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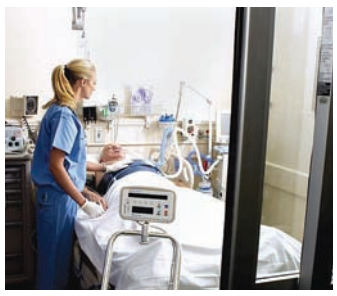

Induced hypothermia post cardiac arrest can be neuro-protective.

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NNA
NEVADA NURSES ASSOCIATION

Medical Reserve Corps nurses ready to respond in an emergency.

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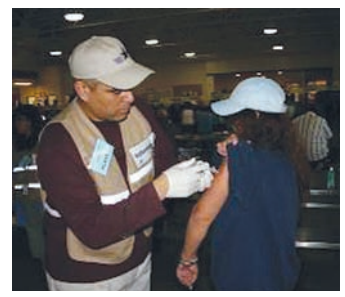

Nurses Day at the Legislature

100 Nurses Meet with Legislators

(Left to right) Betty Razor, RN, Senator Bernice Mathews, Senator Valerie Wiener, and Mary Ann Lambert, RN, discuss issues of importance to nursing over lunch.

The tenth Nurses Day at the Legislature started early on a beautiful morning with a gathering in the Assembly Lobby of over 100 nurses and student nurses attending from across the state. Our purpose in meeting in the lobby was to impress legislators and lobbyists with our numbers. Nevada's nurses present a united front in health care advocacy, and a proactive force in the legislative process.

The day's activities began with a tour of the facility and a review of the legislative process from the "docents", EMTs

(Continued on page 4)

Stepping Chicago Style: Dance to Benefit Your Body, Mind, & Soul

By Janice Muhammad

While millions of sedentary Americans are sitting to watch *Dancing with the Stars*, thousands across the U.S. are up, and on the floor actively engaged in the popular "Chicago-style Stepping". And the word is it's a dance work-out that will make you shine like a star!

Dancing is an exceptional way to have fun, socialize and stay in shape—or start a new fitness routine.

(Continued on page 10)

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President's Message

Tracy Singh, RN, JD

On behalf of the Nevada Nurses Association, we wish you all a very Happy Nurses Day. I hope each of you take the time to recognize not only how special other nurses are, but how extraordinary you are for being one of the few who have dedicated your lives to helping others.

In 2008, Nevada's population was approximately 2.6 million. According to the 2007-2008 Annual Report from the Nevada State Board of Nursing, less than one percent of our citizens (17,594) were active Registered Nurses licensed and living in Nevada. Most people admit they could not do what nurses do and you truly are an exceptional human being!

If you are not yet a member of NNA, I would like to personally invite you to join today. We are very excited about 2009 and the changes we are making in our organization and we very much want you to be a part of NNA. In recent years, NNA struggled to stay afloat and now that we are back on our feet, it is time to give back. Nurses and citizens in our communities are struggling to keep their homes, to keep food on the table and to keep clothes on their backs. Even pets are struggling to keep their homes as their owners' situations change.

This year, it is our goal to bring nurses together, not just to fight for nurses' rights at the Legislature but also to support each other through networking opportunities and social events and to give back to the community through community service projects. Some events will include a little of both. We are planning various events independently and in conjunction with other charity events where nurses can come together and give to others.

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Healthcare Leadership Training
Learn disaster management, complete with chaos, noise, & power failures.
See page 7

Check out the new, revised NNA mission statement on Page 2.

President's Message (Continued)

Our next event will be held in Las Vegas on Saturday, June 27, 2009. This will be a combined social & community service event called the "NNA Clothes Swap for Charity." All nurses are invited to clean out your closets and bring all of the clothes you no longer enjoy wearing to the swap. Take what you like in return and all remaining clothes will be donated to various charities to help the homeless, foster children and battered women.

This event will be a great opportunity to meet new friends, get some new things to wear and give to others who are in need. A $5.00 entrance fee will cover snacks, beverages and transportation for donations. Location, materials and preparation time will be donated by the Law Offices of Tracy L. Singh, LLC. Please call (702) 444-5520 for directions, reservations and more information. We look forward to seeing you and your clothes!

To join NNA, or for more information on our future social and community service events throughout Nevada including upcoming walk-a-thons, "NNA Goes to the Movies" and holiday functions for charity, please visit our website at www.nvnurses.org.

We are also looking for new committee members so if you have other social or charitable ideas and passions, please call our Communications Director, Margaret Curley at (775) 747-2333 or send us an email today at NNA@nvnurses.org.

NNA Mission Statement

New!

MISSION

The Nevada Nurses Association promotes professional nursing practice through continuing education, community service, nursing leadership, and legislative activities to advocate for improved health and high quality health care for citizens of Nevada.

NNA Board of Directors

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NNA 2009 Legislative Update

By Beatrice Razor, RN, BSN, CWOCN
Co-Chair, NNA Legislative Committee

The opening of the Nevada State 2009 Legislative session was very difficult for the legislators and those involved in health care advocacy. The budget deficit took precedence over the majority of issues and legislators were unwilling or disinclined to address bills that had a fiscal note attachment. This report is written in the first week of March and at this date the debate continues on the budget. It is probable that any bill that requires major funding will be scrutinized closely and may never get to the Governor's desk.

That stated, the key issues for the health care industries have focused on the Las Vegas event and its widespread ramifications. Numerous bills have been proposed to remedy the leaks in the system that became self-evident. The Assembly Health and Human services along with the Senate Health Education Committee had an unusual Saturday session with the majority of the committee in Las Vegas and video conference to Carson City. Numerous presentations dealt with the investigators timeline, the CDC involvement and the various bills (AB 206, AB 16, SB 76, AB 123, SB 70, AB 123 and AB 10)

The NNA testimony focused on AB 10, enhancement of whistle-blower protection. Martha Drohobyczer read Lisa Black's excellent written testimony and report on the NNA survey on the WB issue (check the NNA web page for copy of testimony). Martha responded well to the numerous difficult questions from the legislators. The NNA legislative committee will continue to be actively involved with all of these bills and others as they surface. You may access any bill of interest to you on the Nevada legislative website at: www.**leg.state.nv.us** then go to "session info" to "2009 session" and finally "bill information" or try the following: www.leg.state.nv.us/75th2009/Reports/.

Even if you are unable to be part of the legislative committee, your voice does make a difference. We encourage you to read the bills that perk your interest and voice your concerns and opinions to the legislative co-chairs. Your comments will be presented at the weekly NNA legislative committee meeting and we will respond accordingly.

Beatrice (Betty) Razor
etbetty@sbcglobal.net (775) 560-3350
Martha Drohobyczer
Marthadrohobyczer@yahoo.com (702)365-9929

Check It Out!

As our newly elected leaders consider the difficult problems our country is facing, the American Nurses Association provides both federal and state updates on legislative activities at ***Nursing World***. From the homepage, click on "government affairs" and then choose your area of interest. "Federal government affairs" includes legislation and issues, bills and votes in the U.S. Congress, and an RN activist toolkit.

"Capitol updates" is an online newsletter dealing with political and legislative issues affecting nursing.

"State government affairs" highlights selected proposed legislation for nursing and allied health providers, and summarizes legislative trends. In addition, this section offers examples of model legislation and talking points.

Please visit ***Nursing World*** at www.nursingworld.org/

Interested in learning more about Nevada's state government? The ***State of Nevada*** maintains a website detailing activities of the executive, legislative, and judicial branches. "Nevada state government" lists links for communicating with elected federal and state officials. "Legislature" includes the Nevada law library, personalized bill tracking, and 2009 session information. "Supreme court" connects readers to legislative calendars and tracking reports.

Please visit the ***State of Nevada*** website at www.nv.gov/

The ***Nevada Legislature*** aims to educate and inform Nevada residents by offering a wide array of topics. "General info" presents a directory of state and local government, legislator and committee information, and a brief overview of the legislative process. "Interim info" introduces the committees and studies that continue beyond the legislative session. "Session info" lists the bill draft requests under consideration during the legislative session. Please note that these are just a few of the topics available. In addition, readers are invited to share opinions and offer suggestions on controversial issues. This is a perfect opportunity to make your voice heard, and to help in shaping the future of Nevada.

Please visit the ***Nevada Legislature*** at www.leg.state.nv.us/

The broad language of statutory law guides the creation of administrative law through agencies like the ***Nevada State Board of Nursing***. In meeting their goal of protecting public health, safety, and welfare, they join with individuals and groups to seek input, establish basic standards for practice, and develop regulations. To see this process in action, please visit "meeting dates, agendas, and minutes". "The nurse practice act" contains the laws, regulations, and practice decisions that govern Nevada nursing practice.

Please visit the ***Nevada State Board of Nursing*** at http://nursingboard.state.nv.us/

If advancing your concerns regarding the future of health care in Nevada is a new frontier for you, ***From Silence to Voice*** is a must read! Authors Bernice Buresh and Suzanne Gordon suggest guidelines for effective communication, exercises that take you from theory to practice to skill, and tips for media presentations.

Please visit the ***From Silence to Voice*** website at http://silencetovoice.com/

NNA NEEDS YOU!

Calling all NNA nurses to become leaders in the professional organization that represents you by running for elected office!

Why Become an NNA Leader?

In deciding to run for an NNA elected office you choose to invest in your own future and in the future of health care in Nevada. Whether serving on the board of directors, or on committees, NNA leaders have the capacity to influence public policy, professional nursing standards, and the advancement of the association.

As a leader, you will become a part of the history and traditions of NNA – forging the way for the health care system of the future and ensuring that nurses remain essential providers in all practice settings. You will help NNA and the nursing profession remain strong and united.

What are the Benefits of Being an NNA Leader?

Benefits are both personal and professional, and provide you with skills that can advance your standing in other areas of your life. Here are just a few to think about…

- enhance your development in communication and organizational skills
- increase your opportunities to mentor, to gain peer recognition, to share your expertise and ideas
- develop marketable skills while articulating your views, engaging with a diverse membership, and speaking publicly
- be on the cutting edge of a new and better health care system for Nevada

Positions for Election in 2009

President Elect	Secretary
Director at Large	Nominating Committee

Who Qualifies?

Any NNA member who meets the criteria established by the NNA/ANA.

What's Expected?

NNA expects the best from its leaders, just as you have the right to expect the best from NNA. Your time commitment to the association will depend on the position you fill. You may need to request your employer's support – most employers will view your leadership role as a benefit to them through your increased knowledge and distinction as an NNA leader.

What's the Next Step?

Please begin to consider the difference you can make in your profession and your professional organization. Members of the Nominating Committee will be calling you soon– please answer that call and join our leadership. **And please feel free to self-nominate.**

If you're new to NNA, we especially encourage you to become involved and learn more about us. For information on these positions, and a consent to serve, please visit our website at www.nvnurses.org.

We're hoping to hear from you, and thank you!

Nurses Day at

"The best part to me was the numbers who participated… that and the young student nurses. They are the future of nursing and it is wonderful to see them engaged at the legislative level since they will be impacted (and impacting as voters and maybe even legislators) by the process in the near future."
—Participant

Nurses gathered in the Gallery for Assembly Session

Nurses Day *(Cont'd from page 1)*

assigned to the legislative building during the session. The tour ended with a view of the Senate Chamber and the Assembly Chambers (while in session).

Our group was recognized as NNA nurses and introduced by Speaker of the Assembly Barbara Buckley. One attendee, Chris Figueroa, President of the Nevada Student Nurses Association, was invited to sit in the Senate Floor Chambers with Senator Bernice Mathews during the Senate session. Later the Senator stated "that young man will go far". The number of attendees impressed the legislators and numerous comments were made to that effect throughout the day.

Following the tour the attendees were encouraged to network and visit the sponsoring exhibitors: Carson Tahoe Regional Medical Center, VA Sierra Nevada Health Care System, Saint Mary's Regional Medical Center, and the University of Phoenix.

The NNA President, Tracy Singh, welcomed everyone, introduced our special guests, and provided an overview of NNA legislative priorities. Beatrice 'Betty' Razor, NNA Legislative Committee Co-Chair, outlined the events planned for the remainder of the day, and reviewed the "Guide to the Legislature" booklet and the resources in the handouts. This review included current nursing legislative issues.

Our NNA lobbyist, Cheryl Blomstrom, reviewed her role as a lobbyist and stated that the number of attendees made a strong impression on the legislators of nursing's interest in the legislative process. She emphasized that all nurses should become well acquainted with our part-time legislators and communicate often, and that the best time is in-between sessions.

David Humke, Washoe County Commissioner and former state legislator, presented "Communicating Effectively with Legislators" and offered numerous ideas and concepts on how to assist legislators in gathering information. Nurses who assist and educate legislators on nursing practice or health care issues have the power to influence change through the legislative process. He stressed that legislators have a life outside their role as legislators, and we must understand their time limitations. Our legislators are available all year long but very busy

(Continued column 3)

WNC Nursing Students

"As this was the first year I attended, I have nothing to compare. I did note the number of attendees and was especially surprised by the number of nursing students (even some from southern NV) in attendance. On a personal note I found it interesting the amount of support I received from my fellow nurses on topics of continuing my education and the unabashed support I received when I stated my intent to obtain my APN and work at a clinic in a rural area. This was quite gratifying… The last item of particular interest to me was the anecdote from our lobbyist who reported a number of legislators asked about the group touring the building and the purpose of the tour. This interest drove home the point of our keynote speaker about the fact that 100 members of the public arriving at a meeting will be noted, and their voices heard by our elected officials."
—Participant

Christopher Figuerroa, Nevada Student Nurses Association President, addresses crowd.

(Left to right) Panelists Betty Razor, RN, Legislative Committee Chair, Tracy Singh, RN, JD, President, NNA, Debra Scott, RN, Executive Director, Nevada State Board of Nursing, & Cheryl Blomstrom, NNA Lobbyist

David Humke, Chair, Washoe County Commission, Former Nevada State Legislator.

"It inspired me to interact with nurses and student nurses who were so eager to learn about---and engage in---the legislative process."
—Senator Valerie Wiener
Chair, Senate Committee on Health and Education

Nurses look at displays by vendors

during the legislative session, so contact time is very limited. If you have a concern, let them know.

Mr. Humke's presentation was followed by a panel on current nursing issues and a lively Q & A period. Valuable information and knowledge was provided on many specific nursing bills. We thank Tracy Singh and Debra Scott, Executive Director of the Nevada State Board of Nursing, for their insightful and timely presentations and informative updates on issues affecting health care in Nevada.

At this time we broke for lunch with the legislators and we know many enjoyed the tasty menu provided by Ralph Swagler from Carson City's "Local BBQ". This was a great time to meet our legislators in a less stressful environment. The room buzzed with conversation.

The panel resumed for a short period with an additional Q & A period before the attendees were encouraged to sit in on various Assembly and Senate committee hearings to observe how legislators obtain information on proposed bills. The day ended with a photo shoot on the front steps of the Legislative Building.

Nurses Day at the Legislature provided attendees with valuable information about the legislative process and NNA's legislative agenda. It also provided nursing students with an opportunity to network with colleagues from around the state.

Plans are already underway for the next Nurse's Day in 2011. Each year has a different agenda and 2011's program will challenge the newcomer and returnee alike, and continue the tradition of education for nurses and legislators.

We hope to see you there!

the Legislature

"The students of the class of 2009 had very positive things to say about Legislature day. The comments were as from An Bui 'I learned more in 4 hours than I learned in law and civics in a whole semester.' The students were both amazed and disgusted at how the legislation can affect healthcare, and their jobs, and future, without the public realizing what was happening.
Being RN/BSN students, they were very upset about the CNA's being able to pass meds, without being aware of drug interactions or differences in patient age and pharmacology. They were concerned that even if the mortality rates went up in the long term care facilities where the MA's would practice, that the public would not be aware and remain apathetic.
As a whole I think it was a very rewarding and eye opening experience. I highly recommend that last year nursing students take advantage of the opportunity to see our state congress at work.
As a side comment, I found the state legislature to be a much nicer environment than the national government and capitol hill which I visited last year."

— Rebecca Cailor, RN, MSN, FNP-C
Assistant Professor of Nursing
University of Southern Nevada

University of Southern Nevada Nursing Students

Assemblyman Harry Mortensen and Pat Van Betten, RN

Effective Advocacy Includes YOU!

By Cheryl Blomstrom, NNA Lobbyist

There is a phrase often repeated during a legislative session, "You're either at the table or you're on the menu." As nurses, you are clearly the subject matter experts on the topics with which you work daily. Things like staffing ratios, infection control procedures, access to healthcare and a host of other topics, and all are being discussed and possibly legislated this session.

So, how do you get involved? First, just do it. Take a minute to find your legislators. Most of you will have one assemblyman/woman and one senator. Remember, they are part-time legislators and most have another full-time job so be considerate of their time at home.

Legislators definitely like to hear from their constituents. You can do this any number of ways. During the off-session time, try a call to schedule coffee. A half hour spent this way will give you lots of credibility when the session is in. The legislator is very likely to remember the time you took to get to know him/her.

During session, it is also easy. You can phone the legislator's Carson City office or send an email. You can also send letters or visit. The Carson City Legislative Building is at 401 S. Carson Street, Carson City, Nevada 89701-4747. The mail is distributed within the building so you don't need to include an office number (although it helps).

You can find office numbers and individual telephone numbers/emails on the Legislature's website at www.leg.state.nv.us. Select either Assembly or Senate from the left side of the page and then Contact Information. Legislator biographies are also included here.

The Legislative website is a wonderful tool as the session progresses. You can track bills, research hearings, minutes and activities and can actually sign up to be notified (for free if you stay under 10 bills) when actions are scheduled or taken on bills of interest to you. Find Individual Bill Tracking on the right side of the front page of the site.

There are some easy dos and don'ts as you contact legislators. Remember, they are very busy during session so hit the key points. Make sure you ask for what you want---support for or opposition to a bill.

Remember that you are the expert. Legislators need information to make educated decisions. Always be completely truthful. If you are asked a question for which you don't know the answer, always say you'll try to find the information and get back to them---and then follow up. Consistency is much prized by these busy people. Even when a legislator doesn't agree with you, he/she will appreciate the information that you bring to the issue.

Please get and stay involved. It makes nursing better for you and for all the nurses who will follow you.

Student Nurses

ANA recognizes that nursing students are not only the nurses of tomorrow, they are the ANA members of tomorrow!!

Please take this time to explore the ANA site and see all that we have to offer. Feel free to ask the nursing community questions on ***NurseSpace***, find your first nursing job in **ANA's *Nurses Career Center***, or find out about the latest nursing news from ***ANA's publications***.

For access to *all* available resources, be sure to sign up for access to the Members Only section of the site. As a nursing student, access is **FREE.** Please see below for instructions as well as a full list of available benefits, such as special discounts, resources, and articles.

Sign Up Today!

- **Members Only Benefits for Students**
  http://www.nursingworld.org/EspeciallyForYou/NursingStudents/StudentBenefits.aspx
- **Getting Started on Your Nursing Career**
  http://www.nursingworld.org/EspeciallyForYou/NursingStudents/Gettingstarted.aspx
  Preparing for nursing school and getting financial assistance.

SAVE THE DATE!

NV'r Miss A Shot

2009 Early Childhood Health and Immunization Summit

September 14-15, 2009 at Renaissance Las Vegas Hotel

Don't miss this event featuring local and national experts on current health and mental health issues faced in early childhood. We are thrilled to announce one of the keynote presenters - Paul Offit, MD, an internationally known expert on vaccines, immunology, and virology, Chief of the Division of Infectious Diseases, and the Director of the Vaccine Education Center at The Children's Hospital of Philadelphia. CME and CEU will be provided. To receive a program brochure please email cari.rovig@chw.edu.

Book Reviews

"Do Vaccines Cause That?" is a thoughtful and clearly written book looking at vaccine safety concerns. The authors, Martin G. Myers, MD, and Diego Pineda, MS, are experts in immunization issues; they work together at the National Network for Immunization Information (NNii) and have co-authored more than 80 peer-reviewed articles on vaccines. Dr. Myers is the former director of the National Vaccine Program Office and is a professor in the Departments of Pediatrics and Preventive Medicine and Community Health at the University of Texas Medical Branch at Galveston.

This new book is divided into two sections. The first section discusses side effects, risk perception, cause versus coincidence, finding reliable information about vaccines, and other topics. The second half of the book is devoted to specific vaccine safety concerns, such as autism, asthma, immune disorders, SIDS, birth defects, and cancer.

The table of contents and a sample chapter are available on the book's Web site, www.dovaccinescausethat.com

"Autism's False Prophets" by Dr. Paul Offit, follows the journey of theories purporting that vaccines cause autism. Beginning with the idea that the MMR vaccine caused autism and moving to thimerosal and finally, too many vaccines causing autism, Dr. Offit outlines how media, politics and law have played a role in making parents around the country and the world fear one of public health's greatest contributions to human health. Dr. Offit also discusses the real dangers of some of the alternative therapies being promoted to treat autism. Through interviews with several families affected by autism, Dr. Offit conveys their hopes for their children and reveals their frustration with the continued efforts to promote the idea that vaccines led to the development of autism in their families.

—The Vaccine Education Center at The Children's Hospital of Philadelphia®, 2008

One and Only Campaign

In mid February, the Safe Injection Practices Coalition—comprised of patient advocacy organizations, foundations, the Centers for Disease Control and Prevention (CDC), provider associations and industry partners—joined Congressional leaders to launch the groundbreaking One & Only Campaign, an education and awareness initiative aimed at both healthcare providers and patients.

The One & Only Campaign will be piloted in Nevada. It includes a set of training materials designed to remind doctors, nurses and other healthcare providers that syringes must be used one time only. It will also produce a set of patient-focused materials designed to empower patients. For more information, please visit www.oneandonlycampaign.org.

State Cuts Childhood Vaccine Funding

Submitted by the Nevada Immunization Coalition

In 1994, the national Vaccines for Children (VFC) program, a federal entitlement program, began to provide vaccines at no cost to VFC-eligible children through enrolled public and private providers. All children 0-18 years of age who are Medicaid enrolled or Medicaid eligible, uninsured, American Indian or Alaska Native, or underinsured are eligible to receive VFC vaccine. The VFC program covers most children who do not have insurance coverage. The Nevada State Immunization Program (NSIP) took this concept a step further and had worked diligently to finance and provide most vaccines to all Nevada children, regardless of insurance status, at no cost. Most states across the nation do not provide vaccines free to insured children.

Due to decreased federal funds, the increasing number of vaccines, increased cost of vaccines, along with a growing population, the NSIP is no longer able to provide free vaccines to children who have health insurance. As one of the last states in the nation to provide this type of vaccine policy, a critical decision had to be made as we face drastic decreases in funding coupled with increasing vaccine costs. It was determined to change our policy in Nevada to VFC only as of January 1, 2009.

The State Health Division has been working with private providers, health plans, and immunization coalitions to ensure our state's children all continue to receive recommended vaccinations. Information has been sent to schools, clinics, hospitals, and businesses across the state. To access the fact sheets and other articles, visit http://health.nv.gov.

"We regret being forced into the position we must take to protect the financial stability of the Vaccines for Children program, especially in light of the fact that vaccinating our children is extremely important," said Acting State Health Officer Mary Guinan, M.D., PhD. The State Health Division is encouraging parents and caregivers to check their private insurance policies to determine which vaccines are covered. Cost-sharing amounts to consumers will vary, depending upon their insurance plan. Many health insurance plans cover vaccines; however, there are many variations from one health plan to another. If an insurance plan does not cover vaccines, that child is considered underinsured and may be eligible to receive free vaccines through the federal Vaccines for Children program at a Federally Qualified Health Center. Parents or guardians are encouraged to check their benefit booklet for coverage information, or to call their insurance provider.

For more information, contact the Immunization Program at 775-684-5900

Tami Chartraw, Program Manager at 775-684-5934

Eric Pennington, Vaccine/Fiscal Manager at 775-684-5901

Bill Banning Toxic Chemical in Baby Bottles & Sippy Cups Passes Washington House

By Ivy Sager-Rosenthal, Campaign Director Washington Toxics Coalition

Olympia, WA—Doctors, nurses, parents, and children's health advocates cheered today's passage of the Safe Baby Bottle Act (HB 1180) by the Washington State House of Representatives. The bill passed with a vote of 76-21.

Prime sponsor of the legislation, Rep. Mary Lou Dickerson (D-36) said, "We need to protect babies and children against BPA. The danger is here now and we must address it. A baby's first drink from a bottle shouldn't be contaminated with harmful chemicals."

"BPA has no business in bottles or any other product children put in their mouths," said Ivy Sager-Rosenthal, campaign director for the Washington Toxics Coalition. "Passage of this bill sends a message to the chemical industry that harmful chemicals are not welcome on store shelves or in babies mouths in Washington."

The Safe Baby Bottle Act will eliminate the hormone disrupting chemical bisphenol A (BPA) from baby bottles, sippy cups, other children's food containers, and sports water bottles. If the legislation becomes law, Washington State would become the first state in the nation to place restrictions on BPA in children's products. BPA is used in polycarbonate plastic baby bottles, sippy cups, and other containers.

Health professionals applauded the Houses action today. They are concerned because children are especially vulnerable to exposures from toxic chemicals. Even low levels of bisphenol A are linked to harm to reproductive development, cancer, and obesity. A recent study by the Centers for Disease Control found BPA present in 93% of people tested, with children having the highest levels. Karen Bowman with the Washington State Nurses Association said, "The Safe Baby Bottle Act is common sense legislation to protect children's health. This is a great step forward."

Major baby bottle manufacturers, including Avent, and Playtex, have started phasing out the use of BPA in their products. Nalgene and Camelbak, makers of sports water bottles, have already made the switch to BPA-free materials.

The legislation passed days after Suffolk County, New York passed a ban on BPA similar to the one proposed in Washington State. The legislation now moves to the Senate. If the legislation becomes law, Washington States ban would be the first state restrictions on BPA in children's products. Several other states have pending BPA legislation this year, including Connecticut, Hawaii, Maryland, Minnesota, Oregon, Texas, and Vermont.

BPA is a synthetic sex hormone that research links to health effects, including cancer, miscarriage, obesity, reproductive problems, and hyperactivity. In addition, recent scientific studies show infants are more susceptible to BPA because it stays longer in their bodies than adults. Research also shows exposure to BPA puts girls at an increased risk of breast cancer.

More than 30 health, environmental, consumer, and children's advocates have endorsed the bill, including the Washington Chapter of the American Academy of Pediatrics, Washington Physicians for Social Responsibility, the Washington State Nurses Association, Washington Conservation Voters, Children's Alliance, People For Puget Sound, and WashPIRG.

For More Information Contact: Ivy Sager-Rosenthal, WA Toxics Coalition, 206-854-7623.

New Volunteer Nurse License Policy

By Debra Scott, MSN, RN, APN, FRE
Executive Director, NSBN

Caroline Punches and Elaine Hudson from the American Red Cross, Mary Anderson, MD, MPH, Washoe County Health District Health Officer, and Debra Barone, Washoe County District Health Department, Medical Reserve Corps Program Coordinator presented information to the Nevada State Board of Nursing at its November, 2008 Board meeting about their organizations' need for licensed nurses to volunteer to be ready to serve in times of disaster or during other times of need.

Dr. Anderson suggested that in the event of a public health emergency, most licensed nurses would be required to report to their places of employment and may not be available to respond to the call for volunteers. She recommended offering a special, no-cost license to retired or inactive nurses who are willing to volunteer their services. By working with these organizations, the Board would be supporting the expansion of the pool of nurses available for crisis response.

Board staff had previously met with those involved to discuss how to meet the needs of these organizations. An agreement was reached to create a policy that would be considered by the Board which would outline the process to implement a waiver for licensure fees for volunteer nurses if they met all other requirements for licensure in Nevada and if they attested that they would limit their practice to gratuitous nursing in times of natural or manmade disasters for an organized relief organization or in matters of public health such as immunization centers, public health clinics, or indigent clinics.

A comprehensive policy and procedure was presented to the Board at its January, 2009 Board meeting in Las Vegas. If you have questions or are interested in obtaining a Volunteer RN or LPN license, please contact the Board's office. We will begin accepting Volunteer License applications on June 1, 2009.

The Nevada State Board of Nursing seeks to encourage patient safety by supporting nurses who wish to practice as a nursing volunteer by waiving the licensure fee under special conditions outlined in the Board's new policy.

For more on the Volunteer Nurse Policy, visit the Nevada State Board of Nursing website at www.Nursingboard.state.nv.us.

CDP Offers Free Healthcare Leadership Training

By Shannon Arledge, Center for Disaster Preparedness Public Affairs

The Center for Domestic Preparedness offers a number of emergency response courses at the Center for Domestic Preparedness in Anniston, Ala., including the Healthcare Leadership and Decision-Making (HCL) course and the Pandemic Influenza Preparedness course, both approved for CEUs and CMEs.

The former U.S. Army Noble Hospital was converted into a training site for health and medical education in disasters and mass casualty events in 1999. The CDP has operated the Noble Training Facility since 2007, and completely funds all training—to include travel, meals and lodging for state, local, and tribal emergency responders, including registered nurses.

"There is a lot of training to be done, not only with the hospitals but with all other services and agencies that may be involved in a mass casualty incident," remarked Tammy Pass, HCL Manager. "Having participated in HCL training, a healthcare responder will leave here with a better idea of how all the pieces should work together to accomplish this goal."

The 32-hour HCL course lasts four days and includes both classroom instruction and realistic scenario-based exercises—complete with the expected chaos, noise, power failures, media briefs, and even victims from a mass casualty event. Nurses and physicians may earn 32 educational units.

The CDP provides nine healthcare courses. For additional information about training opportunities at the CDP, visit http://cdp.dhs.gov or contact Western Region Coordinator, Mr. Chris Caputo, (866) 213-9548, caputoc@cdpemail.dhs.gov.

The Medical Reserve Corps

By Camilla Camburn, RN,BC, MSN

Did you know that there are three groups of volunteers in the state of Nevada who are trained to strengthen the health and safety of their communities? The Medical Reserve Corps (MRC) of Southern Nevada, Washoe County and Carson City are comprised of over 400 individuals, medical and non-medical volunteers, who have been trained in incident response so they can be deployed quickly when an emergency occurs.

MRC volunteers benefit from preparedness information received through online courses, classroom training and live exercises. In the fall of 2008 in Clark County, licensed and certified MRC volunteers administered flu vaccine to homeless citizens at a local shelter during a communications/point of dispensing (POD) exercise. They also staffed the medical tents at the Silverman full-distance triathlon. The other Nevada MRC units were also active participants in the statewide POD exercise in October.

As a nurse volunteer in your local MRC you can learn how to prepare for and respond to emergencies in order to protect yourself, your family and pets and your neighbors. You can elect to be deployed to other areas of our nation to join other volunteers in the event of disasters such as hurricanes or floods.

To learn more about becoming involved in your local MRC, log on to www.medicalreservecorps.gov

Credits: Medical Reserve Corps 101, US Department of Health and Human Services, Office of the Surgeon General

Editorial

How Are We Doing?

By Margaret Curley, RN, BSN

I assumed the position of Editor of RNFormation (RNF) in January when Betty Razor, who has accomplished so much for Nevada nurses, stepped down. I quickly recognized the difficulty of trying to fill Betty's shoes and went looking for help. I am pleased to announce that Kathy Ryan, RN, MSN, has agreed to act as Co-Editor of RNF. Working with the Editorial Board, we hope to make this the number one nursing publication in Nevada.

The Nevada Nurses Association (NNA) provides a complimentary copy of RNF to every nurse in the state as a service to the members of our profession. Our intent is to provide interesting and timely information of importance to nurses in creative and engaging ways in order to enhance professional nursing practice. We try to share with our readers the issues affecting health care providers statewide. To this end, we will be adding new features and columns to the publication, including "Letters to the Editor". To submit a letter for publication, please put Letter to the Editor in the subject line and email it to us at nna@nvnurses.org or mail it to RNF Letters to the Editor, P.O. Box 34660, Reno, NV 89533. Please include your contact information.

We recognize the rich variety of practice settings, and the challenge in identifying content relevant to these settings, and we need your help and opinions to guide us in shaping the future directions of RNF. Please take a few minutes to answer the following questions:

1. **What kinds of information are most important to you?**
   - **A. Legislative activities**
   - **B. Networking opportunities**
   - **C. Practice updates**
   - **D. Other (Please explain briefly)**
2. **Do you prefer:**
   - **A. In-depth articles?**
   - **B. Brief summaries with additional references?**
   - **C. Other?**
     Please explain briefly)
3. **If <u>you</u> were the editor, how would you change RNFormation?**

We welcome your ideas, we value your feedback, and we look forward to reading your comments. Please email them to nna@nvnurses.org with the subject "RNF Survey" or mail them to NNA Survey, P.O. Box 34660, Reno, NV 89533.

And while we're at it…Do you have an original nursing-related article, study, poem, or cartoon? Please consider submitting it for publication in ***RNFormation***.

Letters to the Editor

Dear NNA,

I see your 'bookbag hunt' has been successful: more bags just arrived. I will send them to the Word Alive School of Nursing in the next shipment. I am already collecting computers and books.

Please thank your Nevada nurses for their generosity. I have attached...photos of the student nurses in Ghana. There are now 660! Wow!! It's a two year program in Community Health Nursing.

Best regards,
Jean Toth

Congratulations!

CCRN Certification Announcement

Lydia Frawley, RN, CCRN

Lydia Frawley, RN, recently attained the coveted CCRN certification offered through the American Association of Critical Care Nurses. Lydia is a graduate of Ohio's Sinclair Community College ADN program. Now that she has completed her CCRN certification, Lydia plans to complete her education to the Master's level in Nursing. She has spent over nine years providing patient care in a Level One Trauma Center in an innercity hospital—six years as a Patient Care Technician, and the last three years as an ICU RN.

Lydia's ICU experience includes one year as a Burn Nurse and over two years as a trauma nurse caring for medical, surgical, and neuro patients. Recently, having moved to Nevada, she plans to add cardiac ICU care to her knowledge base. Lydia maintains additional certifications, including CPR, ACLS, PALS, and ABLS (Burn), and enhances her general nursing skills by working PRN as a floor nurse.

Lydia has committed herself to ICU nursing and is dedicated to encouraging compassion, professionalism, evidence based practice, and patient advocacy. Her ultimate goal is to obtain the important WOCN (Wound-Ostomy-Continence) Certification and hopes to be a driving force in promoting improved wound and skin care practice throughout the nursing profession.

Meet the RNFormation Editorial Board

Lorraine Bonaldi-Moore
RN , BSN , MBA , MSN

Lorraine is a Professor of Nursing at Orvis School of Nursing, University of Nevada Reno. She has an interest in pediatrics and 20 years clinical experience in the nursing care of patients.

John Buehler Garcia

John Buehler Garcia was born of overseas missionaries in Costa Rica and lived in both Costa Rica and Mexico for the first part of his life. As a part of his parent's work he was exposed to aspects of culture and work ethic uncommon in the United States. He participated in all manner of work from farming and collecting mague cactus to raising farm animals to building churches and schools. He came to the United States when his parents undertook a mission to the Sioux Indians in South Dakota again learning and assimilating a culture and experiences much different than that of the "average American."

John's educational background involves various courses of study, including biomedical engineering, chemistry, pre-med, emergency services, social sciences and criminal justice. He obtained Associates Degrees in Medical Technologies and Criminal Justice. He obtained a Bachelor of Science Degree in Public Administration and Criminal Justice from California Baptist University. His Bachelor of Science in Nursing was obtained from Nevada State College. He has undergone various USAF Trainings, as well.

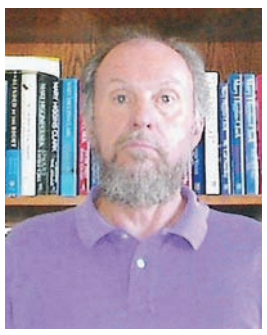
His investigative career began when he graduated from the AFOSI Academy in 1987 and served in multiple assignments worldwide successfully resolving fraud, criminal and counterintelligence investigations. John attended the Defense Language Institute in Monterrey, CA where he studied Arabic for a year, resulting in various trips to the Middle East where he was recognized with various awards in counterintelligence and anti-terrorism work.

John began his second career as a nurse after separating from the USAF and has worked in Hospice and Medical Surgical wards. In his short tenure as a nurse he has been recognized for excelling in providing care to patients and their families during some of the most trying circumstances common to end of life care. He has been recognized by his peers and identified as a coach and mentor for student nurses and subordinates moving towards their nursing degrees. He is active in the Hispanic Nurses Association, American Assembly for Men in Nursing and a supporting member of the Student Nurses Association. As a member of the editorial board for the Nevada Nurses Association newsletter he is charged with gathering and publishing articles on the state's nursing schools and student nursing organizations.

(Continued on page 9)

Editorial Board (Cont'd from page 8)

Wallace (Wally) Henkelman



My name is Wallace (Wally) Henkelman. I hold a BS in zoology from University of Wisconsin, and a BSN and an MSN in Critical Care Nursing from the University of Texas. I practiced as an intensive care nurse for over 26 years. I have taught in nursing programs in Texas, Montana, and Nevada and am currently a full-time Nursing Lecturer at Nevada State College in Henderson, teaching primarily pathophysiology and pharmacology. I have completed 30 credits toward an EdD through Argosy University Online. My wife of 26 years is an elementary school teacher.

Denise S. Rowe, MSN, APRN, BC, FNP

Denise Rowe received her Master in Nursing degree and training in family practice from the Vanderbilt University School of Nursing in Nashville, Tennessee. Ms Rowe currently practices as a nurse practitioner providing primary care to veterans in Geriatrics and Extended Care in Las Vegas, Nevada. She also provides care to families in the retail health setting at Take Care Health clinics in Walgreens drug stores in Las Vegas, Nevada.

Ms Rowe's practice interests include hypertension, heart disease, diabetes, osteoporosis and prostate cancer. She is also dedicated to improving public health and reducing health disparities. She is an active member of the Southern Nevada Black Nurses Association men's health committee working to improve health outcomes through education of underserved and at risk male populations in the Las Vegas community.

Ms Rowe has published an article on osteoporosis in men in the *Federal Practitioner*, the peer reviewed journal for the Department of Veterans Affairs, Department of Defense and Public Health Service. Ms Rowe is on the editorial board of Nevada RNFormation, the official publication of the Nevada Nurses Association and has written several articles for this publication.

Kathy Ryan, RN, MSN

Hello –

I grew up in the beautiful cities of coastal California. After traveling through the rugged mountains of the Sierra Nevada, I moved to rustic South Lake Tahoe and I've been there ever since. After years of playing, I returned to school, and a simple CPR class hooked me on health care.

I recently earned my MSN, and hope one day to become a Clinical Nurse Specialist in cardiac and vascular care. I enjoy epidemiology and investigations, research, teaching, and writing. In addition, I would like to volunteer as a nurse in medically underserved areas, and as a parish nurse and advocate.

I am thankful for God's blessings in my life. I believe that serving others serves Him, and I treasure the opportunities He has provided me.

Debra A. Toney, PhD, RN
President and CEO
TLC Health Care Services

Dr. Debra A. Toney is the President and CEO of TLC Health Care Services in Las Vegas, Nevada, a licensed home health care agency specializing in skilled nursing and supportive care services. Dr. Toney's commitment to quality health care and her belief that people recover better in their own home was the catalyst for her to establish TLC Health Care Services over 10 years ago.

Dr. Toney is a nurse entrepreneur and brings over 25 years of leadership experience to the home health care industry and has experience in family practice management, and business development. Throughout Dr. Toney's career she has been an advocate for the underserved and actively involved with issues related to minority health, health policy and community service.

She is the former chief administrative officer of Rainbow Medical Centers, where she was responsible for leading the single practice organization into a full service multiple site family practice/urgent care organization.

Dr. Toney obtained the following degrees; B.S. in nursing from the University of Oklahoma, in Norman, Oklahoma, M.S. in health services administration from the University of St. Francis, in Joliet, Illinois, and a Ph.D. in human services with a specialization in health care administration from Capella University, in Minneapolis, Minnesota. Dr. Toney is a Robert Wood Johnson Executive Nurse Fellow.

Dr. Toney is active in professional organizations. She is the 10th President of the National Black Nurses Association, a member of the American Nurses Association, Southern Nevada Black Nurses Association, Nevada Nurses Association, board member for the National Coalition of Ethnic Minority Nurse Associations and chair of the advisory committee for the Nevada State Office of Minority Health. Most recently she was appointed by the Nevada Majority Leader, Senator Steven Horsford to serve on the Health Reform Policy Council. She serves on the Nominating Group of the U.S. Food and Drug Administration, is a member of the National Institutes of Health Advisory Committee on Research on Women's Health and the Expert Advisory Panel for The Joint Commission to develop culturally competent hospital standards.

Dr. Toney is involved with a variety of community-based organizations including; Alpha Kappa Alpha Sorority, Links, Inc., A.L. Pollard Foundation, and the Ovarian Cancer Association of Nevada. She is the President of the Jourdan Kasey/Karen Lazarus Foundation named after her younger sister and is dedicated to raising awareness and educating others regarding early detection of ovarian cancer.

Dr. Debra Toney has been recognized for her contributions to society by numerous organizations including: The American Legacy Magazine's Multicultural Healthcare Award; Woman to Watch in 2008, In Business Las Vegas Magazine; Nurse Entrepreneur of the Year, National Black Nurses Association; Nurse of the Year, Southern Nevada Black Nurses Association; and Top Women-Owned Business, In Business Las Vegas.

She is published and frequently speaks on leadership, nursing workforce, health disparities, health policy and clinical practice issues at the national and local levels. Dr. Toney is a visionary and uses her health care knowledge to help the underserved.

Dr. Toney is married and has two children. She enjoys knitting, reading and gardening in her free time.

Stepping Chicago Style *(Cont'd)*

(Continued from page 1)

This is how "Stars" are made, says Iary Israel, founder and lead instructor for the Word of Mouth Entertainment, LLC St. Louis, Missouri. "Our class size has grown from just three to over 300 adult students, who come from all walks of life—housewives, retirees, to professionals. We have had tremendous response to the Community School based program at Stevens Middle Community Education Center where classes have been held weekly, since 2002. A common theme we hear from the students, especially when they first start Stepping class is 'this is a workout. I sweat as much here as if I were at the gym'. This is when I realized what we were providing in class was actually great exercise, and that many folks probably wouldn't get any if it were not for Stepping" according to Israel. "Our class members have a glow about them from the natural high that comes from dancing the Chicago Style Stepping—we truly see a difference." (I. Israel, personal communication, October 5, 2008).

Many other classes and instructors have sprung up across the country, in cities like Detroit, Indianapolis, Cleveland, Los Angeles, Las Vegas, Seattle, Phoenix, Atlanta, Dallas-Fort Worth, Baltimore, Charlotte, Memphis, Miami—the list goes on and on. However the list would not be complete until it includes "The Capital"—Chicago, also home of the R&B icon, R. Kelly. Kelly rocketed Stepping into the national spotlight with the hit tunes and videos *Step in the Name of Love* © 2003 and *Happy People* © 2004 (Zomba Recording LLC.). Stepping is a passion for many, and is referred to by R. Kelly as a "culture," because of the lifestyle participants embrace out of elements evolved from the dance art form.

The dance culture phenomena popularized as Stepping evolved out of the Jitterbug and Lindy Hop of the forties, and the Bop or Boppin' of the sixties and seventies. Stepping is done to a six-count or eight-count on the down beat of urban and R&B/Soul music. The dance involves basic movements—turns, spins, dips, and footwork. When combined with personal style, flair, and coordination, Stepping yields sensuous aesthetic enjoyment for participants and spectators. Also referred to as 'Steppin', the dance has swept the nation not only for its smooth, rhythmic flow and hit tunes, but also for growing recognition of the health promotion and wellness enhancing benefits.

Any activity that increases the heart rate speeds up the metabolism causing calories to be burned. Stepping the night away can burn just as many calories per hour as riding a bike or swimming. The exact calories burned while Steppin' needs further research. According to dance and exercise experts, a 150 pound person dancing the Salsa burns 420 plus calories per hour, Ballroom (fast) comes in at about 374 calories per hour, and Swing around 306 calories per hour. Stepping is similar in the intensity and exertion of all of these dances, especially Salsa. An educated estimate of calories burned using the calculator from HealthStatus.com, Stepping one hour compared with fast Ballroom dance could average around 378 calories—again, based on a 150 pound person

You can forget that you are "exercising" and dance your way to fitness. Regular exercise helps with overall physical conditioning. When combined with other lifestyle changes like healthy food choices, yearly check-ups, health screenings, positive thinking, Chicago-style Stepping can play a vital role in fitness and preventing chronic disease.

The National Heart, Lung and Blood Institute (NHLBI, 2008) reports that regular physical activity such as dancing can lower risk for coronary heart disease, diabetes and some cancers, decrease blood pressure, help manage weight, and strengthen the bones in the hips and legs. Mayo Clinic (1994)

Janice Muhammed and Big Tony, President & CEO, Las Vegas Steppers Club

researchers reported that the social aspects of dancing are beneficial for stress reduction, increasing energy, improving strength and increasing muscle tone and coordination. Individuals with a heart or lung condition, chronic health problems or risk factors for disease should seek medical advice before starting or significantly increasing physical activity.

Learning to Step is easy, and having your own dance partner is not required. "Our instructors love the challenge teaching the person who says they can't dance or thinks they have two left feet," says Tony Owens, President, promoter and lead dance coach of the Las Vegas Steppers Club (LVSC), Inc., in Las Vegas, Nevada. "Most people are surprised they can learn the basic eight step movements on beat in just little time." Owens has been teaching Stepping with LVSC since 1999. "We are happy the word is getting out regarding the health and social benefits of Stepping…our members become like family because of similar interest mainly because we get lots of exercise and relieve stress by having fun dancing. We have worked in the community with organizations like the Southern Nevada Black Nurses Association (SNBNA), Inc., to promote Stepping. It is a classy, grown and sexy dance, that is a great physical fitness alternative." (T. Owens, personal communication, October 9, 2008). The LVSC has provided Stepping demonstrations at local health events for the SNBNA and the Clark County Teachers Union. Let's face it—the evidence is out regarding the benefits of regular exercise, but the average person has challenges to stay motivated. The best thing about dancing is that it does not feel like exercise and may become a good health habit.

Unlike standard exercise, dancing is unique in that it not only provides cardio-healthy benefits of aerobic performance it also has the feature of taking part in a social activity. Albert Einstein College of Medicine neurologist and lead researcher Joe Verghese (2003) published a 21 year study in the New England Journal of Medicine, of participants over age 75, that showed dancing was the only physical activity that was associated with a lower risk of dementia. The most common form of dementia is Alzheimer's disease. This brain disorder seriously affects a person's ability to carry out daily activities because of confusion, forgetfulness and loss of recognition of familiar faces. The scientist believes perhaps, the lower risk of dementia is because dance music engages the dancer's mind. Verghese reports dancing may be a triple benefit for the brain. According to the study, the physical aspect of dancing increases blood flow to the brain and the social aspect of the activity leads to less stress, less depression and loneliness. Moreover, the foot work of structured dancing requires memorizing steps and working with a partner, both of which provide mental challenges vital for a healthy brain.

Music is known for its ability to relax the mind, body, and uplift the spirit. Whether soulful mellow tunes or up-tempo rhythms, music helps to release tension, thereby decreasing stress. Unlike traditional exercise, Stepping is an exercise with a live atmosphere that creates a great ambiance for people to mingle, meet new people, and become friends and dance partners.

Four important reasons to get your Step-on include:

- Flexibility. Dancing requires limber movement. Flexibility is an essential part of being fit. Major muscle groups get a full range workout during Stepping.
- Strength. Dancing builds strength by forcing the muscles to resist against a dancer's own body weight. Stepping develops strength. Consider the muscle mass a male Stepper develops by dipping his partner, or the muscle a female uses to resist against her own weight in the backward motion of the dip during a dance routine.
- Endurance. As mentioned, dance is indeed physical exercise. Exercise develops endurance by conditioning the muscles by working hard for increasingly longer periods of time without getting as tired. Getting the heart rate up can increase stamina (staying power and endurance). Regular Stepping builds endurance. Many tunes last four to five minutes—or longer, times five or more tunes are easily a 30 minute workout set.
- Sense of Well-Being. Stepping is both positive leisure and social past time. Regular physical activity reduces stress and tension. Humans are gregarious beings inclined to group recreational activity and in doing so develop social linkage. Strong social ties lead to improvement of self-esteem and a positive outlook.

Opportunities present to meet people in classes, and at dances which may help to build social skills, and boost self-confidence. According to several anecdotal reports there is a sense of well-being that comes from getting groomed and dressed up for a Steppers social event—maybe Stepping does make "Happy People."

The evidence supporting the health benefit of dance is apparent. However, scientific research is necessary to expound the health and wellness benefit phenomena of participants engaged in this particular physical and recreational activity. Encourage family, colleagues, and clients to take a fun approach to physical fitness by dancing along with the stars. Get fit, stay youthful, prevent disease by finding a Stepping class in your area and get your Step on! Check out these links to view Stepping in action: www.steppersexpress.com/lessons.htm and http://www.youtube.com

Janice L. Muhammad is an assistant professor at the University of Southern Nevada College of Nursing. She serves as Chair of the Men's Health Committee, Southern Nevada Black Nurses Association, Inc., (SNBNA), Chair, National Black Nurses Association (NBNA) Ad Hoc Committee on Advance Practice Nurses, and member, NBNA Nominating Committee, and can be reached at jmuhammad@usn.edu or (702) 968-1638, P.O. Box 20487, Las Vegas, NV 89112.

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Portion Distortion

By Beatrice Razor, RN, BSN, CWOCN

Welcome to the wacky world of portion distortion! We live in the land of gigantic food portions. From the

enormous bowls of pasta and the big slabs of beef served in restaurants to plate-sized pizza slices and jumbo bags of chips and candy, it appears that the distortion of portion size is alive and well. It's all too common to consume three or four or even five "servings" at a time. Think not? Consider these commonly accepted serving sizes* and what they look like.

1 Pasta Serving = 1/2 to 1/3 cup

According to the USDA Dietary Guidelines (and their famous Food Guide Pyramid), a serving of cooked pasta is one-half cup. The American Diabetes Association says a serving is one-third cup.

The visual: A tennis ball sliced in half.

1 Meat, Poultry, or Fish Serving = 2 to 3 ounces

The accepted serving size for this category of food is, generally, three ounces cooked.

The visual: A deck of cards, or a checkbook.

1 Milk or Yogurt Serving = 1 cup

One cup is the serving size almost always used for all types of milk and yogurt.

The visual: A yogurt container, or the size of your fist.

1 Natural Cheese Serving = 1 ½ ounces

Natural cheeses include cheddar, provolone, Muenster, and Swiss. One serving is equal to 1 1/2 ounces, which might be easier to think of as 3 tablespoons. Processed cheese (cheese food, such as American cheese) for some reason gets a serving size of two ounces.

The visual: 4 dice stacked on top of each other, or the

(Continued on page 16)

On Your Feet!

Physical Activity Guidelines from the U.S. Department of Health and Human Services

By Kathy Ryan

In the United States, healthy living recommendations highlight the value of physical activity. Over the past 10 years, the American Heart Association, the CDC, the National Heart, Lung, and Blood Institute, and the U.S. Surgeon General suggested a variety of recipes for the successful incorporation of physical activity into daily life. Despite these efforts, the U.S. Department of Health and Human Services (USDHHS) reported that Americans of all ages remained relatively inactive and at risk for adverse health consequences (2008). The American Heart Association (2008) confirmed that the prevalence of physical activity among Americans was only 30.9%. In response to these disappointing results, the USDHHS published physical activity guidelines with one main focus: get up and on your feet!

Physical Activity Guidelines

Beginning in 2007, the guidelines advisory committee began to identify and evaluate scientific literature relating physical activity to health outcomes. The comprehensive guidelines they produced defined physical activity, and described the amounts and types of physical activity most beneficial for Americans.

Physical activity is simply energy-powered movement. Its benefits for adults include the reduction of risks for hypertension, heart disease, stroke, and early death; non insulin-dependent diabetes and metabolic syndrome; breast, colon, endometrial, and lung cancers; and depression and falls. Adults may also experience improvements in respiratory and cardiac function, bone density and muscle fitness, sleep quality, and cognitive function. Achieving and maintaining optimal weight may also be easier.

Physical activity's benefits for children and adolescents include the reduction of risk for- and symptoms of- anxiety and depression, and improvements in respiratory and cardiac function, bone health, and body composition.In general, health benefits result from at least 150 minutes of moderate physical activity per week. As the frequency, duration, and intensity of physical activity increase, the health benefits increase. For people with activity constraints or disabilities, research indicates that the benefits of physical activity far outweigh the risks of heart attack or injury. For people with time constraints – take heart! Both aerobic and resistance training for just 10 minutes at a time count toward your 150 minute-per-week goal.

Physical Activity Recommendations

Adults 18-64 years of age should aim for 150 minutes per week of moderate intensity or 75 minutes per week of vigorous intensity aerobic exercise, and muscle strengthening exercise two days per week. Adults 65 years and older, and people with disabilities should follow the recommendations according to their physical abilities, with a focus on flexibility and muscle strengthening exercises to assist in fall prevention.

Pregnant and postpartum women should consult with their health care providers, but may continue established exercise routines as long as their health status safely allows. Children and adolescents should aim for 60 minutes per day of moderate to

(Continued on page 16)

ANA, APRNs, and Healthcare Legislation

By Michelle Artz
Chief Associate Director, Department of Government Affairs
American Nurses Association (ANA)

ANA continues to be actively engaged in efforts to remove barriers to practice for APRNs in federal law, and to ensure that they are recognized appropriately in developing federal programs such as Medical Home and Health Information Technology (HIT), as well as in Health Care Reform efforts more broadly. Last Congress we successfully fought for the inclusion of APRNs in the electronic prescribing program that passed in the Medicare Improvements for Patients and Providers Act. We are working toward reintroduction of several APRN bills including: The Medicaid Advanced Practice Nurses and Physician Assistants Access Act (which would remove barriers that keep APRNs from participating fully in state Medicaid Programs) and The Home Health Care Planning Improvement Act (which would change Medicare law to grant Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse Midwives the ability to order home health services and to sign home health plans of care). We are deeply concerned about Medical Home, which remains a demonstration project at the federal level. We sought unsuccessfully to change the language in last year's Medicare Package, and will continue to look for opportunities to address the issue moving forward.

With Regard to the Stimulus HIT provisions, APRNs *are* included as eligible for incentives in the Grant section of the bill, and NPs and CNMs are eligible for funds in the Medicaid Section—APRNs are not, however included under the Medicare incentives. The definition of provider used in this section of the bill covers only physicians, dentists, podiatrists, optometrists and chiropractors. The speed with which the bill was crafted, and more fundamentally the level of funding allocated to the program ($20 billion instead of the originally promised $50 billion) were the key reasons why other vital providers including APRNs were not a part of the Medicare section. A letter, signed by ANA and the broader provider community, went out to key House and Senate committees during the stimulus deliberations.

The HIT provisions in the stimulus bill are being characterized by the administration and hill staff as merely the groundwork for a full program, not the beginning and end. We expect the current Congress to engage in further discussion on HIT—whether on its own or as part of health care reform. ANA will continue to work to ensure that APRNs are appropriately included in HIT and other federal programs and and we will work to further educate members of Congress and their staff about APRNs, their practice, and the vital role that they play in care.

ANA Member Mary Wakefield Named Administrator for HRSA

SILVER SPRING, MD—The American Nurses Association (ANA) commends President Obama on appointing Dr. Mary Wakefield, PhD, RN, FAAN as Administrator of the Health Resources and Services Administration (HRSA). Dr. Wakefield is widely acknowledged as an expert on rural health and nursing workforce issues, and has extensive knowledge of the health care system and policy making process. As HRSA Administrator, Dr. Wakefield will lead the agency in improving access to health care services for people who are uninsured, isolated, or medically vulnerable.

"At a time when the country is in need of bold and innovative health system reform, ANA is confident that Dr. Wakefield will be an invaluable asset to the administration's health care team," remarked ANA President Rebecca M. Patton, MSN, RN, CNOR. "We at ANA are thrilled to see such a qualified and respected nurse selected for HRSA Administrator, especially given the Agency's vital role in delivering much needed care to underserved areas."

Dr. Wakefield, a longstanding ANA member, was most recently the Associate Dean for Rural Health at the University of North Dakota School of Medicine and Health Sciences, where she was a tenured professor and Director for the Center for Rural Health. She has distinguished herself as a dedicated nurse, educator and leader within the nursing profession, as well as the health care public policy arena. She has demonstrated that she can serve as a dynamic catalyst for change at the local, state, and national level.

Office of the National Nurse

By Teri Mills MS, RN, ANP, CNE
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Many of you may be aware that there is a strong grassroots effort underway to create an Office of the National Nurse. The intent of creating an Office of the National Nurse is to have nurses, under the leadership of a National Nurse within the USPHS, deliver messages of health promotion and illness prevention, to every American, in multiple languages. This message delivery would be done through partnering and strengthening the work of existing groups such as the Office of the Surgeon General, the Medical Reserve Corps and others. Nurses are well positioned to provide this much needed change as they are 2.9 million strong, the most trusted of all health professionals, span all cultures, are present in all communities, and are accomplished health educators. Tenets of the Office of the National Nurse proposal are:

1. The Office, led by the National Nurse, would be a position within an established health care agency. We are recommending that the Chief Nurse Officer of the USPHS head the Office of the National Nurse, as this is a position that currently exists and is funded. This position needs to be modernized and the job responsibilities shifted to primarily focus on serving as the driving force to deliver messages of prevention to all Americans.

2. The ONN would serve to inspire and engage nurses to become community service volunteers. Under the ONN, nurses would be encouraged to participate in existing organizations like the Medical Reserve Corps and would add to the focus on delivering health promotion information in their communities. Nurse volunteers would engage community partners to introduce, emphasize and reinforce prevention concepts and establish best practices to change behaviors. Some key focus areas would include exercise, better nutrition, tobacco cessation, and mental health. The goal is to improve health outcomes by teaching and promoting healthier living to create a culture of prevention. Additionally, this system would provide a ready supply of nurses in case of large-scale emergencies.

In a Robert Wood Johnson Foundation September 2007 newsletter, Dr. Susan Hassmiller, Senior Program Officer, states, "Nurses have a pivotal role in promoting preventive care since they spend more time with patients than any other health care professional. By educating and counseling patients about the importance of simple preventive measures, nurses can have a significant impact on improving health and extending lives. The health care system needs to empower and encourage nurses for them to be effectively engaged in this role." This statement represents the foundation of the proposal for an Office of the National Nurse.

America's healthcare system is in serious trouble. Nurses are galvanized by this proposal and want to make a difference. We are the largest sector of healthcare. We have unique and special skills and insights to offer the public. We understand that preventive medicine is better than reactive medicine; that quality of life matters. An Office of the National Nurse would possibly be the most significant way to utilize our collective vast wealth of knowledge to improve our nation's health. And we hope that you, as concerned health care consumers and nurse practitioners, will join us so that the Office of the National Nurse will become a reality in our lifetime.

For more information visit http://nationalnurse.org This website has links to News updates, FAQ, and the growing list of supporters. If you would like to receive the National Nurse Newsletter, please email teri@nationalnurse.info

Avoid Malpractice & Protect Your License: ETHICS IN NURSING

CEU Opportunity!!!

By Tracy L. Singh, RN, JD
Nurse-Attorney at the Law Offices of Tracy L. Singh, LLC

To earn CEUs for this article, visit our website at www.tlsinghlaw.com to obtain all questions and forms for submission. Credits will be issued by the Law Offices of Tracy L. Singh, LLC and a portion of the proceeds will be donated to NNA.

Nurses are faced with ethical issues, conflicts and dilemmas every day. In most cases, nurses are prepared to handle these situations with confidence and doing the right thing on a routine basis helps nurses build strength, character and self-esteem. Every now and then, however, nurses are faced with real challenges and in the moment, "the right thing to do" may not be so readily apparent. In this article, we will discuss some very basic real life examples of ethical decisions you may be faced with and how the choices you make can help you to avoid malpractice claims and protect your nursing license.

The most important thing to remember is that as nurses, first and foremost, you are advocates for your patients and keeping their interests in mind at all times will help lead you to the right decision when faced with ethical dilemmas at work.

Nurses do *not* know it *all*! It is ***not*** a sign of weakness or incompetence to ask questions. Rather, it is a sign of strength and courage to seek more information instead of pretending that you know it all. Nurses are only human and there is no way for any nurse to know every technique, every drug or every disease encountered in nursing practice. Criticizing or punishing a nurse for asking questions is unethical for it discourages rather than fosters the learning process which should be a never-ending endeavor in healthcare.

Years ago, while working as a nurse on a cardiovascular step-down unit we received a detailed in-service on how to set and troubleshoot the external pace-maker routinely used on our floor. Having worked with the device before, some of the nurses in the group were hesitant to admit they did not know how to use certain functions for fear of appearing ignorant or incompetent. When I asked for more information on how the settings worked, the other nurses were relieved to admit they did not know how it worked either. That is when the real discussion and learning began.

A few weeks later, a patient of mine was sitting at the bedside following his "a.m. care" when his external pacemaker wire became dislodged. My patient's heart rate immediately began decreasing and as soon as telemetry called, I knew exactly what to do because I had not been afraid to ask questions during our in-service. This experience gave me the courage to continue asking questions regardless of what others thought of me and I continue to ask questions without hesitation in my practice today.

Asking questions saves lives! Speaking up and asking questions is the ethical thing to do when you are not sure about something. Ultimately, however, it will be your responsibility to ensure that the person you are asking has provided you with the correct information before you proceed.

Nurses are *not* perfect! Every nurse makes mistakes. Knowing the ethical thing to do once a mistake has been made is the key to protecting your license. If you are a nurse, you have probably experienced that dreadful moment when you realize something went wrong, or that you forgot to do something; the all-over-body adrenaline rush that comes over you when it hits you that you have made a mistake. In nursing, even the smallest mistake can have catastrophic results when they are not addressed in time.

Administering the wrong medication, for example, can cause an adverse reaction. Forgetting to flush a patient's hep-lock before a code, feeding a patient who is N.P.O. for surgery, accidentally documenting on the wrong chart, forgetting to obtain consent before giving blood, passing medications before checking current blood levels…the list of common nursing mistakes goes on and on. All of these examples could lead to irreversible harm to a patient if the nurse does not admit to making a mistake and/or fails to take action to correct the situation in time.

The moment nurses make a mistake, they will undoubtedly experience some form of panic. Aside from feeling horrible for making a mistake, nurses may also fear getting into trouble, losing their job or their nursing license. This fear could deter nurses from admitting to their mistakes and from taking action to protect their patients which of course would be the ethical thing to do.

The sooner nurses acknowledge their mistakes and take action to protect their patients, the better the outcomes will be. In each situation above, admitting to a mistake immediately upon discovery could help to prevent further harm. The patient given the wrong medication could be given an antidote; the occluded hep-lock could be replaced; the patient who ate could be rescheduled for another day, or have their stomach contents drained before surgery; charting could be corrected before other mistakes are made; consent can be obtained or the transfusion could be stopped; additional labs can be drawn and precautions can be taken to avoid over-dose and proper monitoring of the patient may be ordered if the nurse involved would just admit to making a mistake.

A nurse who can admit to making a mistake can be *trusted!* Admitting your mistake and taking immediate action to correct it is the ethical thing to do. It may seem counter-intuitive, but this is also the best way to protect your job and your license. Even when a patient dies as a result of your mistake, you are more likely to receive a minimal level of disciplinary action if you take personal responsibility, admit to your mistake and do what is right for your patient. If, however, you opt to do nothing and deny your mistake, you could risk losing your license.

Recently, a nurse gave a baby the wrong medication. She pleaded with the infant's mother not to tell anyone and she tried to hide her mistake to avoid getting into trouble. She later refused to respond to the Nursing Board's Notice of Complaint and Hearing and a hearing was held in her absence. Although the baby was unharmed, the Nursing Board revoked her license; not because of the mistake she made, but because of the way in which she chose to handle herself *after* making a mistake.

Nurses have a duty to report! A business mentor of mine shared a non-nursing story which may serve as a helpful analogy to emphasize the impact and consequence of failing to report. This person owns several businesses and he prides himself in taking exceptional care of his employees. He has very little turn over and he is adored by most of his staff. To his shock and dismay, he recently discovered that two of his employees were stealing money from him. Even worse, he learned that six other employees knew about it and did not report it to him. In his mind, all eight employees were equally guilty of stealing and they were all terminated. Obviously, the ethical thing to do was not to steal. The not-so-obvious ethical thing was to report the knowledge or suspicion that employees were stealing to limit the damages caused to their employer who took such good care of them.

In nursing, your ultimate employers, the people you have a responsibility to protect are your patients. As patient advocates, nurses must be cognizant of the potential harm in not reporting mistakes or intentional acts and omissions that amount to negligence or malpractice. Fear of retaliation, loss of employment and ridicule by others is a real concern in nursing. Yet, reporting when mistakes are made, taking action to correct the situation, and helping each other to continue learning in nursing are the ethical things to do. Nurses should not be ridiculed, out-casted or retaliated against for admitting to their mistakes or seeking additional education.

This is why the Nevada Nurses Association and the Nevada State Board of Nursing are in support of proposed legislation that helps to protect nurses from retaliation when reporting errors and omissions in the healthcare setting.

In sum, nurses must make ethical decisions on a daily basis and the best way to avoid malpractice and protect your license is to admit that you do not know everything there is to know in nursing, seek opportunities to continue your education in nursing, take personal responsibility for your actions, and advocate for patients by reporting mistakes before actual or additional harm is caused.

For Continuing Education Credits issued by the Law Offices of Tracy L. Singh, LLC, please visit our website at www.tlsinghlaw.com and submit your test answers to our office via fax, mail or email. All answers submitted will remain strictly confidential.

New Residency May Improve Retention of Nurses in Rural Facilities

Rural nurses are required to have a breadth and depth of knowledge unparalleled in other specialty nursing fields. The rural nurse is often required to manage complicated patient conditions using limited equipment or technology while simultaneously coordinating care within a variety of social and cultural networks unique to the rural community. The immense generalist role of the rural nurse often leads to early burnout and high turnover rates when compared with more urban nurse roles (up to 65% in the first year of practice). On the other hand, residency programs have been shown to be an effective means of reducing the turnover of new and transitioning nurses. When a nurse participates in a residency program, they are provided with extended support and training which helps to reduce stress while increasing their confidence and proficiency.

And so, it is with great excitement that Idaho State University (ISU), in partnership with health organizations throughout the West and Northwest, has developed the Northwest Rural Nurse Residency (NWRNR) program. The NWRNR is a unique program for many reasons, not least of all is that residents and preceptors can receive all of their training 'at home' in their own facilities and communities. Using new technologies like web-conferencing, telemedicine and high tech simulation make it possible for the program to be offered at no cost to participants. Additionally, because of this innovative technology, participants don't have to travel to an urban center, or even across town to benefit from the 64 hours of seminars and continuing education electives. Additionally, all 104 hours of the supervised clinical experience are completed in the nurse's 'home' facility. Both residents and preceptors receive top-notch training by rural nursing experts from across the country. Program faculty and staff provide a supportive and informative role for preceptors, residents and nurse administrators to help ensure successful completion of the 12-month program. While residents benefit from increased training, accelerated skill acquisition and reduced 'new role' stress, preceptors are supported with training, mentorship, certification, an honorarium and regional recognition.

Due to the high tech convenience of the NWRNR training, participating facilities are required to have high-speed internet available to both the residents and preceptors as well as systems in place to support nurse education. Preceptors must be experienced rural nurses with at least two years in the facility and a license in good standing. Residents must have less than one year at the facility and be a new graduate, re-entering the profession, or transitioning from an urban setting. The second cohort of NWRNR residents will be starting in early May and space is limited. Applications are accepted on a first-come, first-served basis, so apply today! Be one of the first facilities in your area to boast the employment of rural nurse specialists while enjoying the benefits of lower nurse turnover. Call the ISU Office of Professional Development for an application or more information at (208) 282-2982, email at NurseOPD@isu.edu or visit the NWRNR website at http://www.isu.edu/nursing/opd/nwrnr.shtml

Northwest Nevada District One News

In December we welcomed several new board members: Kari Jo Passman, John Morrison, and Beth Bomberger, Nominating Chair. Beatrice Razor, Susanne Byrne and Janet Bryant were re-elected. All members of the district were invited to an orientation to NNA and the district on January 17th. Sadly, newly elected president-elect, Charles Sheeley, resigned due to personal reasons. This huge void will need to be filled in the next election cycle.

The district board meets by teleconference with another meeting held in February to project plans for the coming year. Since District One is strategically located in the area of the state capital the district acts as host and planning committee for the NNA Nurses Day at the Legislature held during the every other year session. Therefore most of the early part of the year was involved in promoting and hosting this critical event to advocate for nursing legislation.

It was a whopping success! A huge thank you to Carol Vickrey, Margaret Curley, Gloria Castillo, and Kathy Ryan. Kathy has excellent writing skills that were employed constantly; what a sharp and dedicated nurse! Gloria Castillo is an icon of nursing in Nevada and even in her so-called retirement is always available to assist and promote nursing values.

The district board voted to continue with the CEU conference on the alternate year (2010) with a theme on Nurses Health Issues; this will coincide with the March "Women's History Month" activities. The board is asking for your suggestions on a title for the program and suggestions for speakers on the topic. A call for volunteers for the committee will go out in March of 2009. The timing for the conference will also coincide with the scholarship raffle and suggestions for donors for the raffle would be appreciated. The scholarship raffle allows the district to provide three scholarships to each of the schools in our area. Consider becoming active with this important committee.

We are looking for ideas for community projects that have a state-wide connection, so that members throughout the state can volunteer and provide strength in numbers. We welcome and appreciate all suggestions and ideas where nurses can make a true impact to their local community.

Membership meetings have been poorly attended; therefore a short survey will be emailed out to obtain information from the members on the most effective style of meetings. Please respond in a timely manner.

The major fall event will be the annual legislative roundtable to meet your local legislators and discuss the legislative outcomes from the 2009 legislative session that affect nursing practice. Watch for the announcements and flyer.

Reminder: The beautiful and well-constructed NNA polo shirts are still available in sizes S, M, L, XL. Place your order soon. The cost of $25 includes mailing. Make check payable to NNA District One and send to Carol Vickrey at P.O. Box 2574, Minden, NV 89423. Be sure to include your size and address.

I hope to get to know you as a volunteer on one of our committees; call or email me for a full description of the activities and role descriptions. We are currently looking for volunteers for the following committees: Nomination, Raffle, CEU conference.

Beatrice 'Betty' Razor, NNA District One President, cell: 775-560-3350, etbetty @sbcglobal.net

TMCC Community Nurse Mentoring Program

TMCC Seeking Experienced Nurses to Mentor New Students

By Karen Fontaine

The Nursing Program at Truckee Meadows Community College was recently awarded a grant by the US Department of Labor that provides services to nursing students that are predicted to improve retention. The Northern Nevada Nursing Retention Project will follow nursing students from enrollment through the first year of their employment. One component of the retention program is the Community Nurse Mentoring program. The nurse mentoring program pairs experienced nurses who instill the philosophies and values they have developed to TMCC's nursing students who will become the next generation of nurses. Nurses who are working professionals are recruited to support nursing students. The program highlights the relationship that benefits the student best, that of a concerned professional, who has been there and can assist and welcome the student into the nursing profession. Students benefit by having increased self-esteem, development of professional behaviors, networking opportunities, and nurturing. This mentoring program differs from any others cited in literature because it is modeled on psychosocial functions only, not career or job performance function.

Mentors complete a self-study continuing education module which provides information and education about the unique aspect of mentoring nursing students. Most nurses who have been mentored have received a preceptor mode which includes mentoring, but do not understand the differences between how they have been mentored and this program. Mentoring is primarily used in the employment setting to assist with the development of skills.

Both students and mentors complete a profile that focuses on their professional and personal interests and style of communication. Once profiles have been received from both students and mentors, the information from the profile is used to facilitate successful matches based on compatibility. Literature supports the most effective matches are based on common interests, similar likes and dislikes and professional goals.

The mentor and mentee are requested to report any problems they may be experiencing with either their relationship or the mentoring program. They are encouraged to call or email the mentoring program coordinator. The mentor and mentee complete a mentor program evaluation tool at the end of every semester (approximately every 3-4 months). Evaluation components include satisfaction with amount of contact, whether the participants felt that the relationship worked, and what benefits they received.

Problem solving of mentor/mentee issues are resolved by the mentoring program coordinator. Problems could include a poor match due to time constraints, no common interests, strained communication, lack of mentor and/or mentee commitment, lack of mentor and/or mentee understanding of role and the mentor or mentee withdrawing from program. Resolution of the problem(s) may include ascertaining the reason perceived by the participant to determine if the problem between the pair can be resolved; if not, the program coordinator may match both individuals with other participants. The mentor and mentee are advised at the beginning of the program and as a part of their agreement form that they may at any time request a different match or withdraw from program participation without being required to explain (although they are encouraged to provide this feedback).

TMCC is currently recruiting experienced practitioners who are enthusiastic, friendly, professional, organized, patient, caring and understanding to mentor beginning nursing students. Mentors will support students to increase the student's self-worth, competence and identity as a soon-to-be professional nurse. Please contact Wendie Rains, the Mentoring Program Coordinator at Truckee Meadows Community College. Her number is 775-673-7056.

Back to Basics?

Janette Moss RN, MSN, NE-BC
St. Rose de Lima Hospital

In the last few years, the phrase "Back to Basics" has been used frequently. Technology advances have enabled many processes to be brought to the bedside improving data specific to the patient so that care is timely and exacting. But have we so removed ourselves from the hands-on care of our patient that we no longer listen, reach out to touch and look?

When we think of sepsis and the related care necessary do we not consider cleanliness a basic tenet of Maslow's Hierarchy of Needs? Maslow described the physiological needs, as the biological needs. They consist of needs for oxygen, food, water, and a relatively constant body temperature. They are the strongest needs since if a person were deprived of all needs, the physiological ones would come first in the person's search for satisfaction. By delegating baths to our nursing assistants are we taking away our opportunities to inspect, palpate, and listen to our patients? When we wash a patient, we assess so much. When we logroll them onto their side we check their pressure areas, feel their skin under our hands: Are they hot, dry, cold, clammy? When we move them do they cough, does their chest rattle? When we feed a stroke victim, we assess their ability to swallow. When we dress a wound we observe its progress each day: its shape, size, color, odor, discharge. Is it pale red or angry red?

There is so much that an experienced nurse automatically assesses when they look after the basic needs of a patient and it is not for the unskilled. Florence Nightingale is quoted as saying "the thing which strikes the experienced observer most forcibly is this, that the symptoms or the suffering generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different—of the want of fresh air, or of light, or of warmth, or of quiet, or of cleanliness, or of punctuality and care in the administration of diet, or of each or of all of these."

When we think of ventilator-associated pneumonia, have we forgotten that brushing teeth is a basic need to rid the mouth of bacteria? Although pneumonia is a risk faced by any patient being admitted to a hospital, when patients are placed on a ventilator, the risk increases from 3 to 10-fold. Previous research indicates that the bacteria found in the lungs of patients is the same as the germs in their plaque. The simple solution of brushing the patient's teeth can decrease the risk of pneumonia by up to 50%.

When we think of a possible deep vein thrombosis, are we forgetting that man was not meant to lie in bed, but was made to be mobile? By getting our patients out of bed, ambulating, moving about, we decrease depression, offer a higher quality of life, and stimulate the normal sensitivities that we all require to define ourselves. Through increased ambulation and movement we are able to decrease pressure points and skin breakdowns and activate our senses to better outcomes to our patients who have entrusted their care to needs to a caregiver, but better yet, we have now given the patient the ability to do more for themselves—what a gift. Patients are placed in a dependent position when they enter a hospital, we place them in a bed with side rails much like a toddler bed and they feel disenfranchised. We need to increase the patients' independent feelings.

What ever happened to that warm basin of water that we had the patient soak their feet in? That process brought a great deal of joy to the patient —that extra added "touch." It also enabled the nurse to check between the toes during the drying process, apply cream, and teach good hygiene. What ever happened to the evening back rub? What ever happened to staying with the dying patient and holding their hand so that they were not alone?

The basics were founded by Florence Nightingale who entered the hospital and was appalled and horrified by what she saw. Wounded soldiers lay on straw mats that lined the room like coffins waiting for burial. The floor was covered with dirt and blood. There were no hospital gowns: the men still wore their uniforms. As Nightingale passed among them, each soldier tried to act stern and tough, but their boyish faces betrayed unmistakable pain. Those who were able to conquer their convulsions lay still, as if dead. These were the hospital conditions in Scutari, Turkey during the Crimean War. Florence and a group of nurses were sent to this hospital to help make the hospital a more efficient place. The first change Florence made was scrubbing all the injured mens' clothes. Her nurses cleaned the whole hospital so there were fewer germs to contend with and this helped to stop contamination and the spread of disease. Through Florence Nightingale's efforts the profession of nursing was forever changed. Nursing was once an occupation with little respect: people didn't think you needed any special training or skills to do it, and most nurses were poor and uneducated. Hospital conditions were more sanitary after she reorganized everything. Funds and donations flooded into hospitals and the patients received better care. Hospitals around the world were changed forever, and caring for the sick became an honorable profession. As the profession grew, nursing developed and continues to do so in ways which would make Florence proud. Going back to the basics honors our founders and promotes the outcomes we seek for our patients.

Today the public has high regard for nurses and considers it a profession they can trust. Modern day nurses need to reflect and place into our practice the basics that our founders envisioned. No one expects us to take the patients' laundry home, but maybe if we took a few extra minutes with each patient listening—especially for environmental issues and check noise levels at the patient's bedside, touching, checking on the odors in the room, inspecting and using common sense, we can affect the basics through the use of the nurse's five senses. Let us not allow Florence Nightingale's next quote to be our legacy, but rather a reminder that we are more than this and we are infinitely more capable. "If a patient is cold, if a patient is feverish, if a patient is faint, if he is sick after taking food, if he has a bed-sore, it is not generally the fault of the disease, but of the nursing." In conclusion, I leave you all with a thought:

With all the advances in technology are nurses losing the "art" of nursing?

Recommended for Review

- **Decreasing Disruptions Reduces Medication Errors** by Debra Wood, RN

  Reducing distractions during medication administration cut errors in half at one California hospital, and now nurses are spreading the concept, sharing with other facilities safer medication-pass processes.

  Read this article at NurseZone.com
- **Research Links Schedules to Increased Needlestick Risk** by Amanda Sounart, associate editor, NurseZone

  New research shows that one of the biggest factors affecting needlestick risk has little to do with technology and more to do with the world-wide nursing shortage.

  Read this article at NurseZone.com
- **Transformational Change** by David W. Woodruff, MSN, RN-BC, CNS, CEN, President, Ed4Nurses, Inc.

  A new initiative focuses on safety and reliability, care team vitality, patient centeredness and increased value to your patients and their families.

  Read this article at www.ed4nurses.com

Portion Distortion (Cont'd from page 11)

average thumb.

1 Serving of Fruit

With whole fruit, a serving is a medium-sized apple, banana, orange, or pear—keep in mind most of what we see in grocery stores is portion distortion. We tend to get large to extra-large varieties. If it's canned, chopped, or cooked, the serving size is one-half cup.

The visual: A tennis ball sliced in half.

1 Serving of Grains

If the grains are cooked, like oatmeal, serving size is one-half cup. If it's cold cereal, a serving is three-fourths to one cup.

The visual: For oatmeal, an ice cream scoop; for cold cereal, a teacup to a fist.

*Serving sizes are created for the purpose of giving people appropriate and healthy nutrition information and portion size guidelines. Serving sizes are established so that what you see on the Nutrition Facts labels on food products is somewhat standardized. Also, it's a way for government agencies, like the USDA, to recommend amounts of different types of foods for optimal health and weight control.

Five Tips to Help You Avoid Portion Distortion

1. When looking at the Nutrition Facts label on a product, get in the habit of glancing at the serving size (this may be futile; sometimes it's in grams or another unit that's not user-friendly) and automatically doubling or tripling the calories, carbohydrates, and other nutrients you check.
2. At restaurants, send half your plate back to the kitchen to be wrapped up as soon as you can without being rude.
3. Take out your measuring cups and train yourself —using water, dry beans or rice, and some play-dough—to know what recommended portion sizes look like in your everyday bowls.
4. Train yourself to only order small or kid's size when ordering anything at a restaurant, snack bar, and so on.
5. Use a smaller plate when eating at home. When away from home, always leave some food on your plate (cancel your membership to the "clean plate club").

SOURCES:

American Diabetes Association. (2006, February). *Portion sizes: A key to weight loss*. Retrieved August 7, 2007, from www.diabetes.org

National Heart, Lung, and Blood Institute. *Serving size card*. Retrieved August 9, 2007, from http://hp2010.nhlbihin.net/portion/servingcard7.pdf

USDA. *How much are you eating?* Retrieved August 7, 2007, from www.extension.iastate.edu/Publications/HG267X1.pdf

On Your Feet! (Cont'd from page 11)

vigorous intensity aerobic exercise, and bone and muscle strengthening exercise on three or more days per week.

The greatest health benefits accrue from physical activity performed throughout the week. However a key change with these guidelines is the focus on weekly rather than daily exercise. The freedom to design a physical activity program that meets individual needs may help maintain interest in exercise and support success in reaching personal goals. No matter the level of physical activity, the guidelines emphasize that some is better than none!

How To Be Active Your Way is a fact sheet providing answers to frequently asked questions on physical activity planning, and examples of moderate and vigorous intensity aerobic exercise. Moderate exercises include canoeing, dancing, gardening, and walking. Vigorous exercises include hiking uphill, jumping rope, running, swimming, and tennis. *Toolkit* is a resource for community and health policy planners and includes fact sheets, flyers, and posters.

References

American Heart Association. (2008). *Heart disease and stroke statistics – 2008 update.*Retrieved February 27, 2009, from http://www.americanheart.org/downloadable/heart/1200078608862HS_Stats%202008.final.pdf

U.S. Department of Health and Human Services. (2008). *Physical activity guidelines for Americans.* Retrieved February 27, 2009, from http://www.health.gov/paguidelines/

Additional Resources

American College of Sports Medicine – www.acsm.org

Preventive Cardiovascular Nurses Association – www.pcna.net

Kathy Ryan, RN, MSN, is a staff nurse interested in education and counseling for health promotion and maintenance.

Cultural Disparities in the Diagnosis and Treatment of Prostate Cancer

Peggy Ward-Smith, PhD, RN
Urol Nurs. 2006;26(5):397-399,405.

Reviewed by Denise S. Rowe MSN, APRN, FNP, BC

Prostate cancer is a leading cause of death for men in the United States. One out of six men is diagnosed with prostate cancer, and it is the second leading cause of cancer deaths in men. In 2006, the Centers for Disease Control (CDC) projected there would be 234,460 new cases of prostate cancer leading to an estimated 27,350 deaths. With an increased survival rate from 67% to 97% in over 20 years, early diagnosis and treatment has been shown to be very important to increasing survivability from the disease.

Prostate cancer deaths among African American men were higher than that of any other ethnic or racial group, as noted in data from the National Centers for Chronic Disease prevention and Health Promotion and the National Cancer Institute. Their data showed that between 1990 and 1999, prostate cancer death rates among African Americans, American Indian, Alaska Natives and Hispanics, was almost twice the rate of Caucasians and Asian/Pacific Inlanders. This indicates that there are disparities between ethnic groups in the diagnosis and treatment of prostate cancer.

While there are web sites such as the American Cancer Society and the National Cancer Institute that provide education on diagnosis and treatment of prostate cancer to lay persons, the internet is underutilized by older adults. It is also difficult for people to discern what is actual research-based information versus marketing when trying to figure out the accuracy of information found on the internet. Even though, evidence-based information is readily available, there are gaps in educating and motivating men at risk to seek prostate cancer screenings.

African American men are significantly less likely to identify the symptoms of prostate cancer correctly as compared to Caucasian men. Research has shown that African American men preferred private physician screening versus public mass screenings, and the radio was their preferred medium. Educational forums in physicians' offices or radio were underused. One study of 12 African American men interviewed found they often associated symptoms like dribbling and urinary frequency with aging, and many thought a digital rectal exam involved the entire hand being inserted into the rectum when performing a prostate exam. None expressed concern about their prostate, requested a prostate cancer screening or thought they were even at risk for prostate cancer. Another study showed that 30% of African American men would not want to be told they had prostate cancer and 53.2% felt they were unlikely to be diagnosed with prostate cancer. Many believed the diagnosis was like a death sentence. In one comparison, research showed African American participation in free prostate cancer screenings was 59% versus 75% among Caucasians. Clearly, clinicians need to significantly increase this number by decreasing barriers to screenings. One way to increase screenings would be to routinely and consistently educate and screen these men when they are seen in the primary care setting.

Among ethnic groups (African American, Caucasian, Chinese, Filipino) studies showed many lacked information about the causes of cancer and the need for preventative screenings. Other barriers to prostate cancer screenings were marginal education and lower socioeconomic status. I agree with the author that there is a need to make educational programs simple, and available in native languages for different ethnic groups. Studies also showed low income was the greatest predictor of poor physical functioning among Hispanics. Another study showed that when compared to Latino males, Cuban males participated in more prostate cancer screening; the reason(s) for this difference were not mentioned in this article and may have provided relevant data on how to improve screenings among Latinos as population group.

There are notable differences in outcomes in prostate cancer management. After prostatectomy, African Americans were significantly better than non-Hispanic whites in sexual and urinary functioning. The author should have discussed the contributing factors for this finding. African Americans also had twice the risk for more advanced stages of prostate cancer as compared to non-Hispanic whites: 12.3% African American versus 10.5% of Hispanics, versus 6.3% of Caucasians. Other than socioeconomic factors among Hispanic males accounting for some of the statistical differences, it is unclear from this article if education is the other factor that explains such a significant finding of advanced prostate cancer among African Americans.

In conclusion, what can clinicians do to address cultural disparities in diagnosis and treatment of prostate cancer? I agree with the author that ethnic-specific education presented in a forum commonly used by each ethnic groups is the key to transmitting the message of the importance for early prostate cancer screening. The message must be simple, and tailored to the literacy level of these individuals. We must educate that prostate cancer does not have to be a death sentence, but that early detection saves lives. We should consistently discuss prostate health at all appropriate opportunities so men become comfortable with knowing that their prostate health matters, and that we as clinicians also believe it is important. This message when conveyed with the right tone and in the right setting with emphasis on cultural sensitivity, can remove the stigma that many men have with discussing prostate issues. Men need to feel unhindered about discussing digital rectal exams, urinary frequency and urgency, sexual erectile dysfunction and libido, all issues that can be affected by prostate health. The author rightly concludes that healthcare professionals need to be more proactive in reducing health disparities among ethnic groups by eliminating barriers to early diagnosis and treatment of prostate cancer.

Inflammatory Breast Cancer: The cancer without a lump

What is inflammatory breast cancer (IBC)?

Inflammatory breast cancer is a rare but very aggressive type of breast cancer in which the cancer cells block the lymph vessels in the skin of the breast.

Symptoms of IBC may include:

- pink, red, reddish purple, or bruised appearance of the skin of the breast
- skin with ridges or pitting (like the skin of an orange)
- thickening of the skin
- swelling, with a rapid increase in breast size
- breast tissue that is warm to the touch
- persistent itching (IBC is often misdiagnosed as bug bites)
- aching, burning, heaviness, or tenderness
- a nipple that is inverted (facing inward)
- NO distinct lump in the breast.

These symptoms usually develop quickly—over a period of weeks or months, and maybe only one or two of the symptoms occur.

Swollen lymph nodes may also be present under the arm, above the collarbone, or in both places. However, it is important to note that these symptoms may also be signs of other conditions such as infection, injury, or other types of cancer.

Reference

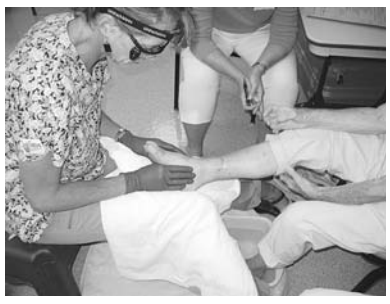
National Cancer Institute. (n.d.). *Inflammatory breast cancer: Questions and answers*. Retrieved March 3, 2009, from www.cancer.gov/cancertopics/factsheet/Sites-Types/IBC

FDA Advisory

The FDA warns of potential hazards of skin products containing numbing ingredients for relieving pain from mammography and other medical tests and conditions. FDA remains concerned about the potential for topical anesthetics to cause serious and life-threatening adverse effects when applied to a large area of skin or when the area of application is covered. For more information, go to **http://www.fda.gov/cder/drug/advisory/topical_anesthetics2009.htm**

LEAD in Older Hypertensive Adults

By Shelly R. Burdette-Taylor RN-BC, MSN, CWCN, CFCN



Lower-extremity arterial disease (LEAD) also known as Peripheral Arterial Disease (PAD) or Peripheral Vascular Disease (PVD) is common in adults with systolic hypertension (raised blood pressure). LEAD develops when the arteries to the lower extremities become narrowed and do not receive enough blood flow to keep up with the demand. In one study of over 1700 participants, LEAD was assessed non-invasively by the ratio of the ankle to arm blood pressure, Ankle-Arm Index (AAI) also known as the Ankle-Brachial Index (ABI). The prevalence of LEAD was 25% in white men, 38% in black men, 23% in white women, and 41% in black women. The prevalence increased with age and was consistently higher in blacks than whites. Independent factors that were associated with the presence of LEAD included age, black race, smoking, diabetes mellitus, history of myocardial infarction (MI / heart attack) or angina, high systolic blood pressure, lower high density lipoprotein cholesterol, and obesity with a body mass index over 30. (Newman, et al, AHA Journals.org). The vast majority of PAD conditions are caused by atherosclerosis (hardening of the arteries).

It is essential for baseline and ongoing assessments for LEAD to be completed by the primary care physician or podiatrist because symptoms of LEAD are often absent. People with diabetes and / or systolic hypertension are at highest risk for LEAD.

Symptoms that may be present are:

- leg pain when walking (intermittent claudication). The location and intensity of the pain depends on the location of the narrowed vessel and severity of the clogged artery.
- painful cramping in the hip or thigh
- leg numbness or weakness
- coldness in the lower leg or foot
- sores on toes, feet, or legs that won't heal
- change in leg color
- hair loss on the feet and legs
- changes in the shape of the toenails

If a patient is experiencing any of these symptoms, they should be reported to the primary care physician. Do not make the mistake of dismissing symptoms as a normal part of aging.

Through medical management and lifestyle changes many people can manage the symptoms of LEAD and stop the progression of the disease. To prevent, stabilize or improve LEAD, patients should:

- Stop smoking—smoking contributes to constriction and damage of your arteries.
- Exercise—success in treatment is often measured by how far the patient can walk without pain.
- Eat a healthy diet—a heart healthy diet can help control blood pressure and cholesterol levels—and the omega-3 fatty acids should be added to the diet.

In addition to the above suggestions, patients with LEAD should take good care of their feet. People with LEAD and especially those with diabetes are at highest risk for poor healing and infections that lead to amputations. Instruct patients to:

- wash their feet daily, be meticulous about drying between the toes
- moisturize the feet and lower legs, avoid between the toes
- apply light powder between the toes
- wear well-fitting shoes at all times, high toe box, wide and long enough, change shoes 2 times per day
- wear light compression socks (8-12mmHg) to reduce swelling of the feet, make sure socks are dry, change socks 2 times per day
- see board certified foot care nurse or podiatrist for any infections of skin and nails
- see board certified foot care nurse or podiatrist for trimming of nails especially if there is no caregiver to facilitate safety in foot care
- avoid walking barefoot
- see the doctor at the first sign of a sore, injury, infection or other condition, such as high blood sugar for no apparent reason

Foot care is now recognized as a board certified specialty in nursing. RN's can become board certified in Foot and Nail Care through the Wound Ostomy Continence Nurses Society National Organization. More information is available on websites such as www.wocncb.org or www.taylordhealth.com for foot and nail care opportunities and certification.

Individuals with LEAD and diabetes are very high risk for limb loss in the event of an injury and/or infection that goes undetected and or non-healing wound that is poorly treated. LEAD is closely related to systolic hypertension. With early and ongoing assessments, diagnosis, and early intervention to include medical, and lifestyle management, complications may be prevented and the quality of life enhanced.

Beta-blockers Perioperatively

By JoAnn Green, MSN, RN, CCNS, CCRN, CNS
Consultant for Ed4Nurses, Inc.,
http://www.ed4nurses.com/

A recent meta-analysis of 33 controlled trials was reviewed to assess the use of the Guidelines set forth for β blocker therapy in the non-cardiac surgery patient population. These Guidelines, presented by the American College of Cardiology (ACC) and American Heart Association (AHA), recommend β blocker therapy for patients who are: already receiving β blockers or who are having vascular surgery and have noted ischemia, for those having vascular surgery or intermediate or high-risk non-vascular surgery with high risk of coronary disease or those with known disease.

Notably the recent POISE trial looked at perioperative metoprolol and found a 30% reduction in non-fatal MIs with a 33% increased risk of all-cause mortality and a 117% increased risk of stroke. So should we be using β blockers perioperatively?

The meta-analysis of randomized controlled trials of patients with non-cardiac surgery did not show a "clear benefit of perioperative β blocker use with control for the prevention of cardiovascular outcomes" (p. 1972).

β blockers were associated with an elevated risk of perioperative bradycardia and perioperative hypotension, both requiring treatment. β blockers were *not* associated with a considerable reduction in risk of all-cause mortality, cardiovascular mortality, or heart failure but *did show* a reduction in non-fatal myocardial infarction and myocardial ischemia. However, there was an increase in non-fatal strokes seen with β blocker therapy, an increase that has also been found on data looking at β blockers in patients with hypertension.

This meta-analysis shows the need to monitor carefully patients on post-operative β blockers for bradycardia, hypotension, and neurological changes.

From:

Bangalore, S., Wetterslev, J., et al. Perioperative β blockers in patients having non-cardiac surgery: a meta-analysis. *Lancet* 2008; 372: 1962-1976.

Chronic Kidney Disease

Maria G. showed up in the Emergency Room because she had been more tired for the past few weeks and noticed her legs were swelling. She was found to have extremely high blood pressure and advanced Chronic Kidney Disease (CKD). She started hemodialysis three times per week in order to survive. Maria hadn't seen a doctor for over 15 years and can't remember the last time her blood pressure was checked.

This story is all too familiar and is occurring in greater frequency all over the country. A recent review in the Journal of the American Medical Association (JAMA) found the prevalence of CKD (Stages 1-4) in the United States has increased from 10% to 13% over a 10-year period[1]. As with Maria G., CKD, for the most part, goes unrecognized until it is in an advanced state. There are limited warning signs and fewer clues that your kidneys are slowly deteriorating and will, at some point, fail to support your body. At that point the only options will be dialysis or transplantation.

This sad tale is made worse by some other alarming statistics. Obesity, Diabetes Mellitus, High Blood Pressure, and an aging population are all risk factors for advancing CKD and are themselves being identified in the population at increasing rates.

Concerned about this emerging epidemic, Medicare has initiated a series of pilot programs aimed at identifying at-risk populations, performing screening tests, and improving communication about CKD between providers and between providers and their patients. The main goal of these programs is to identify people in the early stages of CKD where intervention and risk factor modification can play a valuable role. Early intervention and early nephrology (Kidney Doctor) consultation has been shown to slow disease progression and improve treatment of associated co-morbidities, such as anemia, bone mineral metabolism, and progression of cardiovascular disease. Even in patients where the progression of CKD cannot be halted, early intervention can:

- ♦ Facilitate pre-emptive transplantation,
- ♦ Decrease progression of cardiovascular disease,
- ♦ Promote early AV Fistula (dialysis access) placement, and
- ♦ Decrease overall morbidity associated with CKD.

The Nevada CKD Task Force, a group dedicated to increasing awareness of the risk for kidney disease, has created a valuable resource of education and self-management materials. These materials, available on *HealthInsight's* website, www.healthinsight.org [www.healthinsight.org/hcp/ckd/ckd.html], include a variety of patient educational materials, provider materials, useful links, and practice guidelines aimed at identifying the at-risk population in need of early intervention.

Winning the battle against this silent killer challenges everyone to become more aware of the risk factors for CKD, to promote early screening for those who are at-risk, and to prevent progression of the disease with evidence-based care.

[1] Coresh, J., et al. (2007). Prevalence of chronic kidney disease in the United States. *Journal of the American Medical Association*, 298(17), 2038-2047.

This material was prepared by HealthInsight, the Medicare Quality Improvement Organization for Utah and Nevada, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 9SOW-NV-2009-7.3-025

Achieving Neuroprotection for Cardiac Arrest Patients Through Induced Hypothermia

By Teri Kozik, RN, MSN, PhD Candidate

Out-of-hospital cardiac arrest patients historically have high rates of mortality and morbidity. More than 90% of cardiac arrest patients die before reaching the hospital, accounting for over 450,000 deaths in the United States alone. Of those that survive beyond resuscitation, up to 30% will develop widespread cerebral ischemia and edema that frequently lead to severe neurological impairment. Studies have shown that of those that survive, hyperthermia from ischemia or brain injury clearly exacerbates the degree of permanent neurological damage and contributes to an increased length of in-patient stay.

Recovery correlates with body temperature; lower body temperatures post cardiac arrest are associated with higher levels of neurological recovery. In experimental models, increased brain temperature and cerebral ischemia produced a chain reaction, resulting in increased levels of excitotoxins and reactive oxygen species (also known as oxygen free radicals), unstable cell membranes, and an increased number of abnormal electrical depolarizations. With as little as a 0.5 degree Celsius increase in temperature, the zone of injury expands and the degree of neuronal loss rises.

To improve the outcomes of cardiac arrest survivors it is important to stop the ischemic process as quickly as possible and prevent reperfusion damage. Clinical trials inducing hypothermia to a temperature of 32-34 degrees Celsius for 12-24 hours, have suggested that this treatment may be beneficial in reducing the deleterious neurological outcomes in this population. Hypothermia decreases the metabolic rate by 6-7 percent for every one degree Celsius decrease in temperature. Since the cerebral metabolic rate for oxygen is the main determinant of cerebral blood flow, inducing hypothermia may provide a reduction in oxygen consumption and an improvement in oxygen supply to an ischemic brain. Though the exact mechanism is unknown, hypothermia also decreases intracranial pressure, possibly due to decreased blood flow from cerebral vasoconstriction. Finally, once cerebral perfusion is regained, reperfusion injury occurs as blood flow is restored. The release of glutamate, an excitatory neurotransmitter, is increased from presynaptic terminals causing calcium to shift from the extracellular to the intracellular fluid leading to an accumulation of reactive oxygen species and the activation of degradative enzymes. Advanced Cardiac Life Support guidelines (2005) now advocate avoiding hyperthermia for all patients following resuscitation. In addition, unresponsive cardiac arrest survivors maintaining adequate blood pressure should be evaluated for induced hypothermia.

Inducing hypothermia may take several hours and maintaining the target temperature for 24 hours can be difficult with standard ice blankets. Saint Mary's Regional Medical Center (SMRMC) in Reno, Nevada received funding through their foundation to purchase a cooling device from Medivance called the Arctic Sun (see figure). Pads applied to the patient's body circulate water over 40% of the body. The experience of treating over 30 patients with this device at SMRMC has shown that target temperature is usually achieved in approximately 60-90 minutes. The Arctic Sun allows the nurse to program the target temperature and monitor temperature changes through esophageal, urinary, or rectal probes attached directly to the device. Rewarming is done slowly to prevent severe electrolyte shifts. Again, the Arctic Sun allows the nurse to program the device to rewarm at a specified time interval. At SMRMC, policy sets rewarming at 0.5 degrees Celsius per hour.

Saint Mary's Regional Medical Center has had phenomenal results using the hypothermia protocol. These actual cases demonstrate its value.

Case One

A 56 year old male smoker presented to the emergency room following a cardiac arrest at work. His co-workers called 911 but did not initiate CPR. Seven minutes passed before the paramedics arrived and found the patient in ventricular fibrillation. An additional 21 minutes passed before spontaneous circulation returned. Once he arrived at SMRMC, the hypothermia protocol was initiated within an hour. He was on the ventilator for five days and walked out of the hospital on day eleven neurologically intact. He has since returned to work.

Case Two

A 39 year old female school teacher sustained a cardiac arrest while running. Her friend called 911 and the paramedics arrived within five minutes. She was in ventricular fibrillation and resuscitation continued for 23 minutes. While in the emergency room persistent ventricular fibrillation required multiple defibrillations. After approximately two hours, the patient was stabilized and placed on the hypothermia protocol. On day three she was extubated. She left the hospital shortly thereafter with no neurological deficits and is once again teaching.

Case Three

A 23 year old severely intoxicated male college student attempted suicide by hanging himself in his garage for an undetermined length of time. Once he was found and paramedics arrived, he was apneic and severely bradycardic with no palpable pulse. He was resuscitated in the field but once he arrived at SMRMC he was posturing, indicating a neurological insult. The doctors felt he would not survive, so the hypothermia protocol was initiated approximately four hours after arrival as an "only hope" situation. He left the hospital with his parents on his fourth hospital day with no neurological damage. He had no memory of his suicide attempt or first two hospital days. A year later, his mother came to our critical care unit to let us know he had graduated from college and was working as a computer programmer.

Clearly these examples illustrate how successful inducing hypothermia can be. These scenarios, followed by standard supportive care, would typically produce less successful outcomes. SMRMC has documented shorter lengths of in-patient stay for cardiac arrest survivors, and none of our survivors have sustained any neurological impairment. The result is a reduction in overall healthcare expense. Hospitals seeking to improve quality of care and reduce expenses should consider developing protocols for induced hypothermia in cardiac arrest patients.

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Resource

Medivance – www.medivance.com

Teri Kozik is a cardiovascular and critical care Clinical Nurse Specialist at Saint Mary's Regional Medical Center in Reno focusing on electrophysiology and medical cardiology. She is a PhD candidate at the University of Arizona, Tucson.

Nursing Organizations in Nevada

Nevada State College's Multicultural Student Nurses Association

By Michelle Johnson, EdD, RN, CPNP
Assistant Professor, Nevada State College
MSNA Faculty Advisor

Nevada State College (NSC) has a new association for both pre-nursing students and nursing students. Launched in the spring of 2008, the Multicultural Student Nurses Association (MSNA) is off to a fast start. The purpose of the organization is to promote diversity and cultural awareness at NSC, improve retention and long-term success of both minority and non-minority nursing students, and recruit students into NSC's nursing program. Last fall, MSNA, participated in an information session at El Dorado High School, sponsored by NSC's Office of Multicultural Affairs, to expose high school students to nursing as a potential career. Other fall activities included a gift drive for NSC's Upward Bound students, a program geared toward preparing disadvantaged youth for college. In addition, the organization sponsors a mentorship program in which 1st semester nursing students are mentored by 2nd semester nursing students, 2nd semester nursing students are mentored by 3rd semester nursing students, 3rd semester nursing students are mentored by 4th semester nursing students, and 4th semester nursing students are mentored by practicing RNs, all of which are NSC graduates. The mentorship program has had great success and grows every semester.

MSNA Officers and Faculty Advisor (left to right) Maya Washington, Nicole Manansala, Sharlona Payne, Michelle Johnson

MSNA has a monthly diversity related online discussion topic through WebCampus. Pre-nursing students, nursing students, and faculty have the opportunity to participate in the discussions. Students are also able to use the MSNA site as a bulletin board and open forum. MSNA is also working closely with Nevada State College's Student Nurses Association (SNA) and this spring they are collecting donations for the E-Bunny program, providing Easter baskets for children who may not have them otherwise.

MSNA looks forward to more recruitment activity, including greater interactions between pre-nursing students and current nursing students. The group would like to provide community service through volunteering. In addition, for fellowship and a release from the stressors of nursing school, the group plans to have monthly fun-filled outings.

MSNA is a young organization but its members understand the importance of recruitment and retention of nursing students, especially those from underrepresented groups. MSNA plans to continue to grow and create ways to support each other. There is a planned uniform drive at the end of the semester in which graduating nursing students will be asked to donate their uniforms for incoming nursing students in need. There are even bigger plans on the horizon. Writing for a grant to further the growth of MSNA is planned for the near future.

For more information, contact Michelle Johnson at michelle.ingram@nsc.nevada.edu or call 702-992-2039.

Southern Nevada Black Nurses Association

The Southern Nevada Black Nurses Association (SNBNA) is the local chapter of the National Black Nurses Association (NBNA). The organization is committed to improving the health care of persons of African American heritage as well as the general public. SNBNA is dedicated to educating the community in aspects of prevention and health maintenance and actions that will eliminate health care disparities. NBNA/SNBNA is fully engaged in addressing issues of access and cost of health care, increase in funding for research, improved health outcomes, management of chronic illnesses, culturally sensitive care and the education and development of a diverse and competent workforce. SNBNA hosts and participates in several health fairs, provides health screenings and educational sessions, collaborates with other community organizations, provides scholarships and mentors nursing students.

Upcoming Event:
National Black Nurses Association
37th Annual Institute and Conference
"NBNA: Implementing Strategies to Improve Global Health Outcomes"
Toronto, Ontario, Canada
August 2-August 6, 2009

Contact information:
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Southern Nevada Black Nurses Association
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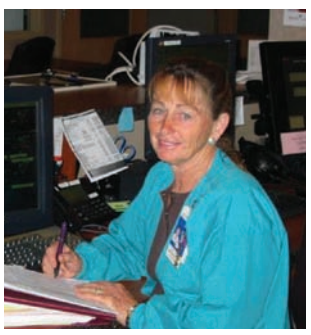
American Association of Critical Care Nurses

By Janet Freeland, RN, CCRN-CMC



The American Association of Critical Care Nurses (AACN) is the largest specialty nursing organization in the world, representing the interests of more than 500,000 nurses caring for acute and critically ill patients and their families since 1969.

AACN defines acute and critical care nursing as a specialty within nursing that deals with human responses to potential and actual life-threatening health problems. AACN is a leader in setting standards for acute and critical care nursing education and practice through several highly respected documents such as *Education Standards for Critical Care, Protocols for Practice, and Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence* among others.

AACN certification programs provide a mechanism for acute and critical care nurses to verify mastery of knowledge and skills in a defined specialty. Some of these specialty certifications include the highly respected Acute/Critical Care Nursing Certification (CCRN), Progressive Care Nursing Certification (PCCN) which recognizes telemetry or step down care, Acute Care Nurse Practitioner Certification (ACNPC), Nurse Manager and Leader Certification (CNML), and 2 Cardiac sub-specialty certifications (CMC and CSC).

AACN journals are recognized nationally as an invaluable resource. Membership includes two quality, evidence based journals: *American Journal of Critical Care* and *Critical Care Nursing*. Membership also includes a monthly *AACN Newspaper.* Anyone can log on to www.aacn.org and receive their FREE e-newsletter with the latest news and information important to acute and critical care nursing.

Opportunities to become involved include:

- AACN Ambassadors—volunteering as a resource to AACN at your place of employment
- Local Chapter Affiliation—AACN now has 240 chapters representing 49 states and 3 foreign countries. (How to start a chapter information is available on the website and Nevada is the only state without a local chapter??!!)
- AACN Volunteers—opportunity to support others, review new programs, and to be part of making a difference in patient care, often without even leaving your computer
- Discussion forums and list serves—provide networking within AACN's professional family of over 70,000 members

E-learning includes quality web-based cost effective courses such as Essentials of Critical Care Orientation (ECCO), a self-paced, interactive program covering cardiac, pulmonary, neuro, renal, GI, hematologic, and endocrine systems with modular exams to ensure mastery of information. Evidence based education is at the heart of all educational programs.

Essentials of Nursing Manager Orientation e-learning was recently developed through a partnership with the American Organization of Nurse Executives (AONE). It is a comprehensive program for frontline managers, charge nurses, and leadership staff.

The Preceptors Challenge: The AACN Preceptor Development Program, and Promoting Excellence in Palliative and End-of-Life Care are 2 of AACN's newest e-learning programs. Multimedia previews can be seen at www.aacn.org/e-learning. These courses have regular updates and revisions with downloadable offline references, supplementary materials and practical tips.

Education is a priority at AACN. The online bookstore with a PDA center offers discounts to members and a large selection of critical care books, CD's and DVD's. The annual National Teaching Institute (NTI) and Critical Care Exposition is a premier educational program with more than 7,000 nurses attending each year, and offering the largest, most comprehensive trade show with more than 500 company exhibits each year. One can order CD's and DVD's from this large symposium of over 500 lecture offerings, however, attendance is a valuable and never-to-be-forgotten experience.

Together members strengthen the voice of acute and critical care nursing and influence the quality of care for patients and their families. Together we can make a difference for ourselves and our profession. Membership includes a wealth of ever-expanding benefits to enrich one's personal and professional life. From unlimited FREE CE credits to award winning journals to local chapter affiliation and discounts on products and programs, AACN dues are tailored to accommodate a range of member types and cost variations.

AACN contact information:
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Nursing Organizations in Nevada

Preventive Cardiovascular Nurses Association

By Kim Newlin, RN, CNS, NP-C

According to the American Heart Association's 2008 Heart Disease and Stroke Statistics, an estimated 80,700,000 American adults (one in three) have one or more types of cardiovascular disease (CVD). The types of CVD include hypertension, coronary heart disease, heart failure, stroke, congenital cardiovascular defects, and arrhythmias. Cardiovascular nurses are engaged in the comprehensive care of patients with all types of CVD in a variety of settings. The Preventive Cardiovascular Nurses Association (PCNA) is the leading nursing organization dedicated to preventing cardiovascular (CV) disease through assessing risk, promoting lifestyle changes, and guiding individuals to achieve treatment goals. Its mission is to promote nurses as leaders in CV risk reduction and disease management so we can care for the growing number of patients with CVD.

PCNA members receive educational publications such as the Journal of Cardiovascular Nursing and a useful pocket guide entitled National CVD Guidelines and Tools for Cardiovascular Risk Reduction. They also have access to many free online CE programs including Move It! Update From the Activity Side of the Energy Balance Equation—Plus Strategies to Get Your Clients off the Couch; Assessment, Treatment, and Evaluation of the Patient with Elevated Triglycerides and Low HDL; Latest Advances in the Treatment of Angina; and a 5 module study of Insulin Resistance. Clinical tools are available, and include downloadable medical evaluation forms, assessment tools, and patient education materials so that you don't have to reinvent the wheel when trying to develop programs or improve the materials you have now.

Members also receive a discount on the cardiac/vascular nurse certification booklet and exam. If you haven't thought about becoming certified, this is a great exam to help you refresh yourself on numerous CV topics.

There are also many opportunities to earn continuing education contact hours and network with peers through PCNA-approved programs both locally and around the nation. The closest chapter to Nevada is in the California Central Valley, which is looking to offer both dinner and half-day programs in Sacramento, Berkeley, Fresno, and hopefully South Lake Tahoe or Reno in 2009. A calendar of events is maintained on the PCNA website. You can also email knewlinpcna@surewest.net if you would like to be on an email list to receive information about upcoming programs.

The PCNA 15th Annual Symposium will be held April 16-18 in Dallas, Texas. This event offers general sessions, breakout sessions, peer-to-peer discussions, and exhibits, with an opportunity to earn up to 18 continuing educational credits. To attend or learn more, visit www.PCNA.net.

Kim Newlin, RN, CNS, NP-C

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WOCN

A nurse embarking on the journey to become a WOC nurse is opening the door to a specialty that makes a tremendous difference in the lives you touch. Whether you plan to specialize in wounds, ostomies or incontinence, all three practice areas offer opportunities for professional growth in a variety of health care settings. WOC nurses provide acute and rehabilitative needs for people with selected disorders of the gastrointestinal, genitourinary and/or integumentary system. WOC nurses provide direct care to people with abdominal stomas, wounds, fistulas, drains, pressure ulcers, and/or continence disorders. As an educator, consultant, researcher and/or administrator the WOC nurse plays a pivotal role in the guidance of optimal patient care.

WOC nurses are Registered Nurses who hold a baccalaureate degree or higher and complete a formal, accredited WOC full scope or specialty education program.

Bringing it all together is no easy task. The WOC nurse's knowledge, leadership and commitment to caring make it happen.

The Reno WOCN support group meetings are scheduled nearly every fourth Thursday for either a luncheon or dinner meeting. Contact Marilee Katz row_boat@msn.com for the specific schedule for the year.

Here are a few comments from those in the specialty:

"The role of the WOCN in acute care hospitals is vital to the hospital's reimbursement with the implementation of CMS's 'Pay for Performance Initiative.' Under pay for performance hospitals will not be paid for services required to care for pressure ulcers the patient develops while in the hospital.

The WOCN will assist with accurate documentation and staging of pressure ulcers that are present at the time of admission to ensure proper reimbursement. The WOCN develops quality improvement programs to identify patients at risk for developing pressure ulcers so prevention measures can be implemented on admission. In addition the WOCN coordinates utilization of specialty beds and other technology to prevent and treat pressure ulcers. Finally the WOCN collects and reports data on pressure ulcer incidence and prevalence at hospitals so the outcomes of the quality improvement programs can be measured."

Melinda Miller

"How does the saying go? With enough time everything comes full circle. Well, that has definitely come true for the WOC nurse. I remember back when WOC's were trying to justify exactly what it was the WOCN did and trying to figure out how to show their worth on paper for QI in the acute care arena asking how do I quantify the value of my position.

It was so difficult to track outcomes for several reasons, some of which are first; most patients were transferred or discharged before having complete wound closure. Secondly, we had poor mechanisms if any in place for capturing data. The scope of our position was too broad and not structured. Many WOC nurses didn't have a clear job description from the get go.

Fast forward to today and the future…This is no longer the case. WOCN's are finally able to begin closing the 'full circle' gap thanks to the new changes by CMS on reimbursement for wound care in acute care. Everywhere I look in N & Central CA facilities are either advertising for their first CWOC nurse or are looking to add on to the already existing CWOCN staff. Finally, the CWOC nurse has gained the respect they truly deserve!

So to answer your question on how I see the WOC as a specialty is 'the sky's the limit.' Now is the time to pull our knowledge and strengths together, re-evaluate the newfound value we bring to the table, and sharpen our focus with the ability to articulate our worth and gain continued respect.

I'm proud to see the changes and look forward to what the future has in store for all of us. The Sky's the Limit!!!"

. . . . . .

"Since you just want some thoughts. . . .

Being a WOCN is not for everyone, a strong stomach is a must(!) for there's always the bad Stage IV pressure ulcers, the colostomies, the colostomy products that won't fit, the wounds that won't heal. But there is also the relationships made with patients, the gratitude for sticking with them and finding a solution to their problem and finding the right product that heals a wound.

Being a CWOCN for 5 years, I have seen some changes. It's an incredible time to be in this field. Not only are you able to enjoy the challenge of a wound healing, educating pts, developing programs and wound product formularies and using critical thinking skills. But now with the Medicare 'Present on Admission' another challenge to educate the physicians as well as staff in assessing and documenting pressure ulcers on admission.

The camaraderie is amazing in this field. If you have a question or concern there will always be a CWOCN near who will always find the time to answer questions and share their knowledge."

Karen Wilson

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"The changes in the field have been immense and reflect the changes in nursing. Becoming an ET (Enterstomal Therapist) Nurse in 1979 opened the doors to autonomy in nursing with the practice limited at that time to ostomy care. Since ET nurses were experts in skin care management we inherited wound and ostomy care and a name change and certification that reflected our practice, Wound, Ostomy and Continence Nurses.

The role is also world wide and the world organization (World Association Of Enterstomal Therapy Nurses) encourages USA WOCN to travel and present and learn from experts around the world. I have been to 12 countries with the WCET and through out the USA. I have worked for Industry, acute hospital, home health, cancer specialty hospital and even formed my own private practice.

What a gratifying experience. But the most gratifying experience is the growth I have seen in the specialty in Northern Nevada. In 1999 when I moved to Carson City the number of WOCN in the area consisted of 3 and a small support group of interested nurses. Now there are 11 WOCN and a support group of over 35 that meets monthly. The numbers will continue to grow as many are attending the required education programs. If you are interested, check out the web site www.wocn.org."

Betty Razor

"Becoming a WOCN has expanded my knowledge base on wounds and even more so on ostomies. I find the autonomy gratifying, having others look to me to make a difference in a person's life. With wounds, chronicity has often defined the person, and I am often able to change that for them. I build relationships with physician's that benefit my patient's.

Ostomies have become my favorite by far. I find them extremely challenging, and the relationships that are developed during my time with the patients and working together to solve their ostomy problems. My goal for them, is to assist in their returning to the most 'normal' life that they can, considering what they have experienced and will experience with the ostomy. I can make the biggest difference in their lives in the shortest amount of time. I believe that if I can assist in making the life-altering disease process and the life-altering body image as positive as possible...I have succeeded in helping an ostomate live. I love what I do, and am grateful for the opportunity to change a life."

Dixie Fox

Congratulations, Nursing Class of 2009! Welcome to nursing.

NEVADA NURSES ASSOCIATION MEMBERSHIP APPLICATION

NEVADA NURSES ASSOCIATION

P.O. BOX 34660, RENO, NEVADA 89533 · 775 747-2333 · FAX 775 329-3334
NNA@NVNURSES.ORG

Please mail your completed application with payment to: NNA, P.O. Box 34660, Reno, NV 89533

Please Print Clearly:

Last Name/First Name/Middle Initial

Credentials

Home Address

City/State/Zip Code + 4

County

Email Address

Date

Home Phone Number

cell phone number

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Basic School of Nursing

Work Phone Number

Graduation (Month/Year)

Work Fax Number

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Position

Employer

Would you like to receive NNA email updates with information relative to nursing & healthcare? YES NO

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Includes full membership to both NNA and the American Nurses Association (ANA) for 12 months.

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***State nurses' association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense.**

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Nurses House, Inc. – Nurses Helping Nurses

Welcome to Nurses House, the only nurse-managed, non-profit organization dedicated to helping registered nurses in need.

Nurses everywhere are indebted to Emily Bourne. In 1922, through a charitable bequest, she created a respite facility for registered nurses that became known as *Nurses House*. The beachfront home, a stately mansion in Babylon, Long Island, could hold up to sixty residents at any given time. It was often filled to capacity during busy summer months as accommodations were peaceful, restful and provided privacy to nurses that came to stay. As times and needs changed the property was eventually sold, but the funds were used to establish a national fund for nurses in need.

Today, Nurses House, Inc. operates as a charitable organization, run by a nurse staff and volunteer board of directors, offering assistance to nurses throughout the country facing hardship. The mission of Nurses House is to provide short-term assistance to any registered nurse in need as a result of illness, injury, disability, or other dire circumstance. A volunteer group of nurses carefully evaluates the needs of Nurses House applicants and disperses funds to assist with everyday living expenses such as food, medicine, health care, rent, mortgage or utility bills.

In 2008, Nurses House offered over $130,000 in grants to nurses in need, but the need has never been greater. Nurses House depends on contributions from nurses and the nursing community to fulfill its mission of helping nurses.

To make a contribution, to request assistance from Nurses House, or to learn more about their work, visit www.nurseshouse.org or call (518) 456-7858.

The original Nurses House in Babylon, Long Island, offered a place where registered nurses could rest and recuperate and recuperate between cases. In 1959, the beachfront home was sold to create a fund for nurses in need, known as "Nurses House" today.

Hospital Compare Continues to Expand

Submitted by Jennifer Robison, HealthInsight

The Hospital Compare website was created through the efforts of the Centers for Medicare & Medicaid Services (CMS) and the Hospital Quality Alliance (HQA). The HQA is a public-private collaboration established to promote reporting on hospital quality of care. The HQA consists of organizations that represent consumers, hospitals, doctors and nurses, employers, accrediting organizations, and Federal agencies. The information on this website is designed for patients needing hospital care, but is most widely used by providers, payers, and public health agencies.

Hospital Compare started small, with ten Process of Care measures showing whether patients receive recommended care for heart attack, heart failure, pneumonia, and surgery. That list has now grown to 27 measures, the newest being two measures on childhood asthma care. More recently, outcome and patient experience measures were added: The 30-day Risk Adjusted Mortality Rates for heart attack, heart failure, and pneumonia, and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). About the same time CMS began to include hospital payment and volume information for certain Diagnosis Related Groups (DRG).

CMS adopted nine claims-based Agency for Healthcare Research and Quality (AHRQ) Patient Safety (PSI) and Inpatient Quality Indicators (IQI) in the Inpatient Prospective Payment System (IPPS) 2009 final rule published in August of 2008. See the table below.

These are claims-based measures that CMS will use to calculate the 2010 IPPS payment and they will be publicly reported on Hospital Compare as early as December 2009. Your QualityNet Administrator has received your *Hospital-Specific Report Dry Run Version*. There are many links within the report directing you to more detailed information about the indicators and the methodology, as well as a link to submit questions and comments. We encourage you to review the report and familiarize yourself with its content. It is important that the executive team be familiar with the data that are published on Hospital Compare, and work with your hospital's quality professional(s) to understand from where the data are derived, how they are collected and reported, and what the results mean. Two percent of your Medicare reimbursement could depend on it.

To review publicly reported results for your hospital or to compare your hospital with others in your city, state, or anywhere in the country, visit http://www.hospitalcompare.hhs.gov. To see where your hospital ranks among all reporting hospitals in the country visit http://www.healthinsight.org/performance/hosp_rankings/hospitals.html To learn more about HealthInsight's role in hospital reporting or how we support your staff in that work, contact Deborah Huber dhuber@healthinsight.org.

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Patient Safety	Inpatient Quality Indicators
Death among surgical patients with treatable serious complications Iatrogenic pneumothorax, adult Postoperative wound dehiscence Accidental puncture or laceration Complication/patient safety for selected indicators (composite)	Abdominal aortic aneurysm (AAA) mortality rate with volume Hip facture mortality rate Composite mortality rates for selected surgical procedures: esophageal resection, pancreatic resection, AAA repair, CABG, craniotomy, hip replacement, PTCA, carotid endarterectomy Composite mortality rates for selected medical conditions: AMI, CHF, stroke, GI hemorrhage, Hip fracture, pneumonia