President’s Message

As President for NNA, and as Chair for the NNA Continuing Education Committee, I would like to personally congratulate the students from University of Southern Nevada for winning the First Annual NNA Student Nurse Competition. The winning team, Jana McKee, Garielle Martinez, Tamika Moore and Elsie Yamane appeared before the Nevada State Board of Nursing on Wednesday, May 19, 2010. The Board was delighted to have the students, Dean Smith and some of the faculty as guests commenting on how wonderful it was to start their meeting on such a positive note. They were very impressed by the students’ presentation praising their obvious time and dedication to the project. Dr. Roseann Colosimo, Education Consultant for NSBN was also impressed with the students’ presentation and suggestion to require a course dedicated to the specific needs of the elderly in all nursing school programs over the next five years. She invited the students to the next NSBN Education Committee meeting to discuss their idea further.

Nurses of Achievement Recognized in Northern Nevada

During the 11th Annual Northern Nevada Nurses of Achievement event on May 14, more than 260 nurses from northern Nevada were nominated by their peers for the (Continued on page 5)

Meet Nevada’s Nurses This Month: Beth Ennis

By Mary Baker MacKenzie, RN, MS, MA

Beth Ennis is an outstanding Nevada nurse who provides health care to Nevadans residing throughout a large area of rural Nevada. Many rural Nevadans receive direct health care from Beth while others benefit from her advocacy efforts promoting health and dental care in rural areas. Beth chooses to live and practice in rural Nevada. Currently, she resides in Tonopah and works as (Continued on page 5)

Visit us online at www.nvnurses.org

Join NNA today!
Membership application available online
of Southern Nevada. Many students expressed that they felt they needed additional time to develop a quality presentation and were looking forward to next year's competition.

As a result, we have already launched the Second Annual NNA Student Nurses Competition and we invite all schools to select their teams for the finals. The rules and deadlines have been sent to each of the schools via email and additional information can be found on our website. This is an exciting event and we look forward to all schools' participation next year.

We would also like to invite all nurses to NNA's Convention in October and to encourage all members to participate in our upcoming elections. Additional information may be found on our website.

**RNFORMATION** is the official publication of the Nevada Nurses Association. Published by the Nevada Nurses Association, P.O. Box 34660, Reno, NV 89533, 775-747-2333, Email: NNA@NVNurses.org, Web site: www.nvnurses.org. Indexed in the Cumulative Index to Nursing and Allied Health Literature and International Nursing Index and published quarterly.

**Editorial Staff**

Co-Editors: Margaret Curley, RN, BSN nvnursesassn@mvqn.net

Kathy Ryan, RN, MSN

State Board Liaison: Mary Bondmass, PhD, RN

Lorraine Bonaldi-Moore, RN, MBA, MSN

Eliza J. Fountain, RN, BSN

Wallace J. Henkelman, MSN, RN

Mary Rack Mackenzie, RN

John Malek, PhD, MSN, FNP-C

Janice Muhammad, RN, CNM, MS

Eliza J. Fountain, RN, BSN

Denise Rowe, MSN, RN, FNP-C

Debra Toney, PhD, RN

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. 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 Nevada 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. NNA 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 NNA or those of the national or local associations.
Advocacy can be as simple as providing personal insight and information during a decision making process in the workplace to being an active member of a committee or nursing organization that addresses patient and/or nursing issues to much more elaborate and time consuming projects such as legislative action for a state or nationwide change. As one of the largest groups of health care providers we have the ability to effect positive changes by simply getting involved.

Recent NNA initiatives such as whistleblower protection, safe patient handling and appropriate nurse staffing need to be evaluated for effectiveness. Have there been educational activities in your workplace related to whistleblower policies and procedures? Have you been involved in providing feedback and insight on these issues in your workplace? Does your workplace have a safe patient handling program? Is it working? Have injuries to patients and staff been reduced? Are there more things that need to be done? How are the staffing committees working? Do you have sufficient qualified staff to provide safe, quality care? Do you have a voice in making staffing decisions?

2009 Legislative Tracking sheet of bills impacting nursing available at www.nvnurses.org

The New International Webster's Pocket Dictionary (2002) defines the act of advocating as “promoting a cause or point of view.” As nurses, we are all familiar with advocacy as it relates to our patients and their loved ones but seem unsure or uncomfortable in advocating for our profession. Advocating for changes that assist us in providing the best care to our patients is the best sort of advocacy, but too few of us are actively involved in these processes.

In the next legislative session, the Nevada Nurses Association will be working within the legislative framework to improve the access to care for Nevadans by promoting autonomous practice for advanced practice nurses. By eliminating barriers created by the formal written collaborative agreement currently required, nurse practitioners can use their knowledge, skills and expertise to meet the health care needs across the state. Nevada nurses, whether we are nurse practitioners or not, can help by familiarizing ourselves then educating those around us about the educational background and clinical expertise of those in our profession with advanced practice degrees.

Finally, we assume that everyone knows what we, as nurses, do and that they believe we are an essential part of the health care team, yet we all have stories about the funny comment made by a patient, a patient’s family member, a physician, or our own families about “what nurses do.” Most of what the public knows about nurses and nursing is what they have seen in movies and on television...and we know how accurate that is! Clearly there is work to be done in educating the public on what nurses really do and our profession is the best one to do it! Efforts big or small do make a difference and, after all, isn't that why we became nurses?

Teresa Serrat RN, Ph.D., graduated from Amarillo College’s associate degree in nursing program in 1991. The majority of her career has been at the bedside providing care to critically ill adult patients. She completed her bachelors and masters degrees in nursing at The University of Texas at Tyler and, subsequently, held hospital education and administrative positions. Frustrated by the lack of nursing input in key federal and state government initiatives, she enrolled in and later graduated from the University of California, San Francisco doctoral program in nursing with a specialty in health policy.

Teresa moved to Nevada in 2008 and is a professor at the Orvis School of Nursing at the University of Nevada, Reno. Wanting to put her health policy knowledge and skills to work, she has assumed the position of the Nevada Nurses Association Legislative Committee co-chair and looks forward to working on key initiatives that will improve the work environment for Nevada nurses and the access to and quality of care for Nevadans.

The Nevada Nurses Association needs your help. As the 2011 legislative session approaches, we will be calling for nurses to speak up, send letters, contact legislators, and be involved in supporting the NNA legislative action. If you don’t know the legislators from your district, please visit http://mapserve.leg.state.nv.us/website/lcb/viewer.htm to find out who they are. If you aren’t sure how to contact them please visit http://www.nvnurses.org/legislation/contact.htm. Watch our website, www.nvnurses.org, for upcoming Calls to Action!
Congratulations & Welcome, Nursing Classes of 2010

Great Basin College

With nearly 200 family members and friends in attendance, Great Basin College held its annual Pinning Ceremony in the College’s theater on the evening of May 20th. Twenty-two graduates of the Associate of Applied Science Degree in Nursing and 7 graduates of the Bachelor of Science in Nursing Program were pinned. The following day, Great Basin College held its Commencement Ceremony at the Convention Center. Three hundred twenty-five Great Basin College students graduated with certificates of achievement, associate or bachelor’s degrees.

National University

National University is a not-for-profit, private University offering over 70 programs throughout California and Nevada. Several of the programs are offered completely online. The National University Nevada, Associate of Science in Nursing (ASN) program is offered on-site at our Henderson campus. Once a student has completed all the pre-requisites and is accepted to the nursing program, they can complete the ASN in as little as 15 months.

An RN to BSN program is also available in an online, hybrid format for nurses wanting to return to complete the BSN degree. The requirements for these degree programs and others can be found at our website www.nu.edu or by calling an Admissions Advisor at 702-531-7800.

UNLV

Congratulations to the Second class to graduate from National University’s Associate of Science in Nursing Program! These students completed the nursing program and attended a Recognition Ceremony in their honor on May 7th, 2010.

National University is a not-for-profit, private University offering over 70 programs throughout California and Nevada. Several of the programs are offered completely online. The National University Nevada, Associate of Science in Nursing (ASN) program is offered on-site at our Henderson campus. Once a student has completed all the pre-requisites and is accepted to the nursing program, they can complete the ASN in as little as 15 months.

An RN to BSN program is also available in an online, hybrid format for nurses wanting to return to complete the BSN degree. The requirements for these degree programs and others can be found at our website www.nu.edu or by calling an Admissions Advisor at 702-531-7800.

UNLV

The UNLV School of Nursing BSN Graduates

Several UNLV School of Nursing BSN graduates, many displaying purple honor cords

Dean Carolyn Yucha congratulates Dee Riley - Outstanding MSN (nursing educator program) award recipient

The UNLV School of Nursing Spring 2010 Recognition Ceremony was held at the UNLV Student Union on May 6, 2010 wherein 31 BSN, 32 MSN, 3 Post Masters, and 4 PhD graduates were honored. Outstanding graduate student awards were given to Linda Silvestri (PhD), Dee Riley (MS/EDucator), and Tigger Laird (MSN/PNP). Undergraduate award recipients included Brianne Ricker (Academic Excellence), Laurel Newlon (Clinical Excellence), Holli Hall (Leadership), and Sophia Jacas (Spirit of Nursing).

Faculty awards were presented to Deanna St. Cyr, MSN, RN (UNLV/School of Nursing outstanding Teaching Faculty 2010) and Michele Taylor, MSN, RN of Desert Springs Hospital (outstanding clinical teaching award).

Invited guest speakers at the ceremony included Nevada System of Higher Education Board of Regents, Chairman of the Board, James Dean Leavit, former UNLV nursing graduate and US Veteran, Major Maureen Nolan, USAR, and Dr. Michael Bowers, UNLV Executive Vice President and Provost. Student speakers from the PhD, MS, and BSN programs were Linda Silvestri, Daniel Narvano, and Brian Boehm, respectively.

Students from the School of Nursing also joined in the graduation ceremony for the entire UNLV student community which was held May 8, 2010 at the Thomas and Mack Center on the UNLV campus.

College of Southern Nevada

The CSN nursing faculty and students conduct a traditional nursing Pinning Ceremony twice a year to mark the passage from the student nurse role to the practice role. Pinning is not graduation; during our pinning ceremony, the nursing faculty inducts the new Graduate Nurses into the profession of nursing. It is a solemn, distinguished and emotional event shared with family and friends.

This spring CSN welcomed 81 graduates to the profession of nursing. The ceremony concluded with the International Nurses Pledge and candlelighting; the Graduate Nurses recited the pledge reflecting the deep-seated vision and values of nursing.

TMCC

Truckee Meadows Community College Nursing Program will have had three pinning ceremonies this academic year. The graduating class of December 2009 included 24 graduates. Tara Brogan received the Academic Excellence Award and was the class salutatorian. Holly Gomez received the Clinical Excellence Award. Jennifer Abbott received the Leadership Award. Jessica Repp was the class valedictorian. They had a 100% NCLEX first time pass rate. The graduating class of spring 2010 included 28 graduates. The pinning ceremony was held on May 20, 2010. Joan Hunt received the Academic Excellence Award and was the class salutatorian. Shelly Lac was the class valedictorian. There will be a summer 2010 graduating class in August. The pinning ceremony will be held on August 19, 2010 at the Dandini Campus Student Services Center.

Nurse Heroes

Here is my nomination for “Nurse Hero.”

Let me introduce you to Kathy Ferrel, RN. Kathy is a staff nurse on Renown’s Medical-Nephrology Unit (Sierra Tower, 6th floor). While providing quality care to her patients, Kathy consistently goes out of her way to provide teaching, encouragement & optimal learning experiences for nursing students. As every nurse knows, it requires extra energy & patience to supervise & mentor nursing students, while carrying a full patient load. Kathy, a true Nursing Hero, does this on a daily basis, and does it with a caring, nurturing smile!

As a nursing faculty at TMCC, I’ve found it impossible to be with all 8 of my students at once. Staff nurses like Kathy, assist students when faculty are tied up with other students.

This is why Kathy Ferrel and staff nurses like her are my ‘unsung heroes’. I speak for all nursing faculty when I say, “Thank you from the bottom of our hearts! We couldn’t do it without you!”

Linda Saunders, RN
Meet Nevada's Nurses: Beth Ennis, MS, APN, BC-FNP  
(Continued from page 1)

Beth Ennis is a truly extraordinary Community Health Nurse with NV State’s Rural and Frontier Health program. Beth is a qualified Family Nurse Practitioner and skillfully utilizes her APN privileges as well as her RN skills in her practice. Although her primary office is in Tonopah, Beth provides care over a territory comprising a 70 mile radius to include communities in Nye and Esmeralda Counties, and once a month travels 100 miles to Hawthorne to deliver Family Nurse Practitioner care. She also provides care in other rural communities assisting or substituting for the assigned community health nurse when needed.

Raised in upstate New York, Beth obtained her RN through a diploma program at the Arnot Ogden School of Nursing in Elmira, New York, and baccalaureate degree from the University of Rochester in Rochester, New York. She attended graduate school at the University of Utah completing the Family Nurse Practitioner program, earning a MS in 1996. Beth worked for many years in a variety of clinical and geographic settings prior to becoming a Nurse Practitioner. Although she worked in the large metropolitan area of Los Angeles, CA, Beth prefers practicing in rural settings. While working as a RN in Kodiak, Alaska and for the Wyoming State Health Department in Kemmerer, Wyoming, Beth appreciated the need for nurse practitioner services and was motivated to obtain the appropriate certification / license to provide an expanded level of health care. Beth finds that practice in smaller communities affords her the advantage of knowing clients and their family history providing her a more complete picture of a client’s risks, challenges and strengths with regard to health promotion and prevention.

As the only Community Health Nurse working in Tonopah and servicing surrounding rural areas, Beth describes herself as wearing “many hats.” Her APN practice focuses on women’s health, family planning, cancer screening, and sexually transmitted infections (STI). This practice allows her to provide health education and to promote wellness practices. Beth is ingenious at providing care while working in community center and school settings that were not designed for privacy or physical exams. When working in less than ideal settings, she makes use of closets and bathrooms to accomplish services. Beth performs health exams related to birth control, cancer screening and STI. She prescribes birth control and is qualified to insert intrauterine devices. Beth manages a wide variety of problems and makes referrals when necessary.

In addition to performing APN care, Beth provides RN services related to immunizations, well child exams, fluoride varnish applications, school nursing services, communicable diseases, and disaster preparedness. Beth serves as school nurse for three communities in Esmeralda County School District. She provides puberty education and HIV awareness classes for these schools. She performs Healthy Kids exams and developmental, vision and hearing screenings and she ensures immunization compliance utilizing immunizations available through the Vaccines for Children program. During this last year, Beth’s office was the major provider of HIN1 vaccine to the Tonopah area and the surrounding communities.

As a member of her area’s local emergency planning committee (LEPC), in the event of a disaster, Beth is designated to coordinate mass dispensing of required vaccines and / or medication. Last year when pertussis occurred in one of her assigned communities, Beth became the on-site provider coordinating care with private providers and the State Epidemiology Program. Both northern Nye and Esmeralda counties are designated as underserved areas for medical and dental care. Beth’s efforts were instrumental in preserving mammogram services to the area. Beth partnered with UNLV Dental School through the oral health coalition to conduct a yearly Dental Health Fair open to all residents of her territory. Participants receive oral health screenings and, if qualified, may receive fluoride varnish and dental sealants. When childhood immunizations became unavailable from private providers within 100 to 200 miles of her office, Beth coordinated with the Northern Nevada Immunization Coalition and the State Immunization Program to establish an annual Childhood Immunization week. During the immunization week, vaccines are provided to all children within the underserved area.

Professionally, Beth is most rewarded when people take charge of their health and demonstrate the ability to make healthy choices. She feels especially proud when high school students (both male and female) graduate without becoming involved in teen pregnancy. Beth’s future goal is to do more health promotion and health education. Beth encourages prospective nursing students to enter the profession and to obtain as much education as possible considering time and money resources. She admonishes that “you are never too old to go to college” and emphasizes the variety of jobs and geographical locations open to nurses. Beth advises all graduates to find a “mentor as a partner to help you through the nervous times.”

Family Nurse Practitioner Beth Ennis is a truly outstanding Nevada nurse providing care, promoting health and advocating for rural Nevadans in Tonopah and a large territory surrounding it. Her efforts ensure the availability of health care for many Nevadans residing in extremely underserved medical and dental care areas. While benefiting many through direct service, Beth’s chosen practice provides her satisfying rewards and an opportunity to focus on health and wellness promotion, areas she feels are essential. Beth’s career path and satisfaction with her current practice provide encouragement for other nurses to pursue their passionate interests and to take the actions necessary to achieve their goals, including the completion of additional education when required.

Northern Nevada Nurses of Achievement  
(Continued from page 1)

Sari Jokela-Willis, RN  
Masters of Nursing Degree Student - Orvis School of Nursing

Jennifer Mahlberg, RN  
RN to Bachelor of Science Degree in Nursing Student - Great Basin College

Ashley Olpin  
Associate of Applied Science Degree in Nursing Student - Great Basin College

Amber Orsi  
Associate of Applied Science Degree in Nursing Student - Apollo School of Nursing

Krystin Macdonald  
Associate of Applied Science Degree in Nursing Student - Western Nevada College

Natalie Tegio  
Associate of Applied Science Degree in Nursing Student - Truckee Meadows Community College

Founded in 1999 by a handful of local nurses to honor and raise awareness of the nursing profession, Northern Nevada Nurses of Achievement has distributed more than $90,000 in nursing scholarships for local students and has grown to an awards ceremony of more than 600 attendees.

---

Kori Berolo, RN  
RN to Bachelor of Science Degree in Nursing Student - Orvis School of Nursing

Carole Wiseman, Carson Tahoe Regional Healthcare - Medical/Surgical / Maternal Child Health

Debra Holst, VA Sierra Nevada Health Care System - Office/Outpatient

Catherine Estipona, Advanced Medical Arts - Patient Advocacy

Julie Hager, Saint Mary’s Regional Medical Center - Rural Health

“Nurses in general are not comfortable with talking about their achievements,” said Melinda Miller, a nurse with the VA Sierra Nevada Health Care System in Reno and Northern Nevada Nurses of Achievement committee member. “This was an opportunity to recognize nurses who give to this community through their work.”

Also, the recipients of eight $1,500 nursing scholarships funded by Northern Nevada Nurses of Achievement and selected by five area nursing schools were announced:

Kori Berolo, RN  
RN to Bachelor of Science Degree in Nursing Student - Orvis School of Nursing

Christine L. Young  
Baccalaureate of Nursing Degree Student - Orvis School of Nursing

---

Sari Jokela-Willis, RN  
Masters of Nursing Degree Student - Orvis School of Nursing

Jennifer Mahlberg, RN  
RN to Bachelor of Science Degree in Nursing Student - Great Basin College

Ashley Olpin  
Associate of Applied Science Degree in Nursing Student - Great Basin College

Amber Orsi  
Associate of Applied Science Degree in Nursing Student - Apollo School of Nursing

Krystin Macdonald  
Associate of Applied Science Degree in Nursing Student - Western Nevada College

Natalie Tegio  
Associate of Applied Science Degree in Nursing Student - Truckee Meadows Community College

Founded in 1999 by a handful of local nurses to honor and raise awareness of the nursing profession, Northern Nevada Nurses of Achievement has distributed more than $90,000 in nursing scholarships for local students and has grown to an awards ceremony of more than 600 attendees.
Evidence-based Practice: Part One of a Four-part Series on Evidence-based Practice

By Mary Bondmass, RN, PhD, CNE, Associate Professor of Nursing
School of Nursing, University of Nevada Las Vegas
Director at Large: Nevada Nurses Association

Although the IOM (1999, 2001) reports sounded appropriate alerts and have since triggered important changes, the performance of the health care system remains far short of where it should be. Among other initiatives to effectively ‘cross the quality chasm,’ the IOM (2001, 2003) called for “...creating an infrastructure to support evidence-based practice (EBP), and reorienting the culture of health care to promote better serve patients in a world of expanding knowledge and rapid change.” In 2003, an IOM report mandated that “all health professionals should be educated to deliver patient-centered care as well as evidence-based practice,” and emphasized evidence-based practice (EBP), quality improvement approaches, and informatics” (Institute of Medicine of the National Academies, 2003, p. 3).

Evidence-based practice is seen as key to quality improvement and patient safety (IOM, 2001, 2003, 2008) and has been defined as the conscientious use of current best evidence in making decisions about patient care through the integration of best research evidence available, clinical expertise, and patient values (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2000). A more recent revision of the Sackett et al. definition also includes circumstances or context of the practice setting (Strauss, Richardson, Glazsou, & Haynes, 2005). Both of the above IOM accepted definitions of EBP move beyond the earlier concepts of simply either evidence-based-medicine or research utilization.

Research utilization can be defined as the use of research in practice or the application of research to practice. Key to note in differentiating between EBP and research utilization is the term best preceding the words research evidence available in the IOM accepted definitions. To what end constitutes the best research evidence available as well as the skill to apply the best research evidence available to our bedside care and/or to implement it institution-wide that may be deficient in U.S. nursing practice related to EBP.

Clearly, nurses make up the majority of the health care workforce, yet available national data (Pravikoff, et al., 2003, 2005; Brown, et al., 2009), and state-wide Nevada data (Bondmass & Stucke, 2008), indicate a general lack of readiness for nurses to EBP. Many barriers to EBP have also been identified in the nursing literature; the most frequently cited barriers to EBP implementation are a lack of time, knowledge, and administrative support for EBP application in practice. Encouragingly, some data indicate that attitudes toward research and EBP may be changing in a positive direction (Bondmass & Stucke, 2008).

Although the majority of U.S. nurses still lack the knowledge and application skills for EBP, the question is therefore asked: How will Nursing as a profession and discipline ever catch up with, and participate in the exciting trends in evidence-based practice (EBP) articles in this EBP series will begin to address this and other issues with a focus on EBP research, models of EBP, and strategies to increase nursing knowledge and application of EBP at the bedside as well as within institution-wide practice settings.

By Shendry Thom, MSN, RN, FNP-BC

Prior to beginning my Family Nurse Practitioner (FNP) program, one of my children was diagnosed with Celiac Disease (CD). Throughout the diagnosing process, I realized that health care providers were under-informed about the etiology, presentation, diagnosis and treatment of CD. As I researched the disease, it was clear that there was not much in the literature related to the disease for primary care providers, so that provided the impetus for my master's project. I created a manuscript for primary care providers to better inform them in their diagnosis and treatment of this disease.

CD is a malabsorptive disorder of the small intestine caused by a combination of hereditary, environmental and immune factors in response to the ingestion of gluten. Once considered a rare disorder affecting primarily children, CD is now known to affect people of all ages with an estimated prevalence of 1/133.

Diagnosing CD can be difficult because any or all of the following presenting symptoms may be present at one time or another for patients: diarrhea, iron deficiency anemia, peripheral neuropathy, folie acid deficiency, reduced bone density, vomiting, abdominal pain, failure to thrive, muscle wasting, irritability and malaise, abdominal distention, gastrointestinal reflux disorder (GERD) and weight loss.

A diagnosis of CD is made primarily through clinical presentation, serology and small bowel biopsy. Depending on the clinical presentation, an initial work up may include any or all of the following: CBC, CMP, TSH, O&P, stool cultures, stool H. pylori, and/or Celiac panel. A positive Celiac panel would warrant a referral to a GI specialist for confirmation through small bowel biopsy and serology.

The only current treatment for CD is lifetime abstinence from gluten, a substance found in wheat, barley, rye, and oats. Gluten activates an inflammatory immune response, which eventually leads to malabsorption of nutrients and a loss of certain enzymes in the small intestine.

Eliminating gluten from a diet can be very challenging. Individuals facing this diagnosis will need ongoing support, education and lab work to ensure wellness. Nurse Practitioners are educated to treat people using a holistic framework. For individuals living with this diagnosis, that holistic framework provides the necessary tools to take care of those who will be living with this malady for life.

In the United States (U.S.), evidence-based practice (EBP) care delivery to have become one of the most frequently used terms in health care facilities across our country. While many definitions exist, EBP experts believe nurses may have different ideas of what EBP is, what it isn’t, and even how and/ or why EBP came to the forefront of health care today.

Over the next several issues, RNFormation (RNF) will present a series of articles related to EBP. Future RNF issues will focus on research models of EBP and bedside and institution-wide implementation strategies.

In the United States (U.S.), evidence-based practice (EBP) care delivery to have become one of the most frequently used terms in health care facilities across our country. While many definitions exist, EBP experts believe nurses may have different ideas of what EBP is, what it isn’t, and even how and/or why EBP came to the forefront of health care today.

Over the next several issues, RNFormation (RNF) will present a series of articles related to EBP. Future RNF issues will focus on research models of EBP and bedside and institution-wide implementation strategies.

Origins of Evidence-based Practice

The term ‘evidence-based medicine’ referring specifically to the discipline of Medicine, began to appear in the literature with the 1990 publications of Guyatt et al., with credit being given to the physicians at McMaster University for actually starting the ‘evidence-based medicine’ movement in and around this same decade. Nursing, on the other hand, has a different history related to the use of evidence for practice. Early in the 1970’s nurses were publishing data regarding practice evidence, but we were calling this process ‘research utilization.’ Independent of the name, discipline, and/or contemporary origin of EBP, it has been true since the fourth century BC that patient safety has been a concern and an important part of quality health care. Ensuring that patients are safe is obviously a priority in providing health care, as the ancient and still relevant medical motto primum non nocere (first do no harm) indicates. Today, thousands of years after Hippocrates and the Age of Pericles, patient safety remains a problem in health care; some believe EBP may be part of the solution to the issue of patient safety and quality care.

Recently, evidence has mounted about the complexities of our health care system potentially causing patient deaths and significant unintended adverse effects. The often cited Institute of Medicine (IOM) reports, To Err is Human: Building a Safer Health System (1999) and Crossing the Quality Chasm: A New Health System for the 21st Century (2001), crystallized widespread public concern about the need to take action to reduce the occurrence of apparently common, serious health care related errors. The former publication found that an estimated 44,000 to 98,000 Americans may die annually due to medical errors. If mortality tables routinely included medical errors as a formal cause of death, they would rank well within the ten leading killers in the U.S. (IOM, 1999). The latter report indicates “…the U.S. health delivery system does not provide consistent, high quality medical care to all people.” Moreover, available data provide strong evidence that Americans cannot count on receiving care that meets their needs and that is based on the best scientific knowledge. The IOM proposes that change in the structures and processes of the environment in which health professionals and organizations function are among the first steps to providing consistent, high-quality care to all. One of the four main areas of environmental change delineated in the IOM’s 2001 report is the preparation of the workforce, with stress placed on teaching EBP. The IOM clearly made the connection between safety given to the patient and EBP: “understanding the need for redesigning health care to address the key dimensions wherein most improvement is needed. The key dimensions of change suggested by the IOM include safety, effectiveness, patient centeredness, timeliness, efficiency, and equity (IOM, 2001),

Evidence-based practice is seen as key to quality improvement and patient safety (IOM, 2001, 2003, 2008) and has been defined as the conscientious use of current best evidence in making decisions about patient care through the integration of best research evidence available, clinical expertise, and patient values (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2000). A more recent revision of the Sackett et al. definition also includes circumstances or context of the practice setting (Strauss, Richardson, Glazsou, & Haynes, 2005). Both of the above IOM accepted definitions of EBP move beyond the earlier concepts of simply either evidence-based-medicine or research utilization.

Research utilization can be defined as the use of research in practice or the application of research to practice. Key to note in differentiating between EBP and research utilization is the term best preceding the words research evidence available in the IOM accepted definitions. To what end constitutes the best research evidence available as well as the skill to apply the best research evidence available to our bedside care and/or to implement it institution-wide that may be deficient in U.S. nursing practice related to EBP.

Clearly, nurses make up the majority of the health care workforce, yet available national data (Pravikoff, et al., 2003, 2005; Brown, et al., 2009), and state-wide Nevada data (Bondmass & Stucke, 2008), indicate a general lack of readiness for nurses to EBP. Many barriers to EBP have also been identified in the nursing literature; the most frequently cited barriers to EBP implementation are a lack of time, knowledge, and administrative support for EBP application in practice. Encouragingly, some data indicate that attitudes toward research and EBP may be changing in a positive direction (Bondmass & Stucke, 2008).

Although the majority of U.S. nurses still lack the knowledge and application skills for EBP, the question is therefore asked: How will Nursing as a profession and discipline ever catch up with, and participate in the exciting trends in evidence-based practice (EBP) articles in this EBP series will begin to address this and other issues with a focus on EBP research, models of EBP, and strategies to increase nursing knowledge and application of EBP at the bedside as well as within institution-wide practice settings.

References Available on Request.
Federal healthcare reform, specifically, The Patient Protection and Affordable Care Act (PPACA) was passed into law by Congress in March, 2010. The legislation was passed after a year of intense debate on the pros and cons of the federal government’s role and responsibilities in healthcare. It is hoped the law will increase access to healthcare for its citizens. In this article, Stokowski does not rehash the debate, but offers insights on the implications of PPACA from two nationally known nurses. The article summarizes key provisions of PPACA that affect nursing.

Stokowski states that the expectation of 32 million people becoming newly insured will significantly affect our healthcare system and that nurses will continue to be at the forefront of providing or increasing access to healthcare for its citizens. In this article, Stokowski and Kennedy suggest that the law creates a grant program for health clinics to be managed by nurse practitioners (NP). Kennedy also points out that the law increases the number of NPs able to go into independent practice. She also pointed out that even though physicians raise the issue of safety when they perceive NPs are tending into their turf and affecting their bottom line, NP-delivered care has been shown to be as safe as physician delivered care.

Another question asked was whether there would be enough nurse practitioners to meet the demands of millions more people with health insurance. Hasmiller commented that when the 2006 Massachusetts law offered health insurance to virtually all its residents, there was initially a shortage of primary care providers and emergency room visits went up sharply, initially causing a spike in healthcare costs. Subsequently Massachusetts passed a law requiring recognition and reimbursement for NPs as primary care providers by health insurance plans. Under PPACA, Certified Midwives will receive the same pay as physicians for Medicare Part B, which covers physician fees. The Joint Commission is also working on a medical home designation which expands leadership roles in primary care beyond just physicians to include independent practitioners including NPs.

What about the paradigm shift from a sick care model to a health care model which also targets chronic disease management? Hasmiller was emphatic that nursing has always been about prevention and wellness and was excited to see this approach as a significant focus of the new law. She said nursing education curricula while continuing to address acute care, must now include more emphasis on community care and address cultural competencies and training for new multidisciplinary healthcare settings to meet the needs of a more diverse and aging population.

Stokowski asked if healthcare reform would lead to staff reduction among hospital-based nurses. Kennedy suggested that more nurses would be needed due to the expected increase in patient volumes. She stated that nurses are at the center of promoting optimal wellness because they have the most direct interaction with patients. She added that whether at the emergency room or at doctors’ offices, nurses are on the front lines to assess where patients fit on the health-illness continuum. Hasmiller pointed out that PPACA would also reward delivery of higher quality of care in hospitals, trauma care, prevention, wellness, safety and disaster preparedness. Therefore, more nurses with better training will be needed. Should nurses be worried about losing their jobs as a result of healthcare reform? Kennedy said while the nurse work force has resulted in some job losses related to the economy, nurses must continue to strongly advocate for the economic value that nurses bring to the workplace.

Key PPACA provisions include but are not limited to the following:

- Increases the total amount for nurse education from $13,000 to $17,000 (at 5% interest)
- Provides fellowship programs for nursing faculty and advance practice RNs to practice in geriatrics, long term care, or chronic care for 5 years and offers traineeships for advanced practice nursing degrees in geriatric care
- Provides education grants for Nurse Midwives, removing the 10% cap on doctoral education
- Provides nurse retention programs including career ladders and funding for nursing residencies and internships
- Expands scholarships and repayments to nurses working as nursing faculty for 2 years in accredited schools
- Increases the nurse faculty loan repayment program from a maximum of $30,000 to $35,000. Master’s graduates working as nursing faculty at accredited programs for 4 years would be eligible for $40,000 loan repayment, while doctoral graduates would be eligible for $60,000
- Provides stipends for racial and ethnic minorities with diplomas or associate degrees to enter bridge or higher degree programs. Grants would also be available for pre-entry preparation and advanced degree preparation and retention
- Offers grants to train family NPs in primary care in federally qualified facilities or clinics managed by nurses
- Provides grants for the delivery of comprehensive primary care services in schools for underserved children and adolescents
- Offers incentive programs that increase payments to providers including NPs and clinical nurse specialists by 10%
- Optionally covers home visitation services to new mothers among low-income and at-risk families
- Funds patient-centered outcomes research which will compare health outcomes, clinical effectiveness, risks and benefits of medical treatments and services
- Increases payment rates to Nurse Midwives for covered services from 65% to the rate that a physician providing the same service would receive

In summary, I agree with Stokowski that healthcare reform will bring new opportunities and challenges. As nurses we need to educate ourselves about the law’s provisions so we can in turn educate our patients. The American Nurses Association President, Rebecca Patton, in discussing how nurses can help people understand the changes that lie ahead in healthcare reiterated that as devoted patient advocates, nurses are uniquely positioned to educate patients on how healthcare reform will directly impact them. I completely agree. By doing so, we have the ability to impact patient outcomes when we educate and advocate for our patients. Many of them will be newly insured, accessing care, and navigating through the new healthcare network with the ultimate goal of getting the best care for themselves and their families. While it may initially be challenging as the law is phased in, PPACA provides opportunities for nurses to grow and to lead. As we approach the changes ahead, I believe there is much on the horizon for nurses to be excited about.

With kind regards,
Norman
Norman S. Marks, MD, MHA
Medical Director, MedWatch Program
US Food and Drug Administration
norman.marks@fda.hhs.gov
www.fda.gov/medwatch

(Continued on page 17)
Calling all Northern Nevada Nurses
to join in and support the...

12th Annual Northern Nevada Susan G. Komen Race for the Cure on Sunday, October 3, 2010

The Northern Nevada Affiliate of Susan G. Komen for the Cure was voted Number 1 in “Charities/Causes You Support” in Reno Magazine’s Best of Reno 2010 readers’ poll. Komen’s annual event has raised more than $2.4 million for local breast cancer education, screening, and treatment programs over the last 11 years.

NNA is proud to participate in this event by forming a team to walk to raise money for those facing breast cancer in our communities—we all know someone who is struggling with this disease. But just as we can’t face cancer alone, we can’t fight cancer alone—we need your help! Please join us in racing toward a cure.

The Race begins at the University of Nevada, Reno and “runs” from 8 AM to 12 PM. You can donate and participate in a 5k timed run, 5k fitness walk, or 1-mile fitness walk, or you can donate, relax at home and we will exercise for you.

If you are interested in registering for the NNA team in October, please visit http://komennorthnv2010/kintera.org/fast/search/ searchTeamPart.asp?ievent=345895&team=3747698 or http://www.komennorthnv.org; click “Race Page” see “Team Rank” then click “More” then click “NNA Nurse” then click “Join our Team.”

For more information please visit www.komennorthnv.org or contact NNA’s Race organizer Charmaine Cruet at ccruet@sbcglobal.net.

We hope to see you there!

ANA Gains ACNM, Recognizes WOCN

The American Nurses Association (ANA) announced that the American College of Nurse-Midwives (ACNM) is joining ANA as an organizational affiliate.

“This new partnership ensures that ANA will continue the long tradition of representing the interests of all nurses,” said former ANA President Rebecca M. Patton, MSN, RN, CNOR. “Through organizational affiliates like the American College of Nurse-Midwives, we grow and give all nurses a stronger voice as we work together to achieve mutual goals and advocate for the issues that matter most to the nursing community and the patients we serve.”

ANA also announced the formal recognition of wound, ostomy and continence (WOC) nursing as a specialty. WOC nursing is an evidence-based practice designed to improve the quality of life for persons with select disorders of the gastrointestinal, genitourinary (reproductive and urinary), and integumentary (skin and associated structure) systems.

“ANA is pleased to recognize the specialty status of this essential area of nursing practice,” remarked Patton.
**American Association of Critical Care Nurses**  
(800) 899-2226  
www.aacn.org & info@aacn.org

**American Association of Neuroscience Nurses - Northern Nevada Chapter**  
(702) 383-7326 or (775) 445-8410  
rencottleagie@gmail.com or sheliahall@ctrh.org

**Association of periOperative Registered Nurses**  
Ren Scott-Las Vegas or Sheila Hall-Reno  
(702) 383-7326 or (775) 445-8410  
rencottleagie@gmail.com or sheliahall@ctrh.org

**Hospice and Palliative Nursing Association in Northern Nevada**  
Nicolina Miller  
(702) 239-9684  
milipscombrn@aol.com

**National Association of Hispanic Nurses**  
Maria Lipscomb  
(702) 239-9684  
milipscombrn@aol.com

**Nevada Association of Occupational Health Nurses**  
Nancy Menzel  
(702) 895-5970  
nancy.menzel@unlv.edu

**Nevada Nurses Association**  
Margaret Curley  
(775) 327-9421  
www.nvnurses.org & nvnursesassn@mvqn.net

**Nevada Organization of Nurse Leaders**  
Susan Adamek  
(702) 995-0239  
president@nloni.org

**Philippine Nurses Association of Nevada**  
(702) 258-1224  
PNANV.org

**Preventive Cardiovascular Nurses Association**  
Kim Newlin  
(702) 258-1224  
knewlinpcna@surewest.net pcna.net

**Society for Vascular Nursing**  
Kathy Ware (Sierra Chapter)  
916-734-7701 or 888-536-43VN (4378)  
svn@administrare.com or www.svnnet.org

**Southern Nevada Black Nurses Association**  
Marcia Evans  
(702) 615-3575 or (702) 338-0524  
www.snbnb.net

**Wound, Ostomy, Continence Nurses**  
Joyce Moss  
www.pcr.org

---

**Recommended for Review**

The Joint Commission has issued a Sentinel Alert about the rising violence in health care facilities with 13 recommended steps. View the full alert on the Joint Commission website at [http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_45.htm](http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_45.htm).

---

**Editorial**

**Dear Readers—**

Margaret and I have enjoyed our first year as coordinators of RNFormation. We have faced and overcome challenges and grown in the process, and laughed a time or two as well. We continue to be thankful for our Editorial Board and their contributions of time and expertise—they are the reasons for our success!

One of the gauges of our success is the feedback we receive from our readers. Please keep telling us what you think and what you want—your ideas and opinions are important to us. We appreciate your kudos for our “themes” or clusters of articles addressing a specific topic. Please send us your suggestions for future themes.

One of our concerns is the future of health care providers in Nevada. Substance abuse is on the rise among nurses in Nevada, and we are exploring this issue in this edition.

Mother Teresa wrote “There is a light in this world, a healing spirit more powerful than any darkness we may encounter. We sometimes lose sight of this force when there is suffering, too much pain. Then suddenly the spirit will emerge through the lives of ordinary people who hear the call and answer in extraordinary ways.”

We at RNFormation honor all the ordinary people who answer in extraordinary ways—nurses.

Blessings to you all, Margaret and Kathy
and the Centers for Disease Control and Prevention, healthcare-associated infections (HAIs) are emerging public health issues and have received increasing public attention. The Department of Health and Human Services (HHS) in 2002 stated that HAIs were among the leading causes of preventable death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths. In addition to the substantial human suffering caused by HAIs, the financial burden attributable to infections is staggering. It is estimated that HAIs cause $28 to $33 billion in excess healthcare costs each year.

HAIs occur in all settings of care including acute care hospitals, same day surgical centers, ambulatory care clinics, long term care, and rehabilitation facilities. Nevada healthcare facilities and Infection Preventionists are actively engaged in HAI prevention on a daily basis. By creating infection control plans and implementing proven practices for HAI prevention, they are able to reduce risks associated with acquiring HAIs. Some of these risks include the use of medical devices such as catheters and ventilators, transmission between patients and healthcare workers, the results of surgical complications, and the overuse of antibiotics. Although many professional organizations and Nevada healthcare facilities are routinely working to prevent HAIs, there is limited state-wide coordination of HAI prevention activities. In the past, Nevada has had no legislative mandate in place for HAI reporting, limiting quantification of HAI burden in the state as a whole.

The Nevada Legislature has acknowledged the importance of HAIs through the 2009 passage of Senate Bill 319, which established mandatory reporting of surveillance data from obstetric centers, hospitals and ambulatory surgery centers with the reporting of surveillance data from obstetric centers, hospitals and ambulatory surgery centers, surgical site infections (SSI), antibiotic stewardship, and Methicillin-resistant Staphylococcus aureus (MRSA). The 2 year goals are to decrease CLABSI in intensive care units, SSI specifically for deep sternal wounds and hip and knee replacements, and invasive MRSA by 25%. The following statistics illustrate the importance of addressing HAIs in the state and provide a mechanism to defend against hazards.

Central line-associated blood stream infections.

“Each year, an estimated 250,000 cases of central line-associated (i.e., central venous catheter-associated) blood stream infections occur in hospitals in the United States, with an estimated attributable mortality of 12%-25% for each infection. The marginal cost to the healthcare system is approximately $25,000 per episode. Of the approximately 99,000 deaths associated with HAIs, 30,065 were related to bloodstream infections” (Klevens, 2002).

Surgical Site Infections.

According to the CDC, about 27 million surgical procedures are performed each year in the United States. Since 2001, an estimated 290,000 SSIs occur every year. Approximately 8,000 patient deaths are associated with these infections.

Methicillin-resistant Staphylococcus aureus (MRSA).

According to the CDC, MRSA is a type of staphylococcus bacteria that does not react to certain antibiotics and will normally cause skin infections. But MRSA can also cause other infections, including pneumonia, and can be fatal. In 1994, MRSA infections accounted for 2% of the total number of staph infections; in 1995 it was 22%; in 2004 it was 63%. The CDC estimated that 94,360 invasive MRSA infections occurred in the United States in 2005; 18,650 of these were associated with death.

Antibiotic Stewardship.

Studies conducted over the years indicate that antibiotic use is unnecessary or inappropriate in as many as 50% of cases in the United States, and this creates antimicrobial resistance and decreased efficacy of available antimicrobials. Because the pharmaceutical industry pipeline for new antibiotics has been curtailed in recent years, and in the absence of a pipeline, it may be very difficult for important new antibiotics to treat certain resistant bacteria find their way to market, a premium has been set on maintaining the effectiveness of currently available agents. Several strategies, including prescribing education, formulary restriction, prior approval, streamlining, antibiotic cycling, and computer-assisted programs have been proposed to improve antibiotic use.

The Nevada HAI plan proposes to accomplish these goals by developing and enhancing the State’s HAI program infrastructure through collaborative efforts with community partners. One example is the collaborative efforts between the Health Division and the Nevada Health Association (NHA) in the reduction of central line-associated blood stream infections through Comprehensive Unit-based Safety Program (CUSP).

The following is an excerpt from the NHA's newsletter, Hospital Think, May 5, 2010 issue:

"NHA Joins National Program to Improve Patient Safety and Eliminate HealthCare-Aquired Infections"

"The Comprehensive Unit-based Safety Program (CUSP) is a national collaborative funded by the Agency for Healthcare Research and Quality (AHRQ), a division of Health and Human Services, and administered by the Health Research & Educational Trust of the American Hospital Association. The infection prevention program was modeled after a program developed by the Johns Hopkins University Quality and Safety Research Group (JHU QSRG) and implemented in Hopkins ICUs that reduced central line-associated blood stream infections to near zero.

"CUSP is powerful because it provides a structured systematic framework for safety improvement that can be implemented throughout hospitals, yet is flexible enough to tap into staff wisdom and encourage them to fix hazards that they perceive pose the greatest risks. This program draws from frontline providers who have the most knowledge regarding safety hazards and the means to lessen the severity of those hazards, and provides a mechanism to defend against hazards. Therefore states are currently partnering in this program with an additional 10 states signed on to participate. Participation is open to all acute care and Critical Access Hospitals in all states."

HAIs are among the leading causes of preventable death in the United States. In addition to the substantial human suffering caused by HAIs, the financial burden attributable to infections is staggering. Improvement of HAI detection, reporting, and response will be supported by the use of best practices, evidenced-based HAI guidelines and taught by community partners throughout the state. The ultimate goal of Nevada’s HAI prevention plan is to reduce the numbers of HAIs affecting the citizens of our state.

The Nevada State Quality Improvement team encourages Nevada nurses to become informed about quality healthcare in your state. We urge you to become involved. The NISHD offers a listserv for the public. The listserv will communicate issues such as notices of public workshops for regulations, notices of important events, website updates, major changes in policies, procedures, and personnel, training announcements, press releases, and other news. To sign up use the following link: http://health.nv.gov/HCQG.htm

For More Information Please Visit

The following Websites:

• To view the State’s HAI Plan go to: http://www.hcd.cdc.gov/hai/recoveryact/region9.html

• To view the State’s HAI Plan go to: http://health.nv.gov/HCQC_HealthFacilities.htm

• For the State Health Division’s Bureau of Healthcare Quality and Compliance webpage go to: http://health.nv.gov/HCQC_HealthFacilities.htm

• For information on Bills passed during the 2009 legislative session go to: http://leg.state.nv.us/billstatus/2009JBills/58NRS319_EN.PDF

• For the Nevada State Health Division’s website go to: http://health.nv.gov/
Nurse Heroes Many Ways—Every Day
NNA 2010 State Convention
October 23, 2010

The Nevada Nurses Association is pleased to announce the Nevada Nurses Association 79th State Conference. Please join us on Saturday, October 23, 2010 at the College of Southern Nevada, West Charleston Campus and present your work to a diverse nursing audience. Abstracts are invited for poster presentations on the conference theme: "Nurse Heroes: Many Ways—Every Day." The Conference Abstract Review Committee welcomes abstract submissions from nurses in all settings reflecting the conference theme.

Submission date: The call for abstracts opens on August 15, 2010 and closes at midnight (Pacific Standard Time) on September 15, 2010. The Conference Abstract Review Committee has specific guidelines for abstract submission. Please visit our website at www.nvnurses.org for Abstract Submission Guidelines or contact Elizabeth Fildes, EdD, RN, CNE, CAPN-AP at Elizabeth.fildes@tun.touro.edu for guidelines and additional information.

All conference presenters must be NNA members.

NNA Members,
We need your help and expertise!

NNA needs your help to organize this exciting convention, whether you live in the north or the south. It could mean a nice little get away for the weekend. Our goal is to have enough help so this endeavor is not overwhelming for anyone. There will be conference calls on a regular basis.

This will be an excellent opportunity to get to know other nurses, help organize this exciting event, and have an excellent addition to your CV or resume. If you are interested in helping with this exciting event or have any questions, please contact—Nicki Aaker at naaker@aol.com or call 775-283-3711 or 775-843-8198.

Photo CD Album of Nevada Nurses

The NNA is putting together a PowerPoint Picture presentation of Nevada Nurses—sort of a Photo CD Album. All Nevada nurses, NNA members and non-members, are invited to send pictures of themselves to be included in the picture presentation. The picture presentation will be shown at various break times during the NNA convention in October, 2010. Both old and new pictures are welcome—as many as you want to send is fine—graduation from nursing school pictures are especially fun—provide dates if you dare! We’ve done something like this in the past (2006 Convention) and it was a blast!

Sending your photos will serve as your implied consent to show your photos at the Convention and as consent to have your photos included on a CD that may be given out at the Convention. Please send your photos to mbondmass@cox.net—please put “NNA Photos” in the subject line.

Interested in Exhibiting?

Please call Nicki Aaker at naaker@aol.com or (775)843-8198 or Betty Razor at etbetty@sbcglobal.net or (775) 560-3350 for more information.

Welcome to the Nevada Nurses Association!
We are pleased and proud to warmly welcome our new members.
My first article for this column five years ago advised nurses to purchase and maintain malpractice insurance warning, “If you think it will never happen to you, think again!” However, many nurses are still gambling with their licenses as they practice unprotected. They assume that if they do everything right they will not have to worry about being sued. Some nurses choose not to carry malpractice insurance fearing such policies will merely give plaintiffs another “deep pocket” to go after. Some even advise nurses not to obtain malpractice insurance because they erroneously believe they will be safer without it and I still believe this has to be the worst advice anyone can give to a nurse. You simply cannot work as a nurse in any capacity and expect to be completely immune from litigation. For nurses working in Nevada, the greater risk than being named in a lawsuit is receiving a Notice of Complaint from the Nevada State Board of Nursing. The Board is receiving more complaints than ever before and more nurses are being disciplined every year. Most nurses believe since their employers have purchased malpractice insurance for them, having their own insurance would not be necessary. However, in most cases, those plans do not cover nursing board complaints, especially when it is the employer who has submitted the complaint following termination or other disciplinary action. The key is to look for coverage from an insurance company which specializes in malpractice policies for nurses. NSO, CNA and other carriers offer up to $1,000,000.00 or more for civil liability claims. Although most plans do not pay for legal fees and other related costs until after a board matter is resolved, they do reimburse most of the legal expenses subject to certain rates and conditions. Insurance for nurses is approximately $100 on average per year. Practicing without nursing malpractice insurance can be as risky as driving without auto insurance. Many nurses who receive a nursing board complaint have recently been terminated from their jobs and fear they will have difficulty in finding new employment. Already concerned about making ends meet, coming up with additional funds for legal fees can put quite a strain on them financially. Knowing they will at least be partially reimbursed offers great relief to those who must defend against a complaint which is already perhaps one of the most stressful events they will ever go through. What nurses need to realize is that anyone can submit a complaint against them at any time for any reason, valid or not. Oftentimes, the costliest matters to defend are those which involve false allegations. Myths have been tossed around for years offering reasons not to seek malpractice insurance. However, in my experience, none of these reasons ring true. Malpractice insurance is simply a must for nurses and if you have any doubts, just ask anyone who has been subject to a complaint or lawsuit. You may be next...don’t go unprotected.

For questions or comments, feel free to contact the author at (702) 444-5520 or via email at tsingh@ tlsinghlaw.com.
We all have a deep desire to feel happy and to find peace. At times in our lives, most all of us find this wholeness of peace and beauty alternating with periods of sadness and mourning. This is one of the natural cycles of life. The purpose of this article is to increase awareness and understanding of substance abuse. It is my intention to give the reader a better idea of addiction from a personal and professional perspective.

The process of addiction is an attempt to produce a desired mood change. Because addiction is an illness, mood changes from substance abuse give the illusion that some “need” has been met. That need is physical, psychological or emotional. My relationship with substance abuse was pathological. Through denial I had no substantial awareness of the self-destructive nature of this disease. As my abuse of mood altering substances escalated, relationships with others and social support declined. This led to an even greater reliance on substances to achieve happiness, wholeness, and peace of mind. My priorities were misplaced. Substance abuse came first, people last. I had little regard for myself or others and eventually I was out of control (not that I ever had any to begin with). I was in a vicious cycle of self-destruction that knew no boundaries and that I was unable to stop. I had lost my career, my privilege to practice nursing, and remained “lost” for over six more years before making contact with the board of nursing.

As a child my dream was not to be a nurse or to suffer from addiction. My childhood was spent caring for a younger brother, maintaining a household and just getting through the day. Becoming a nurse was an act of fate and the dream of someone who saw potential in me that I could not see in myself. Coming from a dysfunctional family was just a normal way of life. Nursing school didn’t teach me about addiction. This was a monster that I was born with and a part of me that I didn’t even know existed. It wasn’t until I was much more “seasoned” that my disease began to affect every aspect of my daily life, including my professional work. The behaviors were all there: frequent absenteeism, lack of interest in studies, mood swings, deteriorating health and constant conflicts with colleagues and superiors.

In 1981, I lost the privilege to practice nursing as a result of complaints that were filed with the board of nursing. For more than six years I wandered aimlessly from job to job, state to state, working as a waiter, housekeeper, and office worker. In 1989, I had a spiritual awakening and realized I was going to die if I didn’t get help, and that I was a nurse. For days I struggled with these revelations, not knowing where or how to get the help I needed. Ultimately, with a great deal of courage, I contacted the board of nursing to petition for reinstatement of my license. The dedicated professionals of the board of nursing heard my case and I was offered the direction so desperately needed to deal with my disease. It was not an easy journey. I was filled with guilt, shame, denial and considered myself a “bad” person rather than a “sick” person. Apparently everyone else knew I had a problem except me. Progressing from denial to acceptance was more difficult than it seemed. First I had to admit to myself that a problem existed and then I had to be willing to take direction, to learn, be open-minded and care about myself. From a logical perspective, how could I ever be of benefit to others if I could not care for myself? The foundations of our profession are caring and compassion; two very distinct concepts that were missing from my life.

One concept that is constant in life is change. When I entered recovery there was no option for voluntary surrender of my license. There were no alternative programs or education programs for nurses and administrators regarding recovery programs. For many years the only option for impaired nurses was thirty days of inpatient treatment followed by additional board evaluations. Through the evaluation process the board consistently reviewed my treatment progress, attendance at 12-step programs, nurse support meetings, counseling and letters of recommendation. When it was decided that I was safe to practice and not considered a danger to the health and well being of patients I was offered a five year probationary agreement. The agreement was very structured, legally binding and the ramifications for failing to abide by this agreement clearly defined. This was not a court order but rather stipulations that I needed to complete if I chose to practice nursing again. The decision was mine, and I chose to move forward. I chose to live and I chose to nurse. If I had continued on my path of self-destruction, I know in my heart I would not be here to write these words today. My experience with the board of nursing is nothing short of complete gratitude. While keeping true to their mission statement of protecting the public’s health and safety I found dedicated, knowledgeable, caring and compassionate professionals. Although it seemed as if the world was changing around me, actually it was me who was changing. I wanted to live, to help others, to touch the spirit of my patients and to be a productive member of society.

I was naive about many things, the most important of which was what it meant to be a nurse. When I was in school we didn’t learn about the role of the board of nursing, there was no education on the warning signs of impaired nurses, and nursing leaders didn’t know where to turn for help. Typically, nurses were reprimanded, fired for poor performance, and it became someone else’s problem to deal with. Interventions to help nurses didn’t exactly exist. It was taboo to think that one of our fellow workers could have a problem with alcohol, drugs, or psychological issues. No one spoke of denial, manipulation, or blackouts. When it happened to me, I felt as if I were the only nurse this had ever happened to and that I would never be able to practice my profession again. When you’re in the grip of denial, it’s very easy to rationalize your irrational behaviors. My life was completely unmanageable and this disease was getting progressively worse leading only to jail, institutions, or death. I had no support system, no coping skills, and nowhere to turn for help. I was merely surviving, much like I had been doing all of my life.

Today I write this with an attitude of gratitude. The day is much the same as any other. The sun is shining, there are leaves on trees, and flowers are blooming. I’m grateful today that I am alive. I am a recovering nurse. On a daily basis I must do what is necessary to keep my health and be acutely aware that this disease will kill me if I fail to take the steps necessary to prevent a relapse. I suffer from a disease no different than other diseases that afflict our communities. Although I have recently celebrated 21 years of continuous recovery, it is today that I am most grateful for. If you or someone you work with is suffering from this disease, please, contact the board of nursing for guidance. You may just save another life!
Alcoholism: Some facts, consequences, and costs

- There are more deaths and disabilities each year in the U.S. from substance abuse than from any other cause.
- About 18 million Americans have alcohol problems.
- More than half of all adults have a family history of alcoholism or problem drinking.
- More than nine million children live with a parent dependent on alcohol and/or illicit drugs.
- One quarter of all emergency room admissions, one-third of all suicides and more than half of all homicides and incidents of domestic violence are alcohol-related.
- Heavy drinking contributes to illness in each of the top three causes of death; heart disease, cancer, and stroke.

- Almost half of all traffic fatalities are alcohol-related.
- Fetal alcohol syndrome is the leading known cause of mental retardation.
- Alcohol and drug abuse costs the American economy an estimated $276 billion per year in lost productivity, health care expenditures, crime, motor vehicle crashes and other conditions.
- Untreated addiction is more expensive than heart disease, diabetes and cancer combined.
- Every American adult pays nearly $1,000 per year for the damages of addiction.

Alcoholism is manifested in symptoms such as overdosing, acute withdrawal, or accidents needing emergency care. It is permanent as it requires changes in behavior at the onset of treatment and throughout the addict’s life. It requires adherence to a daily regimen much like diabetes. Without treatment, the symptoms of the disease of addiction are exacerbated, affecting more and more systems with increasing severity. Symptoms may interrupt the symptoms, but the progression of the disease continues. Upon relapse, the severity of the symptoms picks up where it left off.

A colleague of mine once described addiction as a switch that gets flipped. An individual may go through life absent of addictive symptoms when a crisis flips the addiction switch. That crisis may be the loss of a loved one, a divorce, experiences victimization in any form, even surgery or a motor vehicle accident. The switch turns on the disease of addiction and, from that time on, the individual must work daily to manage the symptoms of disease.

Addiction is incurable, irreversible, and ultimately fatal.

Today, there are no effective cures, only management of the symptoms to prevent an acute episode. Complete abstinence from mind altering chemicals, including alcohol, is necessary if the addict is to return to a “normal” life. Addiction is fatal; it actually wants to kill its host. It waits in the wings to consume the addict’s life; give it the opportunity and death is eminent.

As with any other chronic disease, anyone can develop the disease of addiction. The signs and symptoms are not readily apparent in the early stages. There is a genetic element that predisposes an individual to this disease, but this genetic loading does not guarantee the development of addiction. Anyone who is exposed to mind altering substances is at risk for this disease.

The Impaired Nurse

Nurses have a higher predisposition for chemical addiction than the general population. As nurses, we believe that drugs really do work, so why not for us? We self diagnose and self medicate and believe that a pill or an injection will readily relieve pain and suffering because we see that it does every day.Erroneously, we believe that because we are educated about medications we are not as susceptible to abusing them. We have ready access to narcotics, and, as the Board’s attorney puts it, we have the keys to the candy store.

Nursing is an extremely stressful role. Working a variety of shifts can lead to disrupted sleep patterns and deprivation. Although we work in an environment of literal life and death circumstances, we are expected to control our emotions—often a difficult, if not impossible, task. Patients are sicker than ever and resources have dwindled. Crises are commonplace in healthcare settings and nurses are expected to cope and “fix it.”

Employers can enable a nurse to stay steeped in her addiction through a lack of knowledge about the disease of addiction, especially in how to confront suspicious behavior. Denial is strong in the addict and in colleagues and employers who may fear litigation based on an accusation of impairment. Rationalization of a nurse’s behavior and excusing sloppy performance is sometimes easier than confronting what appear to be addictive symptoms. In the absence of a “dirty” drug screen, the employer may doubt having legal grounds for termination and reporting to the Board of Nursing.

This enabling behavior is dangerous. Patients are put in jeopardy as the nurse becomes increasingly ill. The employer does a disservice to the nurse when intervention could be life-saving by recommending treatment and recovery for this deadly disease. We have heard from those nurses who are successful in keeping their disease in remission that they are thankful that their employer and colleagues cared enough to intervene.

(Continued on page 15)
In July of 2007, the Los Angeles County Emergency Medical System (EMS) implemented a revision of its standards for the withholding of resuscitative measures in pre-hospital settings. A study of the results of implementing these new standards has recently been published (Grudzen, Asche & Koenig, 2010).

Prior to the new standards, EMS providers were allowed to withhold resuscitation effort only when there was a written Do Not Resuscitate (DNR) order, or if there were obvious signs of irreversible death such as decapitation, massive crush injury, or decomposition. Those standards are similar to current Nevada standards (NRS 449.620-449.626). The new standards allow EMS providers more flexibility in decision-making regarding end-of-life treatment including the decision to withhold resuscitation efforts if a family member at the scene verbally requests such withholding (without other family members disagreeing) or if the patient is unlikely to respond to resuscitation efforts. An example of the latter would be someone who has been in asystole for longer than 10 minutes (Grudzen, Asche & Koenig, 2010).

Such a policy would be more in line with the ethical principle of autonomy if it were the wishes of the patient that were being followed in withholding treatment. It would also follow the principle of nonmalefice in avoiding prolonging the suffering of patients with no hope of recovery.

A study including a combination of quantitative and qualitative methodologies was used to compare a six-month period prior to implementation of the new policy to a six-month period after implementation. For the quantitative analyses, the researchers collected EMS “run sheets” in order to determine the location of cardiac arrests, the presence of family members at the site, the existence of DNR identification, the condition of the patient upon the arrival of EMS providers, and whether resuscitation was attempted. A majority of the arrests occurred at home with family members present. Written DNR orders were usually not available. In addition, even when DNR orders were produced, they were often not followed. After implementation of the policy, the number of attempted resuscitations declined slightly, but significantly. An unexpected finding was that documentation of irreversible deaths declined after implementation. The researchers suggested that EMS providers had previously used documentation of irreversible death to forgo treatment in cases in which they expected a poor outcome and decided to withhold treatment (Grudzen, Asche & Koenig, 2010).

The qualitative portion of the study was conducted using focus groups of EMS providers to determine their comfort with the new standards. The providers were overwhelmingly positive in their evaluations. Only one paramedic expressed concern that the families expected something to be done at the scene, and that withholding care might create an undesirable impression (Grudzen, Asche & Koenig, 2010).

The researchers also reported that since implementation of the policy there have been no family reports of adverse consequences or reports of negligence, possibly due to better communication between providers and family members. They suggested that bereavement training for the EMS providers could further improve that communication (Grudzen, Asche & Koenig, 2010).

We were such a policy to be implemented in Nevada, one possible problem might be legal challenges to the decisions at the scene. Under Nevada law, when a patient is incapable of making health care decisions, the decision-making capability passes, in a specific order, to relatives (NRS 449.626). Under the California policy “a family member at the scene” (Grudzen, Asche & Koenig, 2010, para. 3) can request the withholding of resuscitation, but if that person is not the legal next of kin, the person who is legal next of kin could later challenge the legality of the decision.

References

The Impaired Nurse (Cont’d)

<table>
<thead>
<tr>
<th>PHYSICAL SYMPTOMS</th>
<th>BEHAVIORAL SYMPTOMS</th>
<th>OCCUPATIONAL RED FLAGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shakiness</td>
<td>Mood alterations/swings</td>
<td>Diligent/extra shifts</td>
</tr>
<tr>
<td>Tremors</td>
<td>Inappropriate laughter</td>
<td>Frequent requests for work schedule/assignment alterations to get drug access</td>
</tr>
<tr>
<td>Slurred speech</td>
<td>Hyperactivity/sedation</td>
<td>Difficulty completing assignments in a timely manner</td>
</tr>
<tr>
<td>Watery eyes</td>
<td>Depression</td>
<td>Sloppy documentation</td>
</tr>
<tr>
<td>ConstRICTED OR DI LATED PUPILS</td>
<td>Impaired concentration</td>
<td>Unacceptable behavior</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>Blackouts</td>
<td>Appearance on unit on days off</td>
</tr>
<tr>
<td>Unsteady gait</td>
<td>Hiding track marks with long sleeves</td>
<td>Frequent trips to bathroom</td>
</tr>
<tr>
<td>Runny nose</td>
<td>Accidents/emergencies</td>
<td>Brief unexplained absences from unit</td>
</tr>
<tr>
<td>Nausea, vomiting, diarrhea</td>
<td>Relationship problems</td>
<td>Medication errors</td>
</tr>
<tr>
<td>Wt loss/gain</td>
<td>C/O physical pain</td>
<td>Isolation from co-workers</td>
</tr>
<tr>
<td></td>
<td>Insomnia</td>
<td>Mood changes after mealt ime</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequent reports of poor pain relief by patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obsession with narcotic cabinet or Pyxis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Volunteering to medicate co-workers’ patients</td>
</tr>
</tbody>
</table>

References available on request.

“Helping the impaired nurse is difficult, but not impossible. The choices for action are varied. The only choice that is clearly wrong is to do nothing.”

NCSBN, 2001
Staphylococcus aureus (S. aureus) is a commonly occurring bacterium, estimated to be present on the skin of about three of every four people. While usually confined to the skin, it can gain access to internal organs or to the blood stream, especially through surgical incisions or other open wounds (Prater, 2006).

Since the identification of penicillin in 1941 and its subsequent widespread use, S. aureus has demonstrated increasing resistance to antibiotics, including the beta-lactamase penicillin-methicillin. The term MRSA was initially coined to refer to methicillin-resistant S. aureus, but is now more commonly used to denote multi-drug resistant S. aureus (Lilly, Collins, Harrington & Snyder, 2011). MRSA was initially seen only in patients confined to health care facilities, but community acquired cases have since occurred. The most common treatment for MRSA has been the intravenous administration of vancomycin (Vancocin).

Even though bacteria reproduce in an asexual manner, there is extensive evidence that they can exchange genetic material, even with bacteria of different species. That is thought to be one mechanism for the development of drug resistance. When a person is colonized by both methicillin-resistant S. aureus (MRSA) and vancomycin-resistant enterococcus (VRE), for example, the MRSA organism can pick up a gene for vancomycin resistance from the VRE bacteria. Resistance to vancomycin therapy for MRSA was first observed in Japan in 1996 and has since been seen in hospitals in the United Kingdom, France, the US, Asia, and Brazil. Initially, this resistance was not complete, and the organisms were designated as vancomycin-intermediate S. aureus (VISA). More recently, strains of S. aureus have been isolated in Michigan, Pennsylvania, and New York that are resistant to vancomycin (VRSA). A detailed account of VRSA is given in the 2002 case in Michigan showed that VRSA was present in a patient with a prosthetic knee who had been on an intravenous drip of vancomycin for vancomycin resistance from the VRE bacteria. The CDC also recommends that the number of persons having contact with the patient be limited and that personnel having extensive contact with the patient, such as members of the academic and support staff, be trained in procedures for the decolonization of any carriers identified by those methods (Hageman, Patel, Careey, Tenover & McDonald, 2006).

The CDC also recommends that if the VRSA organism becomes widespread, this could have serious implications not only for public health, but also for nurses working with those infected. Two possible contributing factors to the development of MRSA, VISA, and VRSA in the environment are the overuse of antibiotics and the widespread carelessness in universal precaution techniques such as frequent hand washing. Nurses are in a key position to affect the latter and to identify people who may have control over the former. A concern now is that if Vzyox and Synergic are used, resistance to those drugs may also develop. Bacteria seem to be evolving faster than the development of new antibiotics needed to combat them.

References Available on Request

By Margaret Konieczny, RNFormation

There are many articles written on the etiology, signs and symptoms, and treatments of latex allergy. However, there are few, if any, personal accounts of living with a latex allergy. I have been diagnosed with a Type 1 IgE mediated latex allergy since October 2002. I would like to share my experiences regarding symptoms, diagnoses, treatments, subsequent reactions, workman’s compensation issues, employer accommodations, and changes to my lifestyle. I am planning to publish a book on my experiences and I want to share excerpts from that book in a three to four part series for RNJormation. For more information about the community of the American Latex Allergy Association Support Group ALERT at their website http://www.latexallergyresources.org

PART 1

Introduction

I am a Registered Nurse and have been for 46 years. I graduated and began working in 1964. At that time, clinical aspensis was washing hands before and after patient care and wearing sterile gloves while performing sterile procedures. It wasn’t until the late 1980’s that health care workers were required to wear gloves during daily patient care activities. In the 1980’s the identification and prevalence of blood borne viruses such as HIV and Hepatitis B became a national care bordering on panic. Health care workers were becoming infected with these viruses through needle sticks and exposures to infected blood. In 1991, the Occupational Safety and Health Administration (OSHA) along with the Center for Disease Control (CDC) mandated Universal Precautions (later changed to Standard Precautions) for all health care workers. Universal precautions state that all persons having contact with the person so infected. Local health departments and the CDC should be notified prior to patient transfer or discharge (Hageman, Patel, Careey, Tenover & McDonald, 2006).

The CDC also recommends that the number of persons having contact with the patient be limited and that personnel having extensive contact with the patient, such as members of the academic and support staff, be trained in procedures for the decolonization of any carriers identified by those methods (Hageman, Patel, Careey, Tenover & McDonald, 2006).

Should the VRSA organism become widespread, this could have serious implications not only for public health, but also for nurses working with those infected. Two possible contributing factors to the development of MRSA, VISA, and VRSA in the environment are the overuse of antibiotics and the widespread carelessness in universal precaution techniques such as frequent hand washing. Nurses are in a key position to affect the latter and to identify people who may have control over the former. A concern now is that if Vzyox and Synergic are used, resistance to those drugs may also develop. Bacteria seem to be evolving faster than the development of new antibiotics needed to combat them.

References Available on Request

By Margaret Konieczny, RN

Margaret Konieczny

There are many articles written on the etiology, signs and symptoms, and treatments of latex allergy. However, there are few, if any, personal accounts of living with a latex allergy. I have been diagnosed with a Type 1 IgE mediated latex allergy since October 2002. I would like to share my experiences regarding symptoms, diagnoses, treatments, subsequent reactions, workman’s compensation issues, employer accommodations, and changes to my lifestyle. I am planning to publish a book on my experiences and I want to share excerpts from that book in a three to four part series for RNJormation. For more information about the community of the American Latex Allergy Association Support Group ALERT at their website http://www.latexallergyresources.org

PART 1

Introduction

I am a Registered Nurse and have been for 46 years. I graduated and began working in 1964. At that time, clinical aspensis was washing hands before and after patient care and wearing sterile gloves while performing sterile procedures. It wasn’t until the late 1980’s that health care workers were required to wear gloves during daily patient care activities. In the 1980’s the identification and prevalence of blood borne viruses such as HIV and Hepatitis B became a national care bordering on panic. Health care workers were becoming infected with these viruses through needle sticks and exposures to infected blood. In 1991, the Occupational Safety and Health Administration (OSHA) along with the Center for Disease Control (CDC) mandated Universal Precautions (later changed to Standard Precautions) for all health care workers. Universal precautions state that all persons having contact with the person so infected. Local health departments and the CDC should be notified prior to patient transfer or discharge (Hageman, Patel, Careey, Tenover & McDonald, 2006).

The CDC also recommends that the number of persons having contact with the patient be limited and that personnel having extensive contact with the patient, such as members of the academic and support staff, be trained in procedures for the decolonization of any carriers identified by those methods (Hageman, Patel, Careey, Tenover & McDonald, 2006).

Should the VRSA organism become widespread, this could have serious implications not only for public health, but also for nurses working with those infected. Two possible contributing factors to the development of MRSA, VISA, and VRSA in the environment are the overuse of antibiotics and the widespread carelessness in universal precaution techniques such as frequent hand washing. Nurses are in a key position to affect the latter and to identify people who may have control over the former. A concern now is that if Vzyox and Synergic are used, resistance to those drugs may also develop. Bacteria seem to be evolving faster than the development of new antibiotics needed to combat them.

References Available on Request

By Margaret Konieczny, RN

Margaret Konieczny
these gloves increased, the manufacturers started to skip steps in the manufacturing process in order to meet the demand. Shorter processing time and shorter wash and shelf times increased the amount of latex proteins remaining in the gloves. Cornstarch powder was used inside the gloves to ease the donning of the glove. This powder facilitates the aerosolization of the natural latex proteins which can then be inhaled by the health care worker. Therefore, the two major routes of exposure are dermal and inhalation (Duffield, 1998; Witt, 1999).

My Story—Signs and Symptoms
My signs and symptoms started in late 1992. I had been wearing gloves for patient care since 1969. During that time I was a nurse manager and then a staff nurse on a general medical unit. I first noticed the skin on my hands and heels was very dry and would crack and itch. I thought at the time that this was the usual winter dry skin. An open red rash began to appear on my hands. My hands would itch and the skin was very dry. I wasn’t sure what was happening. I thought maybe the infantile eczema I had was returning, or maybe I was washing my hands too much. This stage continued for a long time. As I now know, this first stage of contact dermatitis/urticaria, with repeated exposure to the latex proteins by continuing to wear latex gloves, created a pathway for latex proteins to enter my body system. Thus I developed a Type 1 IgE mediated latex hypersensitivity allergy. This type of reaction becomes generalized and spreads beyond the area of contact. This hypersensitivity allergy may also include rhinoconjunctivitis, angioedema and asthma (Witt, 1999).

Eventually, my face developed patchy redness and my eyes began to feel watery and tear constantly. The sclera was red and my eyelids itched. I developed angioedema, and a facial rash with redness, burning and itching which progressed to my entire face, neck, shoulders and then to my entire body (See figure 1). I could not sleep at night because of the severe itching. I would lie awake scratching one itchy area after another. It was maddening! I could not get a full night’s sleep. I tolerated this for a very long time. Initially, I did not relate this to the use of latex gloves as latex allergies were not that well known. Eventually I became physically, mentally, and emotionally drained in the process of diagnosing this problem.

In the next issue of RNFormation, Ms. Konieczny will address the Journey toward Diagnosis!

References Available on Request.

Margaret graduated from Holy Cross School of Nursing in South Bend Indiana in 1964. She moved to Corona, California right after graduation and eventually married and moved to South Lake Tahoe in 1975. She remained in Tahoe until her move to Carson City, NV in 2002. Her major area of expertise is Medical/Surgical nursing and worked in many capacities from staff nurse to manager and eventually nursing professor at Western Nevada College. She retired from teaching in 2010.
The District Board had changes with the appointment of Dr. Julie Wager to complete the term as director of Nancy Magnusson, an outstanding, devoted board member for long time and Marla Johnson was appointed to complete the last 8 months of the director position held by John Morrison. Welcome to the district board these talented, dedicated and energetic nurses. The board meets by teleconference about 7 times a year and twice face to face so we can put a face to the voice. Any NNA members may audit a board meeting just contact me for the information on how and when.

Another very special project is “Nurses Care for Kids” this will be an ongoing project for the next year to provide items needed for “Children in Transition.” The children are those without a solid home base or in financial need. Many go without socks, some girls fail “gym” because they won’t shower (no underwear or can’t shave underarms—no razor). The need is varied and of hug portions; the latest count was over 1400 in Reno, 450 in Carson City. A list of items needed will be emailed to all district one members with information on the deposit and pick-up points for donations.

We encourage nurses’ support community events whenever you can. Some will be developing nursing teams; like the Annual Northern Nevada Susan G. Komen Race for the Cure on Sunday, October 2, 2010. Join the NNA/nursing team by emailing Charmaine Cruet at ccruet@sbcglobal.net for additional information. This is a great event with many booths to visit www.komennorthnv.org.

Recently NNA has promoted free CEU opportunities in the area to educate a “helping professional” that may come in contact with a pregnant female or expectant father, those who have questions on infant adoptions.

Nurses need to be aware of the counseling techniques for those who are seeking assistance.

Our Spring Membership Meeting celebrated the 79th NNA birthday. Displays featured the history of nursing in Nevada and participants viewed the many pictures. A legislative update was presented by Teresa Serratt, NNA Legislative Chair on the legislative priorities for Nevada and include national issues affecting Nevada. A silent auction provided some competitive fun. The dinner was graciously sponsored by KCI with a free CEU presentation. Thank you, Yolanda Crobarger.

At press time tentative plans may include a “Legislative Meet & Greet” in late August in Reno and I will report on this event in the next newsletter. This will be a great opportunity to ask the legislators the tough questions or to discuss issues that may require legislative change.

Hope to see you at the next membership meeting. Develop on understanding of the legislative process and nursing/health care legislative issues affecting nursing practice also become awareness of nursing activities in Northern Nevada. Our doors are open to all nurses for “in unity we have strength.”

Love to hear from you,
May God bless you all
NNA District One President
Betty Razor 775-560-3350 etbetty@sbcglobal.net
Women and Stroke

By Wallace J. Henkelman, MSN, RN
Assistant Professor of Nursing, Touro University Nevada

Traditionally stroke has been seen as primarily a disease of men, a dangerous misperception. Although men and women have comparable rates of stroke, women are significantly more likely to die of stroke. Half of all deaths in women over age 50 are due to heart disease and stroke. Contrary to popular conceptions, one in 2.5 women will die of heart disease or stroke while only one in 30 will die of breast cancer. Each year 40,000 more women than men die of stroke (Women and Stroke, n.d.). If age is reduced as a variable by studying only persons of ages 35-64, women have almost three times as many strokes as men (Seppa, 2010).

Women are more likely than men to experience non-traditional stroke symptoms. The traditional symptoms of stroke include sudden onset of weakness or numbness on one side of the body, trouble speaking or understanding, trouble seeing, loss of balance or coordination, and sudden severe headache. These occur in both sexes. Symptoms unique to women include sudden face or limb pain, sudden hiccups, sudden nausea, general weakness, chest pain, shortness of breath, or palpitations (National Stroke Association, 2005). Altered mental status, including confusion, disorientation, or loss of consciousness, has been identified as the most common nontraditional set of symptoms in women (Medical News Today, 2009).

Women also have some unique risk factors for stroke. Taking birth control pills and becoming pregnant both increase the risk (Catch 22 there). Hormone replacement therapy increases the risk. A thick waist and high triglyceride level in combination is a risk factor. A history of migraine headaches is associated with a higher risk (National Stroke Association, 2009).

Prevention of stroke in women involves the same factors as for men and also reduces the risk of heart attack. Stopping smoking is essential. Physical activity and diet therapy to reduce or maintain weight and assist in cholesterol and blood pressure control are very helpful. Alcohol intake should be no more than moderate. With the assistance of a medical professional, medications for blood pressure control, blood glucose control, and cholesterol maintenance may be used. Aspirin has been shown to be beneficial for those at high risk and not useful for those at low risk. More research is needed on those with moderate risk (Becker, 2005).

Implications for nurses related to stroke care are several. Promotion of healthy life styles, not only in the elderly but also in girls and young women, in such areas as exercise, healthy diets, and avoidance of smoking is a nursing responsibility. Education about symptoms and warning signs of stroke is also necessary since many people do not know how to recognize a stroke, especially if the symptoms are nontraditional. Information about resources and available treatments should be provided to those at high risk and those who have experienced a stroke (Women and Stroke, n.d.).

References Available on Request