The New NDNA website is live! www.ndna.org

The new website was launched March 21, 2008. The site has a new look and some new features. The event calendar was changed to include a feature that allows members to post events to the website. To post an event: Click on Event Calendar, then click on Click Here to Post a New Event to the Site. You will be able to enter your event information, then click submit. This information will come to the NDNA office and after review will be posted to the calendar. Events will not be posted without contact information. This change is an attempt to provide up to date information regarding nursing contact hour offerings, meetings, and activities for NDNA Members. Other features include access to documents needed for CNE-Net nursing contact hour applications, approved provider forms, and Refreshers Course and LPN IV course information and documents. Continuing Nursing Education Offering now on the Website!

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Spring, a Time for Celebration

by NDNA President Wanda Rose,
PhD, RN, BC

Spring is a wonderful time of the year as it brings forth new life. I wait anxiously for the tulips and daffodils to peek their heads through the earth, the grass to grow and turn green so I can walk bare foot through the tender new grass and I love to watch the carefree frolic of new baby calves in the pastures.

Spring also brings the time of celebration for many nursing students who will be graduating in May. In North Dakota, we can anticipate over 400 new graduate nurses being added to our ranks. As a nursing faculty, I find the graduates to be excited about what the profession is going to offer them. They are bursting with energy and have much to offer. I am proud that they are joining the profession of nursing.

For the new graduate, graduation is a time of new beginnings. These new graduates are excited about going into the world to do something they have been working to achieve for a long time. They expect to engage in meaningful work that makes a difference. They also expect us to help them make the transition from nursing student to practicing nurse. As each new graduate takes on their new position, they will be asking about evidence-based practice, standards of care, how to balance their personal life and work schedule, and how to provide safe patient care.

For many, the first weeks and months of their first job as a new graduate nurse will be filled with excitement and new experiences. The new graduate wants to gain the respect and admiration of colleagues and wants to fit in. However, for many the journey from nursing student to practicing nurse is chaotic, unsupported, and painful. Initially perceived as exciting, this transition experience may be daunting as the(Continued to page 2)

The following continuing nursing education offerings: Reducing Exposure Risk in the Operating Room and The Many Dimensions of Stress in Nursing are now available through the NDNA website. The first offering is available in the Prairie Rose and on the website. The second is available on the NDNA website. Each is 1 contact hour in length.

As always continuing nursing education offerings are free to NDNA members. The cost to non-members is $20/ offering.

(Continued to page 3)
We have become desensitized to the needs of the new graduate and have forgotten the intensity of the transition experience from nursing student to practicing nurse. They will look around at the end of the night worrying about what they did or did not do on their last shift. They will look around at their peers and honestly believe they will never possess the knowledge, skills, and abilities of these more seasoned nurses.

For us seasoned nurses I ask you to look back and remember what it was like as a new graduate. I remember my excitement about becoming a professional nurse, being able to write RN behind my name and being able to wear a cap with one full stripe. I also remember the feeling of fear that I would do no harm to my patients. I felt the weight of responsibility on my shoulders in caring for the patients assigned to me. I knew I was entrusted in making the best decisions.

A mentor made my transition from a nursing student to a practicing nurse easier. Having a mentor who took the responsibility for orienting the student to a practicing nurse made a world of difference to me, giving me the support and confidence I needed. Because of my mentor I survived my role as a new graduate nurse, in fact I thrived. I hope you will be a part of a supportive environment and they are looking to you for your experience and wisdom. I hope you will be nonjudgmental and encouraging, willing to answer their questions and willing to share your passion for nursing. The initial experience a new graduate has is critical in the formation of their concept of nursing and their professional value system. Boychuck Duschcher & Cowin (2004) offer strategies to minimize marginalization of new nursing graduates Listed below are a few of their suggested strategies (p. 294):

1. Promote tolerance, acceptance and mutual respect.
2. Consistently present nursing as a “sea of possibilities” rather than mutually exclusive specialized nursing factions (ie, maternal vs. pediatrics).
3. Create a sense of belonging within the nursing team and aim to bring those who feel they work on the periphery close within the team by enhancing team communication, collaboration and leadership.
4. Celebrate differences and find ways to utilize them for the benefit of patient health care advantage.
5. Explore work-based rituals and routines with all nursing staff by encouraging discussion and debate on best practices.
6. Provide new graduates and experienced nurses with an open and ongoing forum for the discussion of potential or actual moral dilemmas.
7. Monitor new graduates closely for signs of isolation, alienation and stress.

Let us welcome the new graduates positively into the profession. Celebrate that they have chosen what we have chosen. Spring, also brings another reason to celebrate. May 6-12 is National Nurses Week. This year’s theme is Nurses: Making A Difference Every Day. Every day nurses touch the lives of patients. In North Dakota, nurses represent the largest group of health care providers. It is important during National Nurses Week to express thanks to your fellow nurse for what they do in caring for patients and populations. Be proud of your profession, respect your fellow colleague and celebrate being a nurse. In honor of National RN Recognition Day, all registered nurses in America are encouraged to proudly wear the official ANA “RN” pin or any other pin that clearly identifies them as registered nurses on May 6, 2008. Let us Celebrate Nursing.


President’s Message . . . (continued from page 1)
Membership is now completed through the ANA website at http://nursingworld.org/memapp/
you may also stop over at the office Monday through Thursday and have one of the staff assist you in joining online.
Dues are $20/ month.

Member registration is now completed at the ANA website.
See the link below. https://nursingworld.org/memapp/index.cfm?fuseaction=renew& onelogin=y or call 1-800-284-2378 (direct to member services).

ANA now manages membership services. Paper registration does not occur through NDNA any longer due to the switch over to ANA. Members will receive notices for renewal from ANA.

The New NDNA Website . . .
(continued from page 1)

Submitted by Karen Macdonald

The American Nurses Credentialing Center hosted the Inaugural Certified Nurses Day on March 19, 2008 at ANCC headquarters in Silver Spring, MD. The event was planned to mark the birthday of a visionary for credentialing in nursing—Margretta Madden Styles. Dr. Styles served as president of the American Nurses Association, the International Congress of Nurses, and the American Nurses Credentialing Center. She was the principle investigator of the ANA research project entitled The Study of Credentialing in Nursing.

Dr. Styles died Nov. 20, 2005 at her home in Clearwater, Fl. She is survived by her three children: Patrick, Michael, and Megan. Megan Styles was present at the celebration as were three past-presidents of ANCC: Jan Jones-Schenk, Mary Germain, and Cecelia Mulvey. The current president of ANCC, Deborah Dawson Hatmaker, presided at the event in Silver Springs. Karen Macdonald, Chair of the ANCC Commission on Certification was also present and presented the information that had been placed in the Congressional Record on March 14, 2008 by Congressman McNerny from California:

Mr. McNerney: Madam Speaker I rise today to ask my colleagues to join me in honoring the life of Dr. Margretta Madden Styles. Born on March 19, 1920 in Mount Union, PA, Dr. Styles found her life's calling in promoting quality nursing. She served as the president of the American Nurses Association, the International Council of Nurses, and the California Board of Registered Nursing. Dr. Styles helped create the American Nurses Credentialing Center, which today is the nation's leader in accreditation of continuing education. Her work on training nurses and advancing our nation's nursing accreditation process is unparalleled. Her legacy lives on every day through the thousands of certified nurses in the United States, the patients they treat, and the lives they save. For these reasons I ask my colleagues to join me in honoring the memory of Dr. Margretta Madden Styles and in sending our thoughts and prayers to her beloved family and friends.

Certified Nurses Day will be celebrated March 19 from henceforth. Other organizations have indicated their willingness to join in the celebration including several international organizations. Nurses are encouraged to visit the web site: www.certifiednursesday.org

Following the ceremony, during the luncheon, those in attendance had the privilege of being on the telephone call from Brenda Kelly, Chair of the Magnet Commission to Jan Kamphius, CNO of Medcenter One Health Systems. Dr. Kamphius was notified that Medcenter One was designated as a Magnet Organization by the American Nurses Credentialing Center. Congratulations to Medcenter One.

Certified Nurses Day Inaugural Event March 19, 2008

Karen Macdonald and Debbie Hatmaker, President of ANCC

North Dakota Community Foundation Address Correction:

In the last edition of the Prairie Rose the address for the North Dakota Community Foundation was inadvertently incorrectly listed. The correct address to make a contribution to the North Dakota Community Foundation is PO Box 387, Bismarck, ND 58502-0387. Thank you to all who have contributed.

ANCC site visit is scheduled for April 17th & 18th. CNE-Net will be visited by two ANCC designated reviewers for re-accreditation as a provider and approver of continuing nursing education activities. Special thanks to Jean Kautzman and Susan Pederson for their tireless work in preparation for this visit.
ANA Advocates for Critical RN Representation on the U.S. Department of Health and Human Services, Secretary’s Advisory Committee on National Health Promotion and Disease Prevention

SILVER SPRING, MD--In advance of a series of regional hearings being convened by the U.S. Department of Health and Human Services (HHS) to discuss the objectives for “Healthy People 2020,” the American Nurses Association (ANA) is calling for representation of the nursing profession and nursing community on the HHS Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. The advisory committee is charged with developing a vision and a plan for improving the nation’s health by the year 2020.

“The Advisory Committee is comprised of several distinguished physicians, academicians, and health administrators. However, the failure to appoint a representative from the single-largest health profession—which is at the forefront of health promotion and disease prevention—represents a failure to recognize both the crucial role that nurses play as well as the need to integrate nurses into any health promotion and disease objectives and plans, and sends the wrong message to the nursing and public health communities,” said Rebecca M. Patton, MSN, RN, CNOR, President, ANA.

ANA urges its members to call upon HHS to name a registered nurse to the Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 through the federal government’s public comment Web site, http://www.healthypeople.gov/hp2020/comments/default.asp.

Comments received through this site by May 1, 2008 will be reported at the June 2008 meeting of the Secretary’s Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020.

The ANA is the only full-service professional organization representing the interests of the nation’s 2.9 million registered nurses through its 54 constituent member nurses associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

Questions Seeking Answers

1) What should the grassroots structure look like? (Should the grassroots structure be a district or region). Currently we have districts within regions. However, most of the activity occurs within 4 major districts in each region. Fargo (South East Region), Grand Forks (North East Region) Minot (North West Region) and Bismarck (South west Region). Should the state be 4 districts rather than regions with all of the nurses living in the current regions belonging to that respective district? If meetings need to occur over distance, how do you see that being accomplished?

2) How should the grassroots structure communicate with the state level? (As proposed with the state structure, each region or district, quadrant of the state would select or elect a board member in the respective areas (Finance, Communication, Programs, Government Relations, Membership, CNE-Net.) Each board member would then have a working committee from these elected (selected) members representing each respective region (district) quadrant.

3) How should the grassroots structure look? Should the grassroots structure be able to develop an individualized structure? For example; maintain a formal structure with elected officers or leadership team. Flexible, with no elections, create a cafe type setting to discuss topics of interest, select a recording secretary (scribe) to take notes if any business is conducted. Virtual format? Grassroots structure would not be spelled out in the NDNA bylaws, only recognized that they exist.

4) Should the current councils (Practice, Education, and Research) continue to exist? Should they be subsumed under the V.P of Programs, where multiple issues can be discussed? During the dialogue it was expressed that none of the activities of the Councils should occur in isolation. Because practice is based on research and education occurs in practice all nurses need to be involved in all there domains.

Your feedback is important, come join our restructuring efforts; join us, and help design your NDNA experience!
UND Nursing Professor Awarded Coveted New Investigator Award

Dr. Cindy Anderson, assistant professor at the University of North Dakota College of Nursing, has been selected to receive the coveted 2008 Harriet H. Werley New Investigator Award from the Midwest Nursing Research Society (MNRS). Dr. Anderson will receive the award at the MNRS annual conference on March 30 in Indianapolis, IN.

This highly prestigious award is given to only one nurse researcher in the nation annually. “The committee was most impressed with your application and program of research and MNRS is proud to count you as one of our own,” Donna L. Algase, president of MNRS said to Anderson. “Dr. Anderson is very deserving of this prestigious honor,” shares Dr. Chandice Covington, dean of nursing at UND. “We are extremely proud of her work and are thrilled that her efforts are being recognized among her peers. We congratulate Dr. Anderson on this wonderful accomplishment and honor.”

The purpose of this award is to recognize the contribution of a new investigator who has conducted nursing research that has the potential to enhance the science and practice of nursing. Dr. Anderson was nominated by Dr. Covington, who was also a recipient of this award in 1996. Among other criteria, awardees must have a research project/program that has high potential for enhancing the science and/or practice of nursing and a publication record reflecting contributions to science and/or practice.

Dr. Anderson’s program of research involves the study of vascular dysfunction and hypertension in pregnancy and uses an animal model of reduced utero-placental perfusion (RuPP) as a model of human preeclampsia (hypertension). She is interested in the changes that preeclampsia causes in the developing fetus, leading to an increased risk for hypertension later in life. Harriet H. Werley is recognized as the first nurse researcher in the nation annually. The full expression of the Forces exemplifies a professional environment guided by a strong visionary nursing leader who advocates and supports development and excellence in nursing practice.

According to the ANCC website as of March 2008, there are 287 Magnet recognized health care organizations in 45 states, as well as one in Australia and New Zealand. Medcenter One joins these esteemed organizations as well as St. Alexius Medical Center, designated Magnet in 2006, as an organization that has achieved nursing excellence.

Medcenter One, in Bismarck, ND was recently recognized as a Magnet Organization by the American Nurses Credentialing Center (ANCC). The Magnet Recognition Program® recognizes healthcare organizations around the world that provide nursing excellence. The Magnet Recognition Program® was developed by the American Nurses Credentialing Center (ANCC) to recognize health care organizations that provide nursing excellence. The program also provides a method for disseminating successful nursing practices and strategies. Recognizing quality patient care, nursing excellence, and innovations in professional nursing practice, the Magnet Recognition Program provides consumers with the ultimate benchmark to measure the quality of care that they can expect to receive.

Before being elected an ACHE Governor, Knodel was the ACHE Regent for North Dakota from 1999 to 2003, and served as chapter president of the North Dakota Healthcare Executives Forum. In addition to her service to ACHE, she has been a member of the boards of the American Organization of Nurses Executives; American College of Healthcare Executives (ACHE), an international professional society of more than 30,000 healthcare executives. Knodel took office March 8, 2008 at the Council of Regents Meeting during ACHE’s 51st Congress on Healthcare Leadership in Chicago. She will serve a three-year term representing ACHE affiliates on ACHE’s Board of Governors, the authority that oversees ACHE operations and member services.

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Recognizing quality patient care, nursing excellence, and innovations in professional nursing practice, the Magnet Recognition Program provides consumers with the ultimate benchmark to measure the quality of care that they can expect to receive. The Magnet designation process includes the evaluation of qualitative factors in nursing. These factors, referred to as “Forces of Magnetism” were first identified through research done in 1983 (McClure & Hinshaw, 2002). The full expression of the Forces exemplifies a professional environment guided by a strong visionary nursing leader who advocates and supports development and excellence in nursing practice.

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Linda Sharkey has worked in a variety of acute care settings as a hospital supervisor, nurse manager for nurses of defenseaulinity to the assistant director and director. In 2003 she joined Fauquier Health System and is Vice President of Patient Care Services/Chief Nurse Executive. She currently serves on the boards of the Fauquier Free Clinic, Piedmont Home Care, and the American Organization for Nurse Executives. Ms. Sharkey received Inova Health System's Manager of the Year and Innovation awards in 2002, was a finalist in Nursing Spectrum's “Advancing and Leading the Profession” nursing excellence award in 2007 and received the Planetree Spirit of Caring Award in 2007. She has served in a key position during the planning and implementation of the Planetree model at Fauquier Hospital in Virginia, which is a patient-centered holistic approach to health care. In 2007, Fauquier Hospital became the fifth hospital internationally to become a Designated Planetree Patient-Centered Hospital.

We recently talked with Ms. Sharkey regarding the Planetree model and what nurses can do to implement some of the changes that promote this individualized patient care environment.

**Center:** Can you explain the guiding principles behind the Planetree model?

**Ms. Sharkey:** A guiding force behind the Planetree model is to treat the patient in making their own healthcare decisions by providing them information. Treating our patients with dignity, respect and providing information needed for patients to care for themselves. Forward-thinking institutions whose physical environments, policies and practices reflect a commitment organization-wide to providing healthcare the way the patient wants it delivered can make changes, such as creating nursing stations with lower walls and counters to promote an environment that is void of barriers. Care partners, whether they are family members or friends, are encouraged to help guide the patient through the hospitalization process and advocate for the patient to care for themselves. Integrative therapies are also used, such as pet therapy, massage and yoga. Community assessments determine the services that are offered.

**Center:** What factors influenced your hospital to adopt this model?

**Ms. Sharkey:** It was the right thing to do for our patients, staff and community to meet their individual needs in a healing environment. In addition, it provides a core that was recognized by Joint Commission (in the form of a special quality award for exceeding accreditation standards).

**Center:** What planning was needed to implement the Planetree model?

**Ms. Sharkey:** There was a strategic alignment around this philosophy: staff and team retreats were completed and a steering committee was created with staff included. The plan involved a grass roots approach with the staff. During the planning, there was construction so there was an architectural adaptation of this philosophy. For example, all of our rooms are private, with a day bed for family to stay in the room with the patient. There is also a kitchen located on each unit for patients and families.

**Center:** What has been your hospital’s greatest challenge in the planning and implementation of the Planetree model?

**Ms. Sharkey:** This is a total culture change: the Planetree model is woven into everything that we do; it was instinctive for staff to say they ‘already do it’ regarding incorporating Planetree principles into patient care. The culture change is involved saying how we were going to achieve a holistic model: changing visiting hours, upholding patient rights and being there for the patient. It is a never-ending journey.

**Center:** What is your vision for nursing regarding making changes to promote a healthy work environment?

**Ms. Sharkey:** We need to look at the patient as a person with feelings and look at the whole person. Nurses also need to examine how we take care of each other, what nurses do really matters and nurses need to be recognized. We have a wellness center for staff, and our next step is to create a concierge service that takes care of all of the things nurses do on their days off (groceries, dry cleaning). It's important that we take care of our own staff so that they can take care of our patients, families and community.

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**Center:** What would you tell nurses about what they can do to implement changes that embrace the Planetree philosophy?

**Ms. Sharkey:** The nursing leaders need to ensure the nurses understand how to support their staff as they learn about the model. Some of the actions nursing leaders can take are having their staff educated on how the individualized care model improves patient outcomes. In addition, all departments and staff need to engage in adopting the Planetree philosophy since we all play a part in the patient's care.

**Center:** What has been your hospital's greatest challenge in adopting the Planetree model?

**Ms. Sharkey:** Educating all staff on how they are a part of the Planetree philosophy and embracing it. We are all one big team and we need to make sure we can deliver what we say we will deliver.

**Center:** What is your vision for nursing regarding making changes to promote a healthy work environment?

**Ms. Sharkey:** We need to look at the patient as a person with feelings and look at the whole person. Nurses also need to examine how we take care of each other, what nurses do really matters and needs to be recognized. We have a wellness center for staff, and our next step is to create a concierge service that takes care of all of the things nurses do on their days off (groceries, dry cleaning). It's important that we take care of our own staff so that they can take care of our patients, families and community.
Dr. Audrey Nelson and Cracking the Code of Patient Falls

by Diane E. Scott, RN, MSN

Reprinted with permission from the Center for American Nurses

The Center for American Nurses is exceptionally proud to have Dr. Audrey Nelson, a nationally known expert and researcher in the field of patient and caregiver safety, as part of the LEAD Summit 2008.

Dr. Nelson has multiple awards, including the first Magnet Prize Award for Innovation in Patient Safety and the John Eisenberg Award for Individual Lifetime Achievement in Quality and Patient Safety. The Eisenberg Award, established by the National Quality Forum (NQF) and The Joint Commission, recognized Dr. Nelson for her tireless efforts in magnifying the scope of practice for patient safety and advocacy for those with disabilities.

With over 30 years of nursing experience, including the roles of staff nurse, nurse administrator, and nurse researcher, Dr. Nelson is currently the Director of the Department of Veterans Affairs (VA) Patient Safety Center of Inquiry, supervising over 63 research staff and a total budget exceeding $15 million.

To find out more about what attendees will learn from her presentation at the LEAD Summit, 2008, we talked with Dr. Nelson about her work.

Center: You have been nationally recognized as a pioneer in patient safety, how did you initially become involved in patient safety research and the patient safety movement?

Beginning in 1980, I started my work focusing on the functional outcomes in persons with a spinal cord injury. During this time, I focused primarily on rehabilitation outcomes and research within this specialty population.

In 1998, Dr. Robert H. Roswell, who then was the Director of VISN 8 (Veterans Integrated Services Network), approached me about research opportunities in patient safety. He convinced me my work in functional outcomes was closely matched to preventing adverse events, and so my research area was redefined to include patient safety.

In 1999, when the Institute of Medicine released its report, To Err Is Human: Building a Safer Health System, patient safety and the reduction of errors made front-line news. Fortunately, I already had a patient safety center and had a head start in developing research to focus on this now very public issue.

Center: Could you provide an overview of your research related to the patient safety movement and patient falls?

Patient safety is a very broad subject and with many different foci. Part of our success was to drill down deep in one area—preventing adverse events associated with mobility/immobility. These are high cost, high volume problems in nursing. One of the adverse events we have focused on is patient falls. Other areas include wandering, pressure ulcers, and safe patient handling.

Center: How will attending this conference help nurses acquire strategies to reduce the risk of falls among patients?

One of my favorite things to do is to take a complex nursing practice problem with thousands of journal articles written about it and to help develop solutions with research based practice. Attendees at this conference will examine past paradigms of looking at patient falls. I hope to change their perspectives of this issue and strategically consider different interventions designed to increase patient safety.

With patient falls, we have over three decades of research, yet we have never ‘cracked the code’ to prevent patient falls. During the conference we will strategically examine whether our focus on preventing falls has actually jeopardized patient safety, by encouraging nurses to chemically or mechanically restrain patients so they would be safe. We inadvertently prevented our patients from being active and mobile, and interfered with quality of life.

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Now, in retrospect, I firmly believe that good quality of care means something needs to happen to make our patients who are at risk more active. If we start to look at how we make our patients more active and mobile, while providing environments that prevent fall-related injuries rather than preventing falls, I think we can finally make significant progress in this area.

For example, imagine a nursing home or a rehab center that looks at the environment, and floor surfaces, which will prevent injuries when a person is becoming more active. If we change our paradigms and increase mobility with the at-risk populations, we may see an increased fall rate, but falls with less significant injuries. This is because of a focus on fall protection and being proactive with increasing the mobility of the patients, which promotes health and quality of life.

Center: During LEAD Summit 2008, you are going to speak to the needs of safe patient handling and the bariatric patient. What do you see as the greatest challenge in the implementation of safe patient movement techniques and strategies in today’s health care settings for the unique needs of the bariatric patient?

Obesity is an incredible rising problem within the United States and is becoming a crisis for healthcare organizations and the nurses who care for these patients. The Center for Disease Control website shows, state by state, the rate of obesity among the United States populations throughout the past years, and how it demonstrates an epidemic.

Nurses have not been equipped to deal with this population in a dignified way. Obese patients are very vulnerable as a result, both emotionally and physically. Even normal nursing activities place nurses and patients at risk because simple nursing interventions are physically challenging.

My talk at LEAD Summit 2008 is going to focus on standardizing nursing practices for the bariatric patient and describing technological innovations. I am thrilled to present at this conference and hope that attendees will gain a greater appreciation of their roles as nurses and leaders in safe patient handling.

Attendees at LEAD Summit 2008 will have the opportunity to hear more about Dr. Audrey Nelson’s groundbreaking work on patient falls and safe patient handling. For more information about LEAD Summit, please visit www.leadsummit2008.org.
Whether you are a new or seasoned healthcare professional knowing when, how, and who to ask for help can prove to be extremely beneficial. By learning how to ask for help and enlisting the support of others, nurses and healthcare providers can reduce unnecessary aggravation. Rather than stress and frustration. Therefore, by reaching out for help and you ask for it, you can often avoid costly mistakes; thereby saving you and your organization money.

Tasks are more enjoyable. With the support of others, tasks will seem less tedious and more enjoyable. This is especially true when you receive help with mundane tasks such as filling out paperwork, sorting, collating, filing, etc.

You save money. When you know you need help and you ask for it, you can often avoid costly mistakes; thereby saving you and your organization money.

You save your sanity. When you need help and don't ask for it, you're likely to experience stress and frustration. Therefore, by reaching out for help and don't ask for it, you're likely to experience stress and frustration. When you need help and don't ask for it, you're likely to experience stress and frustration. When you need help and don't ask for it, you're likely to experience stress and frustration. Therefore, by reaching out for help and don't ask for it, you're likely to experience stress and frustration.

You avoid procrastination. By asking for help, you can spark the enthusiasm needed to get started or continue working towards a specific goal. With help, you're likely to find yourself being more accountable to yourself and others. After all, knowing that you'll need to keep your part of a bargain keeps you on task and on time.

It can be very motivating to know that others, nurses and healthcare providers, are contributing toward a project.

You avoid being viewed as a martyr. If you're a person who always handles everything on your own without ever enlisting the support of others, BEWARE! This may have a negative impact on how you are viewed. Research has shown that co-workers value collaboration and teamwork. Therefore, by asking for help, you will be viewed as less of a solo act and more of a team player.

You empower others. People get a big boost to their self-esteem and self-confidence when they know they are able to help. This is because they are able to use their strengths, talents, knowledge, and abilities to help others. Asking for someone's help can be a big morale boost.

Additionally, when people are not given enough responsibility in an organization, they begin to question their value and whether or not they are needed at all.

You develop future leaders. Imagine if you were never given the opportunity to apply your knowledge, strengths and abilities. Where would you be professionally? The answer: exactly where you started. Typically, people won't progress in their profession unless they are given opportunities to advance. By asking others to take on new challenges and then coach and mentor them to success, you will allow them to develop the knowledge and skills necessary to become the leaders of tomorrow.

DIRECT VS. INDIRECT ASKING

Depending on the situation, there are two ways you can ask for help: directly or indirectly. A direct approach is best when:

1. You know exactly what you want and need.
2. You're short on time.

When using a direct approach use phrases such as:

I need for you to help me with...
I'd like to get your input on...
This would really help me/the team, if you would...
Here's what I need for you to do...
I'd like for you to do the following...
Please show me how to...

INDIRECT ASKING

An indirect approach is best used with individuals who have a solid understanding of what needs to be done. Using an indirect approach gives the person being asked for help the opportunity to give input regarding how they can best contribute. An indirect approach is best when you want to promote collaboration and teamwork.

INDIRECT WAYS TO ASK FOR HELP

When using an indirect approach consider using the following phrases:

How do you think you could help me with...
So what aspect of this would you like to handle?
What ideas do you have with regard to?

What contribution would you like to make...
Based upon your experience, how does this all fit together... and what part of this would you like to take on?

PHRASES TO LOSE WHEN ASKING FOR HELP

If you really want someone's help, it's best to avoid the following phrases (*because this might be what their thinking).

"If it's not too much of an imposition, could you...
"I'm not sure if...
"I'm having trouble with ..., could you...
"I really hate to bother you, but...
"I was just wondering, could you...
Since you're not doing anything right now, could you...
"I don't have time...

Could you just do this for me...

LET OTHERS KNOW WHAT YOUR CONTRIBUTIONS ARE

People often resist helping you if they think that you are passing off your own responsibilities to them. Therefore, you can increase the likelihood that others will cooperate by informing them of how you will be spending your time. For example:

• While I'm turning the patient in room 1210, I need for you to complete passing meds.
• Of course, I need for you to do...
• During the next half hour while I'm in the meeting, I need for you to keep a close watch on Mrs. Lowe. I need for you to watch her vital signs change please come and get me.

ESTABLISH A TIME LINE

No one likes it when he or she is given something to do at the last minute. Therefore, when asking for help, it's best to ask early--giving ample time for the task to be completed.

It's also best to establish a timeline. For example:

• By the end of the week we need to convert all of the patient records to reflect the change in insurance. By the end of today's shift I will need you for a clear list of all of the insurance companies addresses and phone numbers.
• It looks like running low on surgical tape. In the next half hour, I need for you to order 10 packs.

THANKS FOR THE HELP!

There's nothing worse than helping someone and not being acknowledged for it. So, make it a rule to recognize the contributions of others by saying, “Thank you.”

When offering praise, consider using all three of the following steps:

1. Say thank you.
2. Tell them specifically what they did to help you. Here, include the specific behaviors that made a positive difference for you.
3. Tell them how their help impacted you, the team, the organization, etc.

For example:

• Thank you so much for tracking down Dr. Smith earlier. It was really important for Mrs. Jones to learn that her daughter is doing better.
• I really appreciate you passing meds tonight. That allowed me to focus on straightening up the nursing station.

AUTHOR:

Susanne Gaddis, PhD, known as The Communications Doctor, is an acknowledged communications expert, who has been teaching the art of effective and positive communication since 1989. Gaddis’ workshops, seminars, and keynote presentations are packed with tips and techniques that can be immediately applied to help improve morale, decrease staff turn-over, increase productivity and improve interpersonal communication and cooperativeness in a healthcare setting.

Dr. Gaddis has appeared on nationally syndicated radio, TV and video programming and has authored articles appearing in The Journal of Training and Development, The Whole American Nurse, and The Healthcare Career Guide. Her clients include The Virginia Nurses Association, The New Mexico Nurses Association, The Wisconsin Nurses Association, Blue Cross Blue Shield, Bayer Corporation, UNC Hospitals, Rex Hospitals, and East Texas Medical Center.

by Susanne Gaddis, PhD
The Communications Doctor

Increase Your Odds of Getting It

I really appreciate you passing meds tonight. That allowed me to focus on straightening up the nursing station.
The following is a list of CE activities provided by CNE-Net.

Please visit the website for further info
www.ndna.org

<table>
<thead>
<tr>
<th>#</th>
<th>FACILITY</th>
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<td>Sanford School of Medicine</td>
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<td>05-17-10</td>
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<td>ND</td>
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<td>Rock Springs</td>
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<td>08-01-09</td>
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<td>Medcenter One Health Systems</td>
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<td>Rapid City Regional Hospital</td>
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<td>SD</td>
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<tr>
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<td>Bismarck</td>
<td>ND</td>
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<td>SD</td>
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<td>St. John's Hospital</td>
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<td>NE Workforce Training Lake Region College</td>
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### Activity Title

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<tr>
<td>LPN Refresher Course</td>
<td>192</td>
</tr>
<tr>
<td>LPN IV Therapy Course</td>
<td>48</td>
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</table>
The North Dakota Nurses Association is pleased to bring you this continuing education article for nurses. Nurses wishing to earn contact hours for Reducing Exposure Risk in the Operating Room in the April through July, 2008 issue of the Prairie Rose requires the following:

1. Read the complete article. It takes approximately 60 minutes to complete.
2. Complete the post-test found at the end of the article.
3. Non-Members: Please return the entire completed enrollment form, post-test, evaluation, and check or money order for $20 payable to NDNA.
4. NDNA MEMBERS WILL RECEIVE CONTACT HOURS FREE-OF-CHARGE.
5. Please send to: NDNA @ 531 Airport Road, Suite D, Bismarck, ND, 58504 no later than July 31, 2008.

Upon receipt of all required materials and a 70% successful completion of the post-test, you will receive a certificate of completion for 1.0 contact hours from CNE-Net.

CNE-Net, the education division of the North Dakota Nurses Association, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Accreditation as a provider refers to recognition of educational activities only and does not imply ANCC Commission on Accreditation or CNE-Net approval or endorsement of any product.

Reducing Exposure Risk in the Operating Room

Authors
This independent study was developed by Marty Bollin SN & Lisa Murry SN (Wanda Rose PhD, RN, BC Student Advisor/ Faculty) Medcenter One College of Nursing, Bismarck, ND.

Purpose
The purpose of this article is to evaluate and recommend current best practices related to safe handling of sharp instruments in reducing transmission of bloodborne pathogens, specifically HIV, in the operating suite.

Objectives
1) To identify the risk of exposure to bloodborne pathogens from sharps in the OR suite.
2) To identify practices to reduce the risk of exposure to bloodborne pathogens in the OR suite.

Introduction
A danger concerning health care workers today is the risk of exposure to HIV via percutaneous sharps injuries, mucous membranes, or non-intact skin. “The average risk of HIV transmission after percutaneous exposure is estimated to be approximately 0.3%” and “mucous-membrane exposure is estimated to be 0.09%” (CDC, 2004, p.5). The Centers for Disease Control and Prevention (CDC) estimate health care workers experience 385,000 sharps injuries per year, twenty-five per cent of which occur in the operating room. Studies indicate that up to 15% of surgical procedures result in a percutaneous injury (AORN, 2005; Berguer & Heller, 2005). “As the transmission risk increases with the severity of the injury, this finding is relevant both to the bloodborne pathogen transmission risk of the injured health worker and also to the patient’s risk of being inoculated with the blood of the health care worker” (Jagger et al., 1998, p.899). The question posed was: would the use of personal protective equipment, safety instruments, and/or hands-free techniques reduce the exposures to HIV in the operating room? In the following pages, the authors will present evidence-based practices and recommendations to answer this question with an emphatic yes!

Methodology
The information in this paper was synthesized from a literature review and key informant interviews. The literature review consisted of a search in the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database and the Highwire Press database of peer-reviewed scientific journals using keywords such as “operating room,” “prevent,” “protect,” “HIV,” “sharps injuries,” as well as categories such as “occupational exposure prevention and control.” More than five hundred articles were found in the databases searched. Abstracts from approximately seventy-five journal articles were reviewed. From these articles, five studies were chosen for review and rated on the strength of their evidence using the levels identified by Melnyk and Fineout-Overholt (2005) with level I being the strongest level of evidence. See Table 1, Rating System for Hierarchy of Evidence.

(Continued to page 11)
Literature Review

Table 1

<table>
<thead>
<tr>
<th>Level</th>
<th>Evidence from relevant randomized controlled trials or evidence-based clinical practice guidelines based on systematic review of randomized controlled trials.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level II</td>
<td>Evidence generated from at least one well-designed randomized clinical trial.</td>
</tr>
<tr>
<td>Level III</td>
<td>Evidence obtained from well-designed controlled trials without randomization.</td>
</tr>
<tr>
<td>Level IV</td>
<td>Evidence from well-designed case-control and cohort studies.</td>
</tr>
<tr>
<td>Level V</td>
<td>Evidence from systematic reviews of descriptive and qualitative studies.</td>
</tr>
<tr>
<td>Level VI</td>
<td>Evidence from a single descriptive or qualitative study.</td>
</tr>
<tr>
<td>Level VII</td>
<td>Evidence from the opinion of authorities and/or reports of expert committees.</td>
</tr>
</tbody>
</table>

Interviews of key informants were conducted for a local perspective on current practice and compliance with prevention protocols.

Reducing Exposure Risk...

(continued from page 10)

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sharps injuries continue to occur in light of universal precautions. Their review of random control trials indicated that needlestick injuries were decreased six (6) times with the use of blunt-tip suture needles. This study is rated a level I because the evidence is generated from a meta-analysis of randomized control trials.

Local Practice

Interviews were conducted and questions posed about specific practices. Answers confirmed nation wide trends related to the use of double gloving, use of blunt rather than sharp needles, and the consistent use of neutral zones by operating room personnel. Personal preference by some surgeons drove the final set up in some suites. Using any non-approved, non-safety device required the surgeon to document the reason for the device or practice that is considered prohibited. Physician preference and cost were the two most frequently cited reasons for non-consistently following established guidelines.

Sample Cost Analysis

During a surgical procedure, the number of people scrubbing in varies, as does the number of scalpels and suture needles used. For demonstration purposes, a cost comparison was conducted for a figurative procedure that involves four (4) surgical personnel, two (2) disposable scalpels, and six (6) suture needles. The price for one pair of latex surgical gloves is $2.45 (The Medical Supply Company, Inc.), one disposable #22 non-safety scalpel is $1.01 and one disposable #22 safety scalpel is $1.29 (Medical Mail Order), one regular (sharp) half-circle suture needle is $1.13 and one blunt-tip half-circle suture needle is $2.38 (Anchor Products). Doing the math; using safety equipment and double gloving would cost $17.86 more (See Figure 1). If over the course of a year, one of these procedures were performed every day, the surgical budget would bear an additional $6,518.90 burden by using the 2 pairs of gloves per person (4), using two (2) safety scalpels, and using six (6) blunt tipped needles.

Berguer and Heller (2005) reported that up to 15% of surgical procedures result in percutaneous injuries; in the above mentioned scenario there would have been 55 injuries. According to the CDC, prophylactic treatment costs from $500 to $3000 per injury (CDC, 2004). Employee health would need to budget $27,500 to $165,000 for these treatments (See Table 2).

The financial burden for additional equipment cost is far offset by the potential savings in reduced treatment costs to injured workers.

(Continued to page 12)
Table 2. Cost comparison of safety and non-safety equipment for sample cost analysis.

<table>
<thead>
<tr>
<th>Equipment</th>
<th>For 4 Staff</th>
<th>Using 2 scalpels</th>
<th>Using 6 needles</th>
<th>Total cost per case</th>
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</thead>
<tbody>
<tr>
<td>Safety</td>
<td>19.60</td>
<td>2.58</td>
<td>14.28</td>
<td>36.46</td>
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<tr>
<td>Non-Safety</td>
<td>9.80</td>
<td>2.02</td>
<td>6.78</td>
<td>18.60</td>
</tr>
<tr>
<td>(Difference of $17.86/ case)</td>
<td></td>
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<td></td>
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</table>

Blunt-Tip Suture Needles

NIOSH has identified sharp-tip suture needles as not only “the leading source of percutaneous injuries to surgical personnel, ... but also ... a risk to patients from potential exposure to injured staff’s blood” (March 23, 2007, p.2). Referring to Occupational Safety and Health Administration (OSHA) requirements, the NIOSH publication advises:

As an alternative to sharp-tip suture needles, blunt-tip suture needles can be used to suture less-dense tissue such as muscle and fascia. Conventional sharp-tip suture needles may be needed to suture skin, bowel, and blood vessels, although suture-less techniques for these procedures are available for use at the discretion of the surgeon. In addition, use of these devices resulted in minimal clinically apparent adverse effects on patient care... (p.2,3). See Figure 1.

Double Gloving

Accompanying blunt-tip suture needle engineering control interventions are suggestions for double gloving during surgery. According to Berguer and Heller (2005):

Double gloving reduces the risk of exposure to patient blood by as much as 87% when the outer glove is punctured. While the puncture of the outer glove remains common, corresponding punctures of both the inner and outer gloves are rare. Additionally, the volume of blood on a solid (blunt) suture needle is reduced by as much as 95% when passing through two glove layers, thereby reducing the viral load in the event of a contaminated percutaneous injury (p.18-23).

While these barrier items have demonstrated reduced risk of exposure to blood and body fluids, surgeons are hesitant to change their current procedures citing loss of sensitivity and dexterity when double gloving (Berguer & Heller, 2005), and extra gear adding to body heat and making the wearer uncomfortable (Fry, 2005). Studies have shown that there is an adaptation period when switching from single to double gloving, but after that period there is no significant difference in sensitivity or dexterity (Berguer & Heller, 2005).

Hands-Free Neutral Zones

Neutral zones are recommended to avoid direct exchange of sharps, but surgeons express concern about taking their eyes away from the surgical field to find the designated neutral zone. Investigators argue that proper training and adaptation time can quell the fears of the surgeons (Stringer & Haines, 2006).

The neutral or safe zone is a designated area on the sterile field where a sharp can be placed and then picked up by the user. The ideal device for a neutral zone should be large enough to hold sharps, not easily tipped over, and preferably mobile. Only one sharp should be in the neutral zone at a time. Kidney basins tend to be dangerous when used to pass instruments as fingers wind up inside the basin next to the sharp. The person passing the sharp can announce “sharp” when moving the instrument (Sharps Care, 2005, p.2). See Figure 2.

Conclusion

The OSHA (January 1, 2007) and the NIOSH (2007) have issued recommendations for using blunt tipped suture needles, using hands free technique when handling suture needles, using blunt or round-tipped scalpsels, and effectuating a neutral zone to avoid hand-to-hand passing of instruments. With all these recommended preventive measures available, why do we still have so many exposures in the operating room? Distraction and carelessness are cited as causes for percutaneous injury and exposure and must be addressed. Attitudes, behaviors, and willingness to change must be examined in order to educate health care workers about the best practice for reducing their risk of HIV exposure. Holodnick and Barkauskas (2000) state that “…seroconversion

(Continued to page 13)
rates of health care workers remain low, possibly due to a false sense of security” (Holodnick & Barkauskas, p.462).

Changing attitudes and behaviors of healthcare workers is an arduous task in the ongoing challenge of preventing sharps injuries in the operating room. The literature supports the concept of new employee education, initial education upon receiving a new device, continuing education throughout the year, frequent evaluation, and awareness activities to increase compliance with current recommendations.

Many learning modalities can be used to address the importance of following safety recommendations deeply in the minds of healthcare workers. These modalities include, but are not limited to hands-on training with new instruments demonstrated by trained instructors; video instruction followed by discussion; and visual aids posted near scrub sinks, in staff lounges and operating rooms reminding healthcare workers to use appropriate Personal Protective Equipment (PPE), safety instruments and techniques. Review of policies and procedures should occur routinely during staff meetings. The hospital must establish a core group of personnel responsible for acquiring information about new safety recommendations, becoming proficient in the use of the recommended instrument or technique, and disseminating this information. Nurses as patient advocates must insist on the use of safe practices.

Evaluation of these methods can include interviews with healthcare workers, post-training surveys and periodic questionnaires, and random surveillance in the operating room. Healthcare workers should be encouraged to provide feedback for administrative entities to gain insight on training methods that are more effective and to make suggestions for providing a safer work environment.

Fostering the concept of reporting every exposure immediately is imperative. According to OSHA’s Compliance Directive (OSHA, 1998), “The( p.470) which may contribute to under reporting injuries. “Infectious disease exposure underreporting is a major barrier to understanding the risks and factors associated with occupational exposures” (Holodnick & Barkauskas, p.462).

The issue of safety should overcome the reluctance of healthcare workers to try new techniques and safety should prevail over the material cost of safety instruments. No monetary value can be affixed to the health and well being of the healthcare worker or the patient.

**References**


ENROLLMENT FORM POST-TEST EVALUATION FORM

Program Title: Reducing Exposure Risk in the Operating Room
Program Number: P2.42
Date: Please return by July 31, 2008 to NDNA 531 Airport Rd, Suite D, Bismarck, ND 58504

I. ENROLLMENT FORM
Name: _________________________________________________________________
   Last Name First Name Middle Initial
Address: ____________________________ City / State / Zip: ________________________
Telephone: __________________       *Email: ____________________ Fax: ______________
State of Licensure: ___________________ License #: ____________________________
NDNA membership # ______________   *Will email certificate of completion if you provide your email address.

II. POST-TEST  Choose the one correct answer
Reducing Exposure Risk in the Operating Room   P2.42
1. Health care workers experience 385,000 sharps injuries per year.  T  F
2. NIOSH does not encourage the use of blunt-tip suture needles.  T  F
3. When a needle stick injury occurs, the patient is not exposed to blood borne pathogen transmission.  T  F
4. Up to 15% of surgical procedures result in percutaneous injuries.  T  F
5. Sharp-tip suture needles are the leading source of percutaneous injuries to surgical personnel.  T  F
6. Double gloving reduces the risk of exposure to blood borne pathogens by as much as 87%.  T  F
7. The volume of blood on a blunt suture needle is reduced by as much as 95% when passing through a second glove.  T  F
8. A neutral zone is a designated area in the sterile field where no sharps are ever placed.  T  F
9. Infectious disease exposure underreporting is a barrier to understanding the risks from needle stick injuries.  T  F
10. The issue of safety should overcome the reluctance of healthcare workers to try new techniques and safety should prevail over the material cost of safety instruments.  T  F
11. Nursing practices based on studies from random control trials have strong evidence of their efficacy.  T  F
12. Healthcare personnel are responsible for safe practices related to patient care and must determine implementation of these practices based on individual preferences and cost.  T  F

III. EVALUATION
Use the following rating scale for the questions below:
4=Excellent 3=Average 2=Fair 1=Poor N=Not Applicable

TO WHAT EXTENT HAVE YOU ACHIEVED EACH OBJECTIVE?
1. A. To identify the risk of exposure to bloodborne pathogens from sharps in the OR suite.  4 3 2 1 N
   B. To identify practices to reduce the risk of exposure to bloodborne pathogens in the OR suite.  4 3 2 1 N
2. To what extent did the objectives relate to the overall purpose/goal of the activity? The purpose of this article is to evaluate and recommend current best practices related to safe handling of sharp instruments in reducing transmission of blood borne pathogens, specifically HIV, in the operating suite.  4 3 2 1 N
3. To what extent were the teaching/learning resources appropriate and used effectively?  4 3 2 1 N
4. How would you rate your knowledge of this content before reading this article?  4 3 2 1 N
5. How would you rate your knowledge of this content after reading this article?  4 3 2 1 N
6. How long did it take you to complete this activity? _______ Minutes
7. Please print your name as you would like it to appear on your certificate of successful completion:_____________________________________________________________________________________

8. COMMENTS FOR IMPROVEMENTS OR FUTURE CONTINUING EDUCATION: