “back injury prevention” classes over our work life. Why then, are the injuries so high? Is it because we just don’t listen! Or, is it because there is no safe way to manually lift and care for patients? Just look at the diagram on page 2 for a comparison between the NIOSH lifting standards and everyday patient reality.

Join the Utah Nurses Association

See application on page 11
2009 BOARD OF DIRECTORS
President Nancy Wann, RN
President Elect Deborah Judd, MSN, FNP-C
First Vice President Kathleen Kaufman
Second Vice President Donna Nicholson
Treasurer Cordelia Schaffer, RN, BSN, MS
Secretary Peggy H. Anderson

STAFF MEMBERS
Office Staff/Manager Lisa Trim
Director of Continuing Education Donna Eliason, RN
Lobbyist Debra Hobbs, MSN, APRN
Editor Michelle Swift, RN, ID

COMMITTEE/COUNCIL
CHAIRS & LIAISONS
By-Laws Donna Eliason, RN, MS, CNOR
Government Relations C.J. Ewell, MS, APRN-BC
Membership Committee Kathleen Kaufman, MS, RN
Nominating Committee Gail Tushig, PhD, RN
Psych-Mental Health Nurses Sheryl Steadman, APRN
Utah Nurse Practitioners Francis Swasey, RN, MN
Utah Student Nurses Association
Economic & General Welfare

PRODUCTION
Publisher Arthur L. Davis Publishing Agency, Inc.

Utah Nurse is published four times a year, February, May, August, November, and is for the benefit of the Utah Nurses Association Members. Utah Nurse provides a forum for members to express their opinions. Views expressed are the responsibility of the authors and are not necessarily those of the members of the USA.

Articles and letters for publication are welcomed by the editorial committee. UNA Editorial Committee reserves the right to accept or reject articles, advertisements, editorials, and letters for the Utah Nurse. The editorial committee reserves the right to edit articles, editorials, and letters.

Address editorial comments and inquiries to the following address:
Utah Nurses Association
Attn: Editorial Committee
4505 S. Wasatch Blvd., #135
Salt Lake City, UT 84124
una@xmission.com
801-236-1617

No parts of this publication may be reproduced without permission.

Subscription to Utah Nurse is included with membership to the Utah Nurses Association. Complementary copies are sent to all registered nurses in Utah. Subscriptions available to non-nurse or nurses outside Utah for $25. Circulation 27,000.

All address changes should be directed to DOPL at (801) 530-6628.

For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@aldpub.com. UNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

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

There are physiological reasons for this. William Marras, PhD, CPE, Honda Professor and Director of the Biodynamics Laboratory, Institute for Ergonomics at Ohio State University has made extensive studies on what happens to the human back under stress. vi

Biodynamics Laboratory, Institute for Ergonomics at Ohio State University
William Marras, PhD, CPE, Honda Professor and Director of the Biodynamics Laboratory, Institute for Ergonomics at Ohio State University

Pathophysiology, or, We all have our limits

When lifting tolerances are exceeded, the end plate of the intervertebral disc is damaged with tiny tears called microfractures. No pain is felt, since nerve endings are not present in the disc or the end plate. These microfractures then heal with protein agglutinens and scar tissue which is thicker and less permeable than the normal tissue. Over time, with many microfractures occurring, most of the end plate of the vertebra converts to scar tissue. The disc can no longer absorb fluid and nutrients. It becomes weakened, porous, soft and dry, which is the condition we know as degenerated disc.

The softer tissue then bulges into the spinal column causing pain and muscle spasm, or the gel in the center of the disc can even herniate through the end plate, which also attaches the disc to the vertebrae.

No pain is felt, since nerve endings are not present in the disc or the end plate. These microfractures then heal with protein agglutinens and scar tissue which is thicker and less permeable than the normal tissue. Over time, with many microfractures occurring, most of the end plate of the vertebra converts to scar tissue. The disc can no longer absorb fluid and nutrients. It becomes weakened, porous, soft and dry, which is the condition we know as degenerated disc.

The softer tissue then bulges into the spinal column causing pain and muscle spasm, or the gel in the center of the disc can even herniate through the soft porous outer tissue, causing much greater pain. With severe degeneration, the disc can collapse, which narrows the space available for the nerve root. This narrowed space puts pressure on the nerves, causing pain and muscle spasm.
Say ‘Thank You’ To A Nurse Who Has Dared To Care

Nurses are the gatekeepers of patient care, helping to manage treatments, explain to patients what is going on and what to expect, and identifying potential problems before they arise. Twenty-four hours a day, seven days a week, 365 days a year, nurses are relied upon to provide comfort and support in stressful situations. Nurses often work with people when they are extremely ill, scared and confused. At times it may feel like a thankless job. The University of Utah College of Nursing and its Alumni Board are once again leading an effort to remind us to honor nurses for their critical role in health care delivery by saying ‘thank you’ to those who ‘dare to care’.

Each year during National Nurses Week the U of U College of Nursing and its Alumni Association host Honors for Nursing, a regional event which provides recognition and appreciation for individuals within the nursing profession—and those who support nursing. The 16th Annual Honors for Nursing dinner and program will be held Tuesday, May 11, 2010 at Little America Hotel in Salt Lake City. Individual ‘thank you’ honors can be made for $25 and include an invitation for the chosen nurse to attend a recognition dinner. Supporters can also attend the dinner for an additional fee of $25. Revenue generated from Honors for Nursing provides much-needed scholarship assistance to students at the U of U College of Nursing.

“Honors for Nursing is a memorable and cost-effective way to recognize nurses from your organization or even a nursing colleague or friend during National Nurses Week,” said Alumni Advisory Board President Ben Becker, RN, MSN, OCN. “We continue to hear from attendees how much they appreciate the opportunity to enjoy a celebratory dinner while being thanked alongside their peers.”

Among those thanked in 2009 was Jay Rezac, a night nurse at Huntsman Cancer Hospital. Jay was thanked by Marianne Lloyd for the steps he took to connect with and care for her husband Rich when he was diagnosed with an inoperable brain tumor in the summer of 2007. During Rich’s battle with cancer, the Lloyd family came to rely on the tremendous care provided by many individuals at Huntsman: Jay, in particular, had a great sense of what Rich needed on a personal level in order to maintain some sense of normalcy. Rich passed away April 25, 2008, but Marianne says she will always be grateful to Jay for caring for her husband physically, emotionally and spiritually. Lloyd, a nurse herself, also attended the 2009 dinner to demonstrate her unyielding support of the nursing profession.

Celebrate National Nurses Week by saying ‘thank you’ to a nurse who has touched your life! Several options are available for individuals and organizations to participate. To purchase individual recognitions, visit www.honorsfornursing.org before Friday, April 23, 2010. To learn more about reserved group seating packages, contact Sue Onwuegbu at (801) 581-5109. U of U College of Nursing Alumni can stretch their dollars even further by becoming members of the Alumni Association for $25, which includes, as a member benefit, the opportunity to extend one ‘thank you’ honor for free.

2009 Election Results

UNA OFFICERS
NANCY WATTS, President
DEBRA JUDD, President Elect
KATHLEEN KAUFMAN, 1st Vice-President
DONNA NICHOLSON, 2nd Vice-President
PEGGY H. ANDERSON, Secretary
CORDELIA SCHAFFER, Treasurer

ANA DELEGATES
MARIANNE CRAVEN
FRANCES SWASEY
DONNA ELIASON
DEBRA HOBBINS
DEBORAH JUDD (Alternate)
Elephant in the Room continued from page 2

Normal disc

Degenerated disc

Normal spine anatomy, with healthy discs.

Disc degeneration causing bulging or herniated disc, resulting in back pain.

What are safe lifting pressures for the disc, or, Should you lift a “little 100 lb grandma”?

Downward pressure will cause damage to the disc end plate at pressures from 700 to 1100 lbs. Since many caregivers are physically small, the limits should be at the low end of this. However, most manual patient handling includes pushing and pulling elements. With pushing and pulling, damage occurs at about 1/3 the force. Nurses understand shearing: shearing damage to the disc occurs at lower forces than pressure.

This illustration shows only the downward pressure, and doesn’t take into account the pulling (shearing) required to turn a patient on to his side. Nurses are the ONLY people who call 100 lbs light! Since there is no way to keep the weight bearing close to the body, no “good body mechanics” will compensate for the forces that damage your back.

Bed to bed transfer

This illustration shows only the downward pressure, and doesn’t take into account the pulling (shearing) required to turn a patient on to his side. Nurses are the ONLY people who call 100 lbs light! Since there is no way to keep the weight bearing close to the body, no “good body mechanics” will compensate for the forces that damage your back.

Bed to wheelchair transfer

A ceiling lift can facilitate transfers, after placing the patient on a sling. This is an Arjo lift.

An Arjo bariatric lift accommodates heavy patients.

THERE IS NO SAFE WAY TO MANUALLY MOVE A PATIENT!! EVER. You WILL be injured every single time you manually move a patient. This includes not only transfers, but turning, linen changes, rolling a patient on to a sling, boosting the patient up in bed, and assisting the patient to stand.

WHAT IS THE SOLUTION to manual patient handling? Patients must be cared for. Every nurse knows it is not an option to simply refuse to care for their assigned patients.

Lifting Teams? These teams are very expensive, though they have been shown to reduce injuries. But, what about the lifting team? They will be injured as well, inevitably. Also, no lifting team can be everywhere at once, and patients may need repositioning at any time, not just on the lifting team schedule.

Patient Handling equipment is the only answer. There are multiple equipment solutions available on the market today. None does everything; but there is equipment available which will completely eliminate the manual lifting required for patient care.

We apologize to all makers of equipment which are not featured in this article. Care has been taken to present representative examples of equipment performing each task. Each facility should determine its own needs, and investigate each company and brand of equipment. We do not present the pros and cons of different types of equipment. A list of companies who manufacture and sell each type of equipment is provided, to give some place to start to those who might wish to begin. The list of companies is by no means exhaustive. No remuneration has been given by any company.

Tasks which exceed safe spinal loading, requiring Safe Patient Handling Equipment:

- Transfers: bed to bed, or gurney to bed
- Transfers: bed to chair, chair to shower
- Bed repositioning: Side to side turn, and pull away from the side rail
- Bed repositioning: Boosting to the head of the bed
- Bed repositioning: Linen changes and bathing
- Sling placement: Bending and lifting to roll a patient on to a sling
- Assisting patient to stand
- Assisting a patient up from the floor

There are also vehicle transfer solutions. Liko has a video on its web site.
Bed Repositioning: Side to side turn

Advanced hospital beds have skin saving programs, and some abilities to reposition patients. This is the Hill-Rom Versa-Care bed. Some mattress overlays available will turn the patient by inflating the mattress on one side, then another.

This is an advanced mattress by Joerne, for pressure reduction.

Bed Repositioning: Boosting patients up in bed

The ErgoNurse, designed for bed repositioning, boosts a patient using the sheets. It will also lift for side to side turns, linen changes and bathing.

A Liko ceiling lift repositions a patient using a loop sling. Linen can be changed while the patient is suspended.

Some specialty fabrics will allow boosting with minimal effort, then resist sliding again.

Linen changes and bathing of bedridden patients

Ceiling lifts can use repositioning slings to move the patient around for linen changes and bathing.

Placing the patient on a sling

The ErgoNurse uses a sheet to suspend the patient, allowing sling placement without bending and lifting.
In 1947, when India achieved independence from Great Britain, over 80% of the Indian population lived in impoverished rural communities, with little if any access to health care (Biswas, n.d., para. 1). In these unstable times Mother Teresa Bojaxhiu began her ministry of service to the people of India.

According to the Nobel Lectures, Agnes Gonxhe Bojaxhiu took her vows as a nun in May of 1931, chose the name of Teresa, and began working in a girls’ school in Calcutta, India. In Calcutta she saw streets crowded with beggars, lepers, and homeless. Moved by the suffering she witnessed, she sought and received permission to abandon her teaching position to care for the needy in the slums of Calcutta (1997). Mother Teresa was then educated as a nurse and dedicated her life to the care of the poor and infirm. According to the International Code of Ethics for Nurses, “nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering” (2005, p. 3). Mother Teresa exemplified the model nurse by implementing the four fundamental responsibilities described in the International Code of Ethics for nurses.

Mother Teresa spent her days in the slums educating orphans, caring for lepers, and offering help to the very poor. Mother Teresa established the Missionaries of Charity in 1950. They established schools for the uneducated children of the slums, opened orphanages, homes for lepers, people with AIDS, and unwed mothers. During the 1960s and 1970s, Mother Teresa visited numerous countries and established over 200 operations in more than 25 countries (World Biography, 2009, para. 4-8).

Mother Teresa was recognized globally for her service and promotion of peace. She received many awards including the Nobel Peace Prize, the United States Medal of Freedom, the Congressional Gold Medal of Honor as well as the Nehru Prize, the Balzan Prize and the Pope John XXIII Peace Prize (Nobel Lectures, 1997, para. 6). Mother Teresa’s work and influence have had a lasting effect on the entire world. Her work continues today by the Missionaries of Charity who are assisted by over one million Co-Workers in over 40 countries worldwide (Nobel Lectures, 1997, para 5).

Mother Teresa’s life of dedication to serve the needy was not without difficulty. When Mother Teresa initiated her work, she had very little support and no funding. Despite the lack of support, she trusted in God and went out each day to care for those in need. According to Spink, she began by teaching the children hygiene and the alphabet in a dirt field (1981, p. 27). Even in such primitive conditions, she continued with faith and persistence until the community began to offer support.

The lack of funds and support did not discourage Mother Teresa. She approached these obstacles with faith in God and love for the people. Her main purpose was to attend to the poor by offering them love. Mother Teresa said “the poor do not need our pity. They only need our love and our tenderness” (1996, p. 33). One way that she showed love was through educating the poor about hygiene and health, prevented illness, restored health and alleviated suffering.

Just as Mother Teresa taught, love should be the center of nursing care. Mother Teresa was extremely successful as a nurse and a humanitarian because of her unconditional love for everyone. Love should be a driving force behind the actions of a nurse. A loving approach will improve the community’s response to the poor by offering them love. Mother Teresa approached these obstacles with faith and optimism. I want to follow the example of Mother Teresa because she promoted health, prevented illness, restored health and alleviated suffering.

References
How Staffing Shortages Put You at Risk

You’ve surely seen the headlines announcing the nationwide nursing shortage, but have you heard the country is also experiencing an alarming shortage of trained allied health professionals too?

Working in the healthcare field, you’ve undoubtedly encountered a staffing shortage at one time or another. Unfortunately, it appears these shortages may stick around for awhile. The allied health provider shortage is predicted to reach between 1.6 and 2.5 million workers by 2020.1

What does a staffing shortage mean for you?

If you’re working in a setting with reduced staff, you could encounter one of the following situations:

• You may be required to care for more patients or clients than normal
• You may need to assume the responsibilities of a coworker who is absent
• You may be expected to complete duties you don’t normally perform
• You may have less time to spend with your patient or client in order to meet the demand of your practice

Any of these scenarios could impact your ability to provide proper, quality care to your patients and clients. Not only does this compromise them, you become increasingly susceptible to making a mistake—and that puts you at a greater risk for a malpractice lawsuit.

What can you do?

Patient and client safety come first. If you feel your ability to provide quality care is compromised by staffing challenges, you should:

• Speak up and ask for help if asked to do something out of your normal scope
• Prepare for the shortage ahead of time if possible by doing your research and preparing questions
• Ask for direct supervision
• Be proactive about sharing information between clinicians to reduce the risk of miscommunication
• Never leave your workplace in the middle of treating your patients or clients

Reduce your liability risk

Further protect yourself and your career with an individual liability coverage policy. Professional Liability Insurance protects you against covered real or alleged malpractice claims you may encounter from your professional duties. Even if you have Professional Liability coverage through your current employer, it may not be enough. That coverage may have some serious gaps, including:

• Policy limits may not be high enough to protect you and all of your co-workers named in a lawsuit.
• You may not be provided with coverage for lost wage reimbursement, licensing board hearing reimbursement and defense costs.

Medication Errors: Reduce Your Risk

Experts estimate that nearly 98,000 people die in any given year from medical errors. A significant number of those deaths are due to medication errors.2

The National Coordinating Council for Medication Error and Prevention defines a medication error as “any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.”

Mistakes can happen

As a nurse, you dispense medication to your patients on a regular basis. Consequently, you’re charged with knowing the “five rights” in administering medication—right patient, right drug, right dose, right time, and right route. And while you take every precaution to avoid making errors that may put your patients at risk, mistakes can happen.

Common reasons for mistakes include distractions and interruptions during medication administration, inadequate staffing, illegible medication orders, and sound-alike drug names and packaging.

Reduce your risk

To reduce your risk of liability, take the time to read medication labels—especially those that you’re not familiar with. It is also your responsibility to know the drug’s dosage range, possible adverse effects, toxicity levels, indications and contraindications. Understand the medications you administer and don’t hesitate to ask questions. Consult your nurse drug guide, the physician, a pharmacist or your supervisor if you have any questions.

Further protect yourself and your career with an individual liability coverage policy. Professional Liability Insurance protects you against real or alleged malpractice claims you may encounter from your professional duties as a nurse. Even if you have Professional Liability coverage through your current employer, it may not be enough. That coverage may have some serious gaps, including:

• Policy limits may not be high enough to protect you and all of your co-workers
• You may not be provided with coverage for approved lost wage reimbursement, licensing board hearing reimbursement and defense reimbursement
• You may not be covered outside of the workplace, such as when you engage in volunteer or part-time work
• You may not be covered for suits filed after you have terminated your employment

In the event of a lawsuit, your own Professional Liability Insurance policy would:

• You may not be covered outside of the workplace, such as volunteer and part-time work.

In the event of a lawsuit, your own Professional Liability Insurance policy would:

• Provide you with your own attorney
• Pay all reasonable costs incurred in the defense or investigation of a covered claim
• Pay for approved lost wages up to the limits of the policy
• Provide reimbursement of defense costs if licensing board investigations are involved
• Pay approved court costs and settlements in addition to the limits of liability

Working in an environment that is understaffed can be difficult and frustrating. Arm yourself with the protection you need so you can focus on providing excellent patient care and reduce your exposure to liability.

For more information about Professional Liability Insurance, visit www.proliability.com.

This article contains a summary of the insurance certificate provisions. In the instance of conflict between this article and the actual certificate, the insurance certificate language will prevail and control.

For more information about Professional Liability Insurance, visit www.proliability.com.

This article contains a summary of the insurance certificate provisions. In the instance of conflict between this article and the actual certificate, the insurance certificate language will prevail and control.

The Professional Liability Insurance Plan is underwritten by Chicago Insurance Company, a member company of the Fireman’s Fund Insurance Companies.

The Professional Liability Insurance Plan is underwritten by Chicago Insurance Company, a member company of the Fireman’s Fund Insurance Companies.

Utah Nurse • Page 7
Workplace Abuse in the Medical Workplace: Fact vs. Myth

A physician demands that a prescription be filled despite proof that it has been prescribed from faulty information; an intimidated ER nurse doesn’t dare speak up when a life-threatening condition is overlooked; a surgical team stands knowingly, yet silently by as a surgeon makes a life-threatening error; despite the plea of a mother, a knowledgeable nursing staff refuses to challenge the doctor’s written order resulting in the senseless death of a toddler; a senior nurse refuses to assist a junior nurse as a critically-injured patient slips away. What is the common factor in these, and other similar and actual situations?

Workplace bullying involves repeated health-harming mistreatment usually directed toward underlings or peers, but affecting the quality of patient care and life in general. Workplace bullying falls into one or more of the following categories: work sabotage, verbal abuse, or conduct that is threatening or intimidating or humiliating. Conduct that is in opposition to the employer’s legitimate business interests, workplace bullying leveres real costs, financially, emotionally, physically, and in every other way. In the medical workplace it contradicts professional ethics, including the Hippocratic Oath, for it severely compromises patient safety and quality care.

Bullying is about the bully, not the target. The bully puts his/her personal agenda of controlling another human being above the interests of patients and the employing medical organization. A bully’s weapons of choice often include deliberate humiliation, the withholding of critical resources or information, social manipulation, and professional sabotage.

What are the myths that allow the destructive behaviors to continue and thrive?

Myth 1: Bullying behavior is not prevalent.

Intimidating behaviors are increasing at an alarming rate. A survey conducted by the Institute for Safe Medical Practices (ISMP) found that 88 percent of the medical practitioners surveyed encountered condescending language or voice intonation, 87 percent encountered impatience with questions, 79 percent dealt with reluctance to provide clear responses, 43 percent experienced strong verbal abuse, 43 percent reported suffering from professional growth opportunities. In a survey conducted by Zagby International, 45 percent of targets reported strong verbal abuse, 43 percent experienced threatened body language, and 4 percent reported physical abuse.

Intimidating and disruptive behavior involves more than one or two offending individuals in a given medical organization. Thirty-eight percent of respondents reported that three to five individuals were involved in negative encounters, and 19 percent reported that more than five individuals were involved in negative encounters. Moreover, only small differences between male and female respondents showed up in reports, with male respondents somewhat more reluctant to confront a known intimidator, and female respondents somewhat more willing to ask for help in dealing with a known intimidator.

Myth 2: Targets deserve or ask for abuse. Smart people don’t become targets.

Individuals most often targeted by bullies prove to be independent, skilled, bright, cooperative, nice, ethical, just and fair people. In fact, targets are often amongst the most highly skilled, competent, and altruistic individuals. Bullies, seemingly driven by their own personal insecurities, perceive skilled and competent coworkers as a threat. Bullies tend to thrive in environments in which (1) there are opportunities to behave in a cutthroat, zero-sum manner, (2) there is a pool of exploitable targets (typically those people with a pro-social helping orientation), and (3) negative personal consequences are negligible, and (4) perpetrators are rewarded for their bullying behavior by those who collude with the intimidation, or those who are afraid to challenge the bully.

Myth 3: There is nothing that can be done about bullying.

In the vast majority of cases, bullying stops only when the target loses his/her job either by quitting, being forced out, or transferring to stay employed. But it’s only a matter of time before the bully identifies a new target. The bully perpetuates the behavior by seeking new victims, usually from among lower-paid employees, until he or she is arrested or fired, then the cycle starts over again. According to the ISMP survey, only 39 percent of medical practitioners felt that their organization dealt effectively with intimidating behavior. Medical corporate cultures typically do not deal effectively with workplace bullying.

Myth 4: Bullies are worth keeping around.

Bullies are exorbitantly expensive. Conservative estimates and prevalent data indicate that bullying behavior is estimated to cost organizations over a million dollars per 50 employees per year in turnover costs alone. Bullies, however, are not easily replaceable. In the vast majority of cases, bullying stops only when the target loses his/her job either by quitting, being forced out, or transferring to stay employed. But it’s only a matter of time before the bully identifies a new target. The bully perpetuates the behavior by seeking new victims, usually from among lower-paid employees, until he or she is arrested or fired, then the cycle starts over again. According to the ISMP survey, only 39 percent of medical practitioners felt that their organization dealt effectively with intimidating behavior. Medical corporate cultures typically do not deal effectively with workplace bullying.

Myth 5: Employers generally recognize the harm done by bullying.

According to a survey of health care practitioners conducted by Zogby International, 45 percent of targets reported strong verbal abuse, 43 percent experienced threatened body language, and 4 percent reported physical abuse. Damages to organizations include poor morale, low productivity, and difficult recruitment and retention of quality workers. The ability of health care workers to work as a team is compromised, the quality of patient care is diminished, and lives are needlessly lost. Medical lawsuits invariably accompany the standard medical care produced by such sabotage, and the cost in this regard may be incalculable[2]. Negative impacts specifically on Targets and their families include damages to psychological and physical health, stress, financial strain, and suicidal thoughts.

Myth 6: Legal protections against workplace bullying are inadequate.

Legal protections are inadequate, but not for the reasons alleged. According to the ISMP survey, 79 percent of targets dealt with reluctance to provide clear responses, 43 percent experienced strong verbal abuse, 43 percent reported suffering from professional growth opportunities.

Myth 7: Bullying is just part of the medical culture necessary to maintain quality patient care.

According to the ISMP survey, a remarkable 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator. Forty-nine percent of respondents reported that intimidation situations excused the behavior of bullies. Yes, there are very real stresses in health care because the stakes are high, and health care professionals are often pushed to the breaking point mentally and physically. But responsible employers understand that a bully’s way and a wrong way to manage that stress.”[3]

Intimidating and disruptive behaviors in no way contribute to, or protect, quality patient care. Instead, they undermine patient safety and devastate staff morale.

Myth 8: There is nothing that can be done about bullying in the medical workplace.

Don’t fall into the trap of believing that abuse in the medical workplace is a necessary evil that cannot be addressed. Each of us can make a difference: First, we can support laws that make health-harming workplace violence illegal. Second, we can support organizations in establishing and enforcing appropriate policies. Third, we can pay attention to those around us. There is safety in numbers and in unity. Bullies try to divide and conquer in order to exert their will. We can refuse to participate in their social manipulation tactics. We can ask questions, insist on answers, and verify facts when coworkers appear to be targeted. We can support ethical behavior. We can treat all of our fellow coworkers with the dignity and respect that they deserve. We as a community can and must demand that our medical workplaces become bully free zones.

References:


A Review of Techniques to Manage Your Depression

by Stanley Popovich

Some people have a difficult time in managing their depression. Sometimes, their depression and fears can get the best of them. As a result, here is a short list of techniques that a person can use to help manage their depression.

One of the ways to manage your depression is to challenge your negative thinking with positive statements and realistic thinking. When encountering thoughts that make your fearful or depressed, challenge those thoughts by asking yourself questions that will maintain objectivity and common sense. For example, your afraid that if you do not get that job promotion then you will be stuck at your job forever. This depresses you, however your thinking in this situation is unrealistic. The fact of the matter is that there are a lot of jobs available and just because you don't get this job promotion doesn't mean that you will never get one. In addition, people change jobs all the time, and you always have that option of going elsewhere if you are unhappy at your present location.

Some people get depressed and have a difficult time getting out of bed in the mornings. When this happens, a person should take a deep breath and try to find something to do to get their mind off of the problem. A person could take a walk, listen to some music, read the newspaper or do an activity that will give them a fresh perspective on things. Doing something will get your mind off of the problem and give you confidence to do other things.

Sometimes, we can get depressed over a task that we will have to perform in the near future. When this happens, visualize yourself doing the task in your mind. For instance, your afraid that if you do not get that job promotion you will get your mind off of the problem and give you confidence.

Whenever you come across an affirmation that makes you feel good, write it down in a small notebook that you can carry around with you in your pocket. Whenever you feel depressed, open up your small notebook and read those statements.

Take advantage of the help that is available around you. If possible, talk to a professional who can help you manage your fears and anxieties. They will be able to provide you with additional advice and insights on how to deal with your current problem. By talking to a professional, a person will be helping themselves in the long run because they will become better able to deal with their problems in the future. Managing your fears and anxieties takes practice. The more you practice, the better you will become.

The techniques that I have just covered are some basic ways to manage your depression, however your best bet is to get some help from a professional.

BIography:

Stan Popovich is the author of “A Layman’s Guide to Managing Fear Using Psychology, Christianity and Non Resistant Methods”—an easy to read book that presents a general overview of techniques that are effective in managing persistent fears and anxieties. For additional information go to: http://www.managingfear.com/
Susie Walking Bear Yellowtail

According to A History of American Nursing: Trends and Eras (Judd, 2010, pp. 101-108), the 1920s was an era of power, education and changes for women and minorities. Also during this time, the American Nursing Association made recommendations for nationally acceptable nursing standards of care that were later adopted by nursing schools. As a result, the overall public health of the nation improved greatly. However, as much as 90% of American Indian school children acquired trachoma which was linked to areas of poverty, crowding and lack of clean water. The occurrence of disease on Indian reservations still remained an epidemic for several years and other major health atrocities were soon to be discovered by Susie Walking Bear Yellowtail.

Born on the Crow Indian reservation in Montana, Susie Walking Bear Yellowtail (Crow/Sioux Indian) lost her father and mother at a very early age and was taken to a Baptist boarding school in Oklahoma (Sonneborn, 2007, p. 282). She continued her education at a Massachusetts nursing school where she graduated with honors in 1927 with her R.N. degree (Scozzari, 2008, ¶ 7). Yellowtail was driven by her desire to help others, was guided with her R.N. degree (Scozzari, 2008, ¶ 7). Yellowtail realized the importance of her education in the success of her and her people (Scozzari, 2008, ¶ 5-8) which sustained her through difficult times. The same approach Yellowtail used still is the driving force of many American Indian students across the nation in realizing how education is vital for the growth of an individual and society.

While practicing as a professional nurse, Yellowtail advocated for patient’s rights, health and safety by travelling to other reservations assessing American Indian health problems. On the Navajo reservation, Yellowtail observed mothers carrying their children as far as 30 miles on their backs to the nearest hospital; unfortunately, many nursetts showed the children died on the way. While Yellowtail was a mentor to help guide the implementation of hospice care in America, she realized the importance of her nursing career, Yellowtail “became the first American Indian nurse to be inducted into the American Nursing Association’s prestigious Hall of Fame” (First American Indian, 2002, ¶ 1) in July 2002 (Scozzari, 2008, ¶ 23; Sonneborn, 2007, p. 282).

In 1969, Wald received a grant and conducted a two year study focusing on pain control in the dying patient (Friedrich, 1999, p. 1684). Physicians and nurses directly opposed the pain control measures proposed by Wald. Traditionally low doses of Demerol were used to treat mild to severe pain. However, Wald recognized the benefit of Morphine in controlling pain—despite the then current medical practice of shunning such a medication. Wald once again resorted to a multidisciplinary approach to overcome this obstacle. Only after Wald hired a research pharmacist, Arthur Lipmann, did doctors and nurses accept the pain control measures (Friedrich, 1999, p. 1684). Despite many obstacles, Wald was successful at establishing hospice care in America for three reasons. First, she developed a profound energy and passion for her work. Secondly, Wald utilized the expertise and support of mentors. Lastly, she developed a multidisciplinary team to provide the needed support and expertise for the cause.

Major Accomplishments and Coping with Change

In 1974, the first hospice was opened in America (Sullivan, 2008, para. 7). The hospice movement immediately spread throughout the nation and as a result Congress required Medicare to reimburse for hospice care in 1982. However, in 1980, “there were over 7,000 hospices in the country” (Adams, 2008, para. 2). Wald’s work greatly affects the individual dying, along with their family and friends. However, Wald did face difficulty while establishing hospice care in America. Due to the legal requirements of implementing hospice care into the hospital, Dennis Rezendez was hired to help provide the needed support and certification. Because of differing administrative styles and staff preference for Rezendez, Wald’s appointment to the board was ended. Wald chose to follow her own passion and energy for hospice care and as a result, she resigned from her deanship in 1968 to travel to St. Christopher’s Hospice to learn from Saunders and directly study the organization and its management. Wald’s travels and her continual contact with Saunders exposed her to different administrative styles and staff preference for hospice care in America. Upon returning to America, Wald organized a multidisciplinary team focused on hospice care comprised of Dr. Ray Duff, Rev. Edward Dobshal, and Dr. Morris Wessel (Houser & Player, 2007, pg 387). The group met regularly to discuss implementing hospice care in America. In 1969, Wald received a grant and conducted a two year study focusing on pain control in the dying patient (Friedrich, 1999, p. 1684). Physicians and nurses directly opposed the pain control measures proposed by Wald. Traditionally low doses of Demerol were used to treat mild to severe pain. However, Wald recognized the benefit of Morphine in controlling pain—despite the then current medical practice of shunning such a medication. Wald once again resorted to a multidisciplinary approach to overcome this obstacle. Only after Wald hired a research pharmacist, Arthur Lipmann, did doctors and nurses accept the pain control measures (Friedrich, 1999, p. 1684). Despite many obstacles, Wald was successful at implementing hospice care in America through her pioneering work in hospice care, she also provided an exceptional model of overcoming obstacles and coping with change. Through applying the principles learned through the life of Florence Wald, one can bring about innovative change in the work-setting or society as a whole. Principles of perseverence, tolerance of risk, and willingness to take chances with a multidisciplinary approach are all essential attributes for successfully overcoming change and obstacles.

References


APPLICATION FOR MEMBERSHIP IN UNA/ANA

Please print this form, fill it out, and mail it to UNA. The address is at the bottom of the page.

<table>
<thead>
<tr>
<th>Today’s Date</th>
<th>Home Phone</th>
<th>First Name/Last Name</th>
<th>Home Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Employer Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Membership Categories**

<table>
<thead>
<tr>
<th>Membership</th>
<th>Reduced Membership</th>
<th>Special Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full:</td>
<td>Not employed: full-time student; or new graduate within six months after graduation from basic nursing education program.</td>
<td>62 years of age or over and not employed, or totally disabled</td>
</tr>
<tr>
<td>Part-time:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAYMENT OPTIONS (Choose either Annual or Monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Payment:</td>
</tr>
<tr>
<td>• Full $249.00/year</td>
</tr>
<tr>
<td>• Reduced $124.50/year</td>
</tr>
<tr>
<td>• Special $62.25/year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Rec’d</th>
<th>District</th>
<th>Paid Thru</th>
<th>Anniversary</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Please return this completed application with your payment to UNA, 4505 S. Wasatch Blvd, #135, Salt Lake City, UT 84124 |

**Becoming a “Friend of Utah Nurses Foundation”**

If you are willing to share some of your experiences or successes in helping patients attain or maintain a healthy weight or healthy lifestyle, or you are aware of a unique community resource that has contributed to patient success in this area, please e-mail them to the Health Lifestyles committee at dot.vorburger@ahplans.com or rhightower@ mail.smarffella.com.

The Utah Medical Association’s Health Lifestyles committee, chaired by Dr Ross Hightower, has elected to support the Utah Department of Health and Utah Partnership for Healthy Weight in promoting physician and health care provider awareness of the need to promote healthy weight among Utah residents, our patients. Since 1989, Utah’s adult obesity rate has increased nearly 20%. Currently, more than half of Utah adults are overweight or obese (54%) and an estimated 22.5% of elementary school students are overweight or at risk of becoming overweight. Additionally, obesity is becoming a leading cause of health care costs, with Utah estimated to have spent almost $400 million in 2002 alone. In response to these alarming statistics, a diverse group of stakeholders have come together to develop Tipping the Scales Toward a Healthier Population: The Utah Blueprint to Promote Healthy Weight for Children, Youth, and Adults [www.health.utah.gov/obesity].

The Blueprint offers a comprehensive, statewide obesity prevention agenda, building on efforts already underway in many Utah settings. With a vision to make the healthy choice the easy choice at home, work, school, and play, the Blueprint focuses on policy and environmental changes that will support Utahns in making healthier choices to improve physical activity and eating patterns. The goal of the Blueprint is that Utah’s families, communities, schools, worksites, media, health care providers, and government will assume active roles in addressing childhood and youth overweight and adult obesity. A coalition, the Utah Partnership for Healthy Weight, has been convened to coordinate efforts to carry out the Blueprint.

Health care professionals and health systems have unique opportunities to encourage children, youth, and adults to engage in health lifestyles. The majority of the prevention and intervention work will be done in schools, worksites, communities, and health care settings. As members of the health care team, health care professionals are trained in measurement techniques and counseling, and offering referrals to professional and community programs that support attainment/maintenance of a healthy weight. Additionally, because of their position of trust within communities, health care professionals have an opportunity to impact community decisions that affect physical activity and healthy eating options.

In upcoming issues of The Bulletin, the Health Lifestyles Committee will be offering a series of articles that can help physicians and other medical health care providers in Utah: promote healthy weight in their patients. The articles will focus on recommendations made in the Blueprint. The committee will also be looking for “Best Practices” and community resources for healthy lifestyles that have brought success to Utah medical practices.