

The Alaska Nurse AaNA

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From our President



Just a few short months ago, hope beamed brightly on the horizon. Vaccines had arrived, and a return to pre-pandemic life seemed just around the corner. Sons hugged mothers not visited for over a year, belated wedding bells rang for newlyweds, and grandparents finally snuggled babies born in the time of COVID. Nurses, doctors, and techs cheered as their final pandemic patients were discharged and dedicated COVID units shut down. The life that we all missed out on was blossoming again this spring.

It's a difficult time to be a nurse right now. Stress, burnout, frustration, and compassion fatigue are at all-time highs, while staffing levels and morale sink to new lows. The virus is surging again, COVID units and testing lines have reopened, and our hospitals are overflowing with patients, many younger and sicker than before.

Many nurses have left the bedside out of fear, exhaustion, or anger at a system that demands their all and gives little in return. Many more are one terrible shift away from walking away from the profession. Those left are stretched thin, caring for more patients than ever, and sounding the alarm that our healthcare system is on the brink of collapse. The

hope that once brimmed within our hearts has been replaced with heaviness.

At a time when nurses are barely holding on, we wanted to create an issue of The Alaska Nurse to help reignite your passion for the nursing profession. We've handpicked some of our favorite articles from throughout the years that showcase what nursing across the Last Frontier has to offer.

While you're reading this issue, take a moment to reconnect with yourself. Why did you choose to become a nurse? Do you remember how you felt when you first started your nursing career? Can you relate to the stories within these pages, and reflect on your own best moments as a nurse? My hope is that these better moments, the reasons for being a nurse, can become a life raft for us to cling onto, together, until hope is on the horizon once again.

Warmest Regards,

Jane Erickson

Jane Erickson, ADN, RN, CCRN
 President, Alaska Nurses Association

In This Issue



- | | |
|---|--|
| 4 A Story of Nurse Sisters | 14 491 Days without a Father |
| 5 "I Do" at the Bedside | 16 A Look Inside a School Nurse's Office |
| 7 Experiences of Itinerant Public Health Nurses | 19 Heart of the Alaska Nurse |
| 10 AFT Roundup | 23 Calendar of Events |
| 12 The Aftermath of Workplace Violence | |

AUTHOR GUIDELINES FOR THE ALASKA NURSE: The Editorial Committee welcomes original articles for publication. Preference is given to nursing and health-related topics in Alaska. Authors are not required to be members of the AaNA. There is no limit on article length. Include names and applicable credentials of all authors. Articles should be Microsoft Word documents. Photos are encouraged and should be high resolution. Please include captions and photo credits at time of submission. All content submitted to The Alaska Nurse becomes property of the Alaska Nurses Association. Submit all content by email to Andrea@aknurse.org.

A BEGINNING AND AN END

A Story of Nurse Sisters

By Andrea Nutty

This article originally appeared in the April 2014 issue of The Alaska Nurse.

At the recognition ceremony for nursing graduates in December 2013 at UAA, sisters Shelley Rogers and Londa Larson stood side by side, posing for photographs and smiling as they celebrated Londa's graduation. In many ways, the scene resembled a day seven years earlier when Shelley stood in cap and gown, celebrating her own graduation from the UAA BSN program in 2006. Both sisters have the type of eyes that sparkle with radiance and compassion but on this day also carried a bittersweet note: as one sister's nursing career began, the other's had come to an unanticipated, premature ending.

Just three short years after becoming a nurse, Shelley was diagnosed with breast cancer in 2009. She underwent a double mastectomy – half prophylactic, half to rid her body of the disease. In 2011, two families became one when Shelley married Jim Rogers. The pair met shortly after Shelley graduated, when both signed up to chaperone a science field trip for their sons at Knik Elementary School. Londa says that when Jim came into Shelley's life, he was "just what she needed."

Meanwhile, Shelley worked on growing a seed she had planted in Londa's mind years ago: the quest for Londa to become a nurse.

It didn't take convincing so much as it did support. Londa had watched Shelley become a nurse a few years earlier, attending school while balancing the trials of work and single motherhood. With three children of her own to raise, Londa began taking prerequisite courses, and formally enrolled in the AAS Nursing program in Fall 2011 at UAA.

Shelley is vivacious, a cheerleader for the people she loves. Shelley is the younger sister, but she's also Londa's biggest supporter. Londa has a calm and soothing presence, and her eyes light up when she talks about the things she loves: her children and granddaughter, her sister, and now, nursing. Shelley helped Londa to refocus whenever she got discouraged during school, reminding Londa of the benefits and long-term goals. "She was a big support, a great encourager," Londa says.

Shelley can see things in people that they themselves cannot. Shelley is honest and has great clarity of mind, a trait that allows her to be able to say, "This is what I see in



"I DO" at the Bedside



This article originally appeared in the October 2013 issue of The Alaska Nurse.

Nurses at Providence Alaska Medical Center recently had the rare privilege to arrange for and participate in a wedding ceremony. In late August, Stephanie Nolte and Jody Thoms exchanged vows and said "I Do" inside a hospital room.

A large crowd of supportive family members, friends, nurses, and hospital staff gathered to witness the bittersweet wedding of Stephanie, a radiant bride in spite of her terminal cancer diagnosis, and Jody, the eager groom. The ceremony was officiated by Reverend Susan M. Halvor, Senior Chaplain at Providence Alaska Medical Center. The ceremony centered around Stephanie, who lay in her hospital bed adorned in a beautiful pink scarf and head piece, her make-up gorgeously applied by sisters and friends.

Following the ceremony, family celebrated with food, sparkling cider, and cupcakes in the atrium. Stephanie had a very exciting

and taxing day but was thrilled to have "tied the knot." Her illness had been prolonged and her energy in short supply, but with a solidified bond with new husband and her family and children's support made official, Stephanie said she can "rest easy."

Stephanie Lynn Nolte-Thoms passed away Saturday, September 1, 2013 following a year-long battle with cancer.

"All of us in Stephanie's family would like to thank all of those at Providence Alaska Medical Center: the nurses, doctors, case managers, chaplains, Hospice and everyone at Horizon House for your considerate and loving care of Stephanie. May God Bless."

The nurses at Providence Alaska Medical Center want to express their sincere thanks and well wishes to the Nolte-Thoms family for allowing us the sincere privilege and honor to participate and share in Stephanie's life, wedding, and care.

CONTINUED ON PAGE 6

you that I love in you,” Londa explained. Shelley’s support and guidance gave Londa strength during school, enabling her to pursue scholarships and graduate completely debt-free.

In 2013, it started with a cough. A lung biopsy revealed the devastating diagnosis: Shelley has a reoccurrence of breast cancer, and it has metastasized to other parts of her body. One single word glares menacingly, a detestable utterance, painfully and mercilessly affecting a woman too young, and so full of life. The word no one wants to hear. Terminal.

At the end of last year, just as Londa was donning a tasseled cap, Shelley was ending her nursing career. She was no longer able to work in Adult Critical Care. The forced move left Shelley’s family without an income, as she also recently inspired someone else to become a nurse – her husband, Jim, who is currently pursuing a BSN at UAA.

Still, Shelley is strong. She’s inspired her sister and her husband to nursing careers. She helped Londa through her education every step of the way, teaching her the stellar critical

thinking skills and analytical abilities needed by nurses. Because of Shelley, Londa is able to reanalyze after any setback she faces. Currently working as a CNA at Alaska Native Medical Center, Londa is set to take the NCLEX in April, and to begin her long-awaited reward of becoming a registered nurse.

Shelley has lots of plans for this year. She’s receiving palliative care and shows no sign of letting cancer rule her life. She recently took a much-deserved vacation to Costa Rica. Londa and Shelley are in talks of celebrating Christmas in Hawaii. In between family moments and infusions and schooling, Shelley continues to help Jim through nursing school and Londa with the transition from graduate to RN. Possessing an indomitable spirit and a giving nurse’s heart, Shelley Rogers continues to touch lives in spectacular, inspirational ways. Although her nursing career has come to a close, Shelley Rogers will always, always be a nurse.

Editor’s Note: Shelley Rogers passed away on December 11, 2017 surrounded by loved ones. She is dearly missed by her colleagues and friends.



Experiences of Itinerant Public Health Nurses in Alaska

by Michelle A. Rountree, BSN, RN, PHN II

This article originally appeared in the February 2016 issue of The Alaska Nurse.

Itinerant nursing, or nursing that involves traveling to different locations/communities, is an essential part of public health in general. Itinerant public health nursing in Alaska however, is a very distinctive experience. This article will discuss the challenges and experiences of public health nurses who travel to some of the most remote areas of Alaska.

According to the Alaska Department of Commerce, Community, and Economic Development, Alaska has 395,000 square miles of remote region stretching from the North Slope to the Alaska Peninsula, with an area large enough to hold Japan, Germany, and Great Britain. The 60,500 residents live in five regional centers including about 150 small communities. Over half the populations of people are indigenous Alaska natives. One of these five regions is the Yukon-Koyukuk.

In 2010 the population of Yukon-Koyukuk was 5,695 individuals and comprised of 147,805 square miles of land, which is roughly the size of Montana. Its population density, at 0.0449 inhabitants per square mile, is the lowest in the United States. Over half of the population is Alaska Native tribes, including the Athabaskan, Tanana, Gwich’in, Koyukon, Inupiaq, and Han.

Imagine a backdrop of towering snowcapped mountains with temperatures at a crisp 30 degrees below zero as the six-passenger Piper drops you and your eight bags safely along the village airstrip. To greet you is a friendly face on a snow machine with an attached freight sled for all of your gear. The air is cold, fresh and stillness surrounds you. This is an average work day for most itinerant nurses working for the Division of Public Health Nursing. The following is a first-hand account of what a ‘day in the life’ looks like for itinerant nurse Melissa Guy, BSN, RN, PHN III.

Melissa started her public health nursing career in Nome, Alaska as an itinerant public health nurse III and now works out of the Fairbanks Public Health Center providing nursing services to six villages of the Yukon-Koyukuk region. Melissa enjoys the excitement of chartering small planes with anywhere from one to six passengers and on multiple occasions has flown as the lone passenger on freight flights. The Public Health Nurse (PHN) will typically carry 8-10 bags with all the clinical supplies, equipment, food, clothing, survival gear and personal items that may be necessary. Although there are some villages that have inns and B&Bs, there are times when the itinerant PHN will sleep at the clinic,

CONTINUED ON PAGE 8

AaNA General Assembly

Saturday, October 9th via Zoom

All members are encouraged to attend!

The General Assembly is our highest governing body. It’s a great opportunity to meet our Board of Directors, review our organizational progress, and help set goals and priorities for 2022.

RSVP at www.aknurse.org

school, or tribal offices if there is no other lodging available.

At times traveling as a PHN in Alaska can present challenges. Traveling by small plane when weather conditions are poor, with extreme frigid temperatures and forceful winds, can be daunting. The flights usually leave early in the morning so the PHN must get to the clinic and pack temperature sensitive vaccines, make sure all equipment is functioning properly, organize supplies and get to the airport on time. There are times when you may be weather-bound, as was what happened in Anaktuvuk when Melissa's flight was on weather hold due to a blizzard. Despite these hardships, Melissa reports that this is very rewarding work due to the relationships that are developed with the people and communities.

Melissa describes the villagers as "very generous people who take care of their public health nurses. It's not unheard of for a person to offer the coat off their back or food if necessary. The people are full of laughter and have a loving nature, especially towards the children. It's not unusual to form lasting relationships with people and communities in which the PHN serves."

The mission of public health nursing is to protect and improve the health of Alaskans through partnering with individuals, communities, and systems while advancing self-reliance, dignity, and cultural integrity. The services provided by public health nurses, in support of our mission, include a variety of health assessments, health promotion, immunizations, school screenings, tuberculosis screening, and disease prevention. In addition, there are program management services in the area of infectious diseases, family planning, well child

exams, individual health, violence and injury, health data assessment, and community health. While most nurses care for one patient at a time, public health nurses care for entire populations. By working with communities as a whole, public health nurses are able to educate people about health issues, improve community health and safety and increase access to care. Some public health nurses such as Joanne Pross, BSN, RN, PHN III, travel significant distances by road to meet with the community and bring health care services into underserved areas.

Joanne started her career as a social worker prior to getting a bachelor's degree in nursing through the University of Alaska Anchorage. Her initial direction was midwifery but after seeing a posting for a public health nurse in Nome, Alaska, she knew this was her calling. Joanne has worked as an itinerant public health nurse for 22 years and brings a wealth of knowledge and experience to the area she serves.

The Matanuska-Susitna Borough consists of 24,607 square miles of land and a population of 88,995. At the northeast corner along the Glenn Highway the Mat-Su borough empties into the expansive Copper River Basin which is comprised of 20,649 square miles. There are 20 small communities in the Copper River



Basin and a population in 2010 of 2,952 individuals. Communities in both Mat-Su Borough and Copper River Basin are on the Alaska road system, though some of the roads are seasonal. The residents are diverse in ethnicity, age, and socioeconomic background.

As the sole PHN for this vast area for the past 20 years, Joanne has watched children grow into adults, families form and communities change and grow. She serves a diverse culture of individuals and communities each one of which has its own unique personality. Joanne's home base of operation is Mat-Su Public Health Center in Wasilla. Here she organizes equipment, completes necessary paperwork and communicates with communities she will soon visit before she is on the road again. Joanne logs thousands of miles a year serving Alaska's communities along the road. She never tires of the breathtaking scenery and long stretches of open road but what she loves the most is the people and communities she has helped to become more self-reliant and healthy.

As state employees, PHNs are members of the Executive Branch of state government. The governor, as chief executive officer of Alaska, directs the executive office of the state. To accomplish the goals the governor sets forth, there are 14 departments. Public Health Nursing is located under the Department of Health and Social Services (DHSS).

Under DHSS, the Division of Public Health is divided into 6 sections, including the Section of Public Health Nursing. Public health nursing is then divided into geographic regions that are overseen by a Regional Nurse Manager. Regional management is further divided into nurse managers that work in health centers. Overall services in Alaska are provided through a network of 2 administrative offices, 4 regional offices, 20 public health centers, and itinerant services to 250 communities across 663,827 square miles.

Deborah Baley, MSN, RN, WHNP-BC, is an advanced nurse practitioner who provides many primary care services in the area of women's health and screening for sexually transmitted diseases. Deb grew up in Alaska and went outside to Texas University to obtain her master's in Nursing. She worked

in Texas for a while, however, Deb wanted to return and serve the people of Alaska. She saw a posting for an Advanced Nurse Practitioner with Kenai Public Health Center and worked the Southcentral region for three years, traveling to Seward, Valdez, and communities on the Kenai Peninsula. She then relocated to Anchorage for easier access to travel and greater involvement with leadership.

Deb travels to public health centers that are located in rural areas. She travels by air and coordinates her visits with center-based nurses. Sometimes Deb is the only healthcare provider patients have seen for a number of years. Consequently, after gathering a general history which includes questions that identify health risk behaviors, family size, environmental situations, social settings and family planning method, it can take up to an hour to establish the most important reason they have come to the clinic.

Deb serves public health centers in rural communities such as the Haines Borough, which includes Skagway, Klukwan, and Mosquito Lake. She also travels to Valdez, Seward, and the communities of the inside passage: Ketchikan, Sitka, and Juneau while covering for the ANP of that area. The key responsibilities of the PHN nurse practitioner include providing family planning, reproductive health, and sexually transmitted disease screening and treatment.

Deb states that she "hit the jackpot" with this job as it is great to travel Alaska and meet different people and serve rural communities. It's very rewarding to see the child you screened when they were five years old, come back as a teen for services, then later as a young adult starting a family and in control of their destiny.

No matter where she travels she is always greeted by the smiling face of the public health center PHN. Together they work towards creating a healthy community, which is what public health nursing is all about: partnering with people and communities to improve health. Public health nurses are respected in Alaska and we guard that trust carefully, recognizing the responsibility we have to Alaskans in protecting and promoting their health.

AFT Nurses and Health Professionals News Roundup

ABOUT AFT

AFT is a union of 1.7 million professionals that champions fairness, democracy, economic opportunity, and high-quality public education, healthcare and public services for our students, our families and our communities. AFT is the national affiliate of the Alaska Nurses Association.

OSHA CAN DO BETTER WHEN IT COMES TO THE ETS FOR COVID

The Occupational Safety and Health Administration released its emergency temporary standard for COVID-19 on June 9, and it's safe to say that many workers who called for these protections are not impressed. As AFT President Randi Weingarten put it following the ETS announcement: "More needs to be done to protect workers." Read more on AFT Voices about the highs and lows of the emergency temporary standard.

Explore the highs and lows: aftvoices.org/osha-can-do-better-when-it-comes-to-the-ets-for-covid-5593ae752c31

'I DON'T WANT TO LEAVE THE BEDSIDE'

"This pandemic came at us like a freight train. Frontline staff have been squeezed beyond our imagination. As nurses, we are exhausted," says critical care nurse Danielle O'Toole. The result: Hospitals are hemorrhaging nurses—not only from her facility, but from the profession—because they don't want to work like this anymore. "Hospitals wish we would suck it up and be more positive, but that sentiment doesn't deal with the reality: The ongoing exodus of nurses is not sustainable," says O'Toole in a recent post on AFT Voices.

Find out more: aftvoices.org/i-dont-want-to-leave-the-bedside-8995cfef223f

EXHAUSTED NURSES DEMAND BETTER STAFFING

Like most states, New Jersey's healthcare system has seen its challenges exacerbated by the pandemic. According to Barbara Rosen, vice president of the AFT-affiliated Health Professionals and Allied Employees, staffing shortages preceded the pandemic, which then sickened nurses and other frontline workers, reducing their numbers even more. "Our members are still struggling with staffing issues," Rosen told NJ Spotlight News. "Even a lot of [bonus] money isn't enough to bring them in. Nurses are so burnt out." For self-care strategies in response

to such moral injury, read this article in AFT Health Care.

Learn strategies to deal with moral injury: www.aft.org/hc/spring2021/hossain_clatty

See their organizing win: www.aft.org/news/vermont-technologists-say-union-yes-prep-their-first-contract

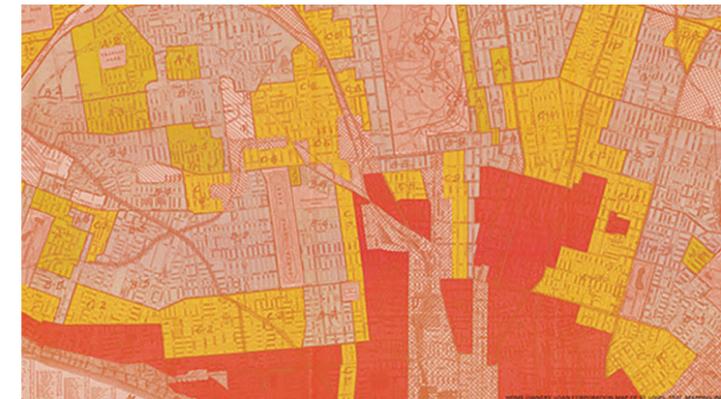
HEALING A POISONED WORLD

Cities are not segregated by accident or because of people's preferences, and the effects of segregation on health and wealth are still with us. In American Educator, read how officials made it difficult for people of color to buy homes—while at the same time making it easy for white people. Even worse, explains AFT Health Care, these officials intentionally placed polluters, such as bus depots and chemical plants, near communities of color, causing everything from asthma to cancer.

Read about environmental racism: www.aft.org/hc/fall2020/washington

VERMONT TECHNOLOGISTS SAY UNION YES, PREP FOR FIRST CONTRACT

Technologists at the University of Vermont Medical Center in Burlington began their quest for representation last year after a cybersecurity attack at the hospital and in response to the COVID-19 pandemic. Even though the workers had tried to organize before, this time was different. Stacey Streeter, a CT scan technologist, says the pandemic was "the straw that broke the camel's back." The health professionals, including sonographers, cardiac technicians, interventional technologists and radiologic technologists, recently voted 123-32 to join the Vermont Federation of Nurses and Health Professionals.





Enduring Trauma

The Aftermath of Workplace Violence

By Stacey Sever, BSN, RN, CCDS AaNA Health and Safety Taskforce Chair

This article originally appeared in the April 2019 issue of The Alaska Nurse.

Once considered safe havens, healthcare facilities today are confronting a steady increase in the rates of violent crimes, including assault, rape and homicide.

“What I experienced happened several years ago, so a lot of the details are blurry at this point,” one Alaskan nurse relates. “What I remember most is being terrified and helpless.”

“It was the middle of my night shift and I honestly don’t remember what led up to the patient’s agitation, but I believe it had to do with pain medication. The patient, who was in a wheelchair, became angry and began yelling, screaming, and cursing at me. I remember trying to verbally de-escalate and acknowledge their feelings, but it wasn’t working.

“The next thing I know, the patient reached down and removed the leg rest from the wheelchair. From across the room, the patient threw the leg rest at me. I remember bringing my leg up and my arm down instinctively to try to protect my stomach, as I was pregnant at the time. Thankfully it missed and I wasn’t injured.

“I quickly left the room and telephoned my charge nurse who told me to call security for assistance. While I was standing in the hallway outside the patient’s room and waiting for security to arrive, the patient rolled their wheelchair to just outside of the door in the hallway.

“Red in the face, the patient continued to scream at me, spit flying out between every hateful and derogatory name they can think up. Finally, security made their way up,

escorted the patient back into the room, and placed them back into the bed. I was shaken up for the rest of the night and I dreaded each time I had to go back into the patient’s room to administer medications or respond to the call light.

“To this day, any time a patient begins to get angry and starts to raise their voice, I instantly become hesitant and a little nervous. I am thankful that my experience didn’t lead to any physical injuries. Other nurses I know haven’t been so lucky.”

Due to growing national attention, workplace violence (WPV) has been identified as a major public health concern (Gates, April 2011). Much has been studied about the risk factors that lead to acts of violence and the culture of complacency that can perpetuate an unsafe work environment. Unfortunately, there are few studies that look at the effects WPV has on the healthcare worker’s emotional wellbeing and how that affects productivity and the quality of care provided.

Nurses and other healthcare workers have long been exposed to WPV, being told either directly or indirectly, that it “is part of the job.” Research has shown that nurses are often expected to return to work after being physically assaulted when there has been no sign of visible injury (Emergency Nurses Association, 2010). Exposure to violence in the workplace can lead to serious consequences that affect the victim, the victim’s employer, and patients.

The cost impact for the employer due to a physical injury sustained during a violent episode may seem obvious with increased workers’ compensation claims, medical

expenditures, lost wages, and potential legal fees. However, with or without physical injury, individuals who experience or witness violence in healthcare institutions are at risk for emotional consequences that can lead to time away from work, burnout, job dissatisfaction, decreased productivity, and leaving the healthcare profession altogether. These and other consequences compromise both worker and patient safety. In a study of Emergency Department (ED) employees, 12 percent of staff met formal diagnostic criteria for posttraumatic stress disorder (PTSD), while 20 percent met symptom criteria of the disorder. It was also noted that the percentage of ED workers with PTSD was proportionately higher than the general population (Laposa, 2003).

As far back as 1980 when the American Psychiatric Association first included PTSD in their Diagnostic and Statistical Manual Mental Disorders (DSM), the continued anxiety workers would feel after being threatened or physically assaulted by a patient or visitor was known and recognized. Victims of workplace violence have reported symptoms of irritability, difficulty thinking, and withdrawal from patients. The emotional distress can manifest itself as hostility, anger, insomnia, nightmares, flashbacks, and feelings of detachment. These symptoms are suspected to have an impact on the nurse’s ability to communicate effectively and provide emotional support for the patient and/or family. After a violent event, some workers have reported being able to maintain their pace of work but have more trouble maintaining cognitive and emotional focus, while others have admitted that they tend to avoid patients who might be or are known to be violent (Gates, April 2011).

Research has found that many nurses and healthcare workers underreport violent incidences assuming that their report will not change the culture as this behavior is expected and tolerated. Other nurses don’t want to report as they feel that it is a sign of their own weakness of being unable to handle the situation. Still others may feel that management and administration don’t want any reports for concern about potential low patient satisfaction scores and other negative publicity.

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The current nursing shortage is projected to worsen over the next few years. Losing valuable healthcare workers due to unsafe work environments and the mental health issues that follow violent episodes should be foremost on the agenda of healthcare administrations. Prevention and management of WPV should be a priority of all healthcare administrations. There are major financial impacts that are triggered by violence against healthcare workers. Additional costs of workplace violence are caused by decreased morale, poor performance, job dissatisfaction, absenteeism, and increased turnover, as well as medical and psychological care, litigation, and increased workers’ compensation.

There are also impacts to patient care quality. Lack of attention to the emotional effects of violence can contribute to PTSD symptoms in nurses and other healthcare staff which puts patient safety at risk. Research has determined that with immediate intervention during the first hours or days following an act of violence can lessen or prevent the more serious and long-term complications of PTSD. Providing a support system of key personnel allows the victim an opportunity to process the event and put in into perspective (Gates, April 2011). The Joint Commission in 2010 published a Sentinel Event Alert regarding workplace violence. One of the suggested actions is to ensure that counseling programs for employees who become victims of workplace crime or violence are in place (Joint Commission, 2010). As the mental health of healthcare workers improves after a traumatic event, so does productivity and quality of patient care.

Violence in the workplace is not merely an occupational hazard. There is a direct correlation that workers who are victims of workplace violence experience stress, anxiety, insomnia, and other symptoms related to PTSD. When a violent incident occurs, measures should be in place to support the victim both physically and mentally immediately after the event and continued support should be available as the victim recovers.



Carlie and her father 1963



Carlie and her father 2013

IT'S PERSONAL

491 Days without a Father, the Devastation of Medical Errors

by Carlie Holmberg, BSN, RN, CPHQ with Lynette Savage, PhD, RN

This article originally appeared in the December 2014 issue of The Alaska Nurse, as the first in a four-part series covering patient safety and medical errors.

A Difficult Story to Tell

On a cold January morning, in a small town in Massachusetts, my father succumbed to the evils of cancer. I lost my mentor, my rock-solid support, and my Daddy. The deep painful ache in my chest is indescribable. The swirling feelings of sadness, anger, and helplessness make it difficult to concentrate. The waves of despair wash over me, making me feel cold and vulnerable. At times the waves drown me making me feel breathless and paralyzed.

An Important Story to Tell

Four years ago, an inattentive pathologist made a horrible assumption about what he saw under the microscope. Later,

he would unapologetically admit his mistake. He had assured my father and my father's physicians that the small kidney tumor was benign. He recommended surgical removal of the tumor. No further treatment was necessary because these tumors never return. At the time, it was glorious news to my father and our family. We could breathe again.

Twelve months after surgery, three new tumors – each larger than the original – were discovered. The original set of pathology slides were sent to Boston for a second opinion. The benign tumor was not benign; it was a treatable cancer. Twelve important months of treatment time had passed. The invisible and veracious cells leftover from the surgery were allowed to uncontrollably proliferate. The miracles of

modern medicine sat on a shelf presumably unneeded for a year. Two years of more surgeries, aggressive chemotherapy, and radiation treatments weakened the once strong man.

An Avid Patient Safety Advocate

Before the cancer, my father had become a huge supporter of patient safety initiatives. He scoured the internet and was an unrelenting patient self-advocate. Ten years ago, through his own research and some pressure on his physician to test him, he had discovered his own hemochromatosis. This easily-treated blood condition, if left unattended has injurious and sometimes fatal results.

My father and I were a dynamic duo. We were like patient safety cheerleaders (minus the cute skirts and pom-poms). Dad could have easily written all of the entries in my blog, Airborne Patient Safety (airbornepatientsafety.wordpress.com). He fed me volumes of information about patient safety that fueled the flames of my patient safety passion. He was an incredible man. He understood the connection between aviation and patient safety. He had signed copies of Atul Gawande's *The Checklist Manifesto*, as well as John Nance's *Why Hospitals Should Fly* and *Charting the Course*.

What Would My Father Want You to Know? What Would My Father Want You to Do?

As a patient, my father would want you to talk about the importance of self-advocacy, researching your own situation, and paying attention to the fact that all healthcare workers are human. Humans are not perfect, they cannot be perfect. He would want you to keep questioning your doctors and healthcare providers until you truly understand. He would want you to tell a healthcare worker to wash their hands before touching you. He would want you to understand your medications. He would want you to teach your loved ones about the dangerous realities in healthcare. He would want you to ask questions and speak-up.

As a healthcare provider, my father would tell you that you are the first line of defense in keeping patients, clients, or residents safe. He would want you to follow the National Patient Safety Goals set forth by The Joint Commission (2014). He would encourage you to read the literature through websites such as the Agency for Healthcare Research and Quality [AHRQ] or the National Patient Safety Foundation (AHRQ, 2014; McTiernan, 2014). He would want you to ask questions and speak-up.

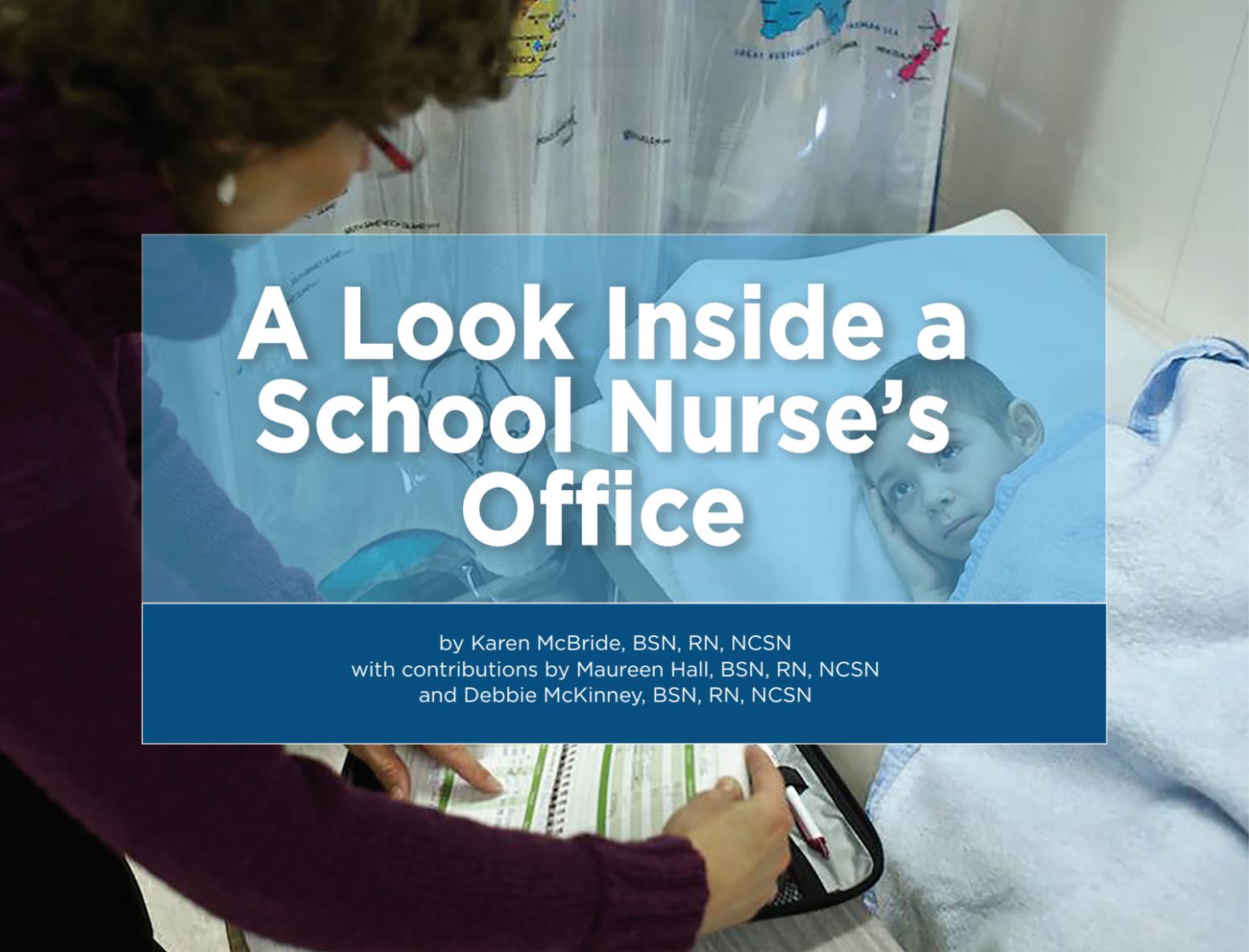
Saying Good-Bye

The last conversation with my father was over the phone. He was very ill and in pain. At the end of the very brief call he said, "I love ya kid, I'm gonna miss you for a long, long, long time." He then quickly passed the phone to my mother. Those words echo in my soul.

It's been 491 days without my father. That is a long, long, long time.

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A Look Inside a School Nurse's Office

by Karen McBride, BSN, RN, NCSN
with contributions by Maureen Hall, BSN, RN, NCSN
and Debbie McKinney, BSN, RN, NCSN

This article originally appeared in the February 2014 issue of The Alaska Nurse.

Working as a school nurse, every day is similar to opening up a box of chocolates; you never know what you might get. At 8:30 a.m., an eight-year-old student from the before-school program is escorted to my office because she is “a little sick.” Just after tucking in this little girl with a blanket she decompensates fast, going from “a little sick” to symptoms of anaphylaxis within 15 minutes. The symptoms start with shortness of breath and I help her use her albuterol inhaler. Her heart rate is 122, and pulse oxygen is at 89 percent. Next, she has generalized hives over her trunk and arms. I give her a dose of school-issued Benadryl, and next she has lethargy, and feels dizzy. She has a known peanut allergy, yet had only eaten saltine crackers. Her mom arrives as

I am preparing to give epinephrine, having concluded that despite no history of peanut ingestion or contact, this could be anaphylaxis: BAM! I inject the epinephrine. In the emergency department, the physician determines this is indeed anaphylaxis and additional emergency medication is given.

The clock reads 9:00 a.m.: time for the “school day” to start. A student arrives with an asthma attack, another student vomiting, and a third student with a 101.4°F fever. Numerous other children, who missed breakfast, have already helped themselves by grabbing a snack from my office on their way to class. Time to exhale; I look up at the clock: 9:30 a.m. What health needs children

will bring the remainder of the day is yet to be seen. The constant triage, assessment, giving of care – be it emergency, urgent, or minor – has begun.

When we aren't busy assessing and giving care to students, there is always work waiting: following up on students who failed their vision and hearing screenings, phone calls to parents and health care providers about care plans for chronic or acute care at school, the completion of two state reports on immunization compliance and tuberculosis testing which are now due. Finding time to complete this work while continuing to meet the healthcare needs of students is challenging.

Here is a look at some specific student problems just this week:

A student has been chronically ill with many absences so far this year and was hospitalized last year for a serious infection. Attended a meeting to discuss creating a 504 accommodation plan with parent and principal. Child is attending half days now. The doctor will be consulting with a specialist.

A student was referred for medical evaluation for swollen eyes. The parent suspected allergy but I thought otherwise. The physician suspects kidney disease. Child was flown out of town to be seen by a specialist and will be on a powerful medication for several weeks. At school we will monitor for medication side effects.

Two viral illnesses causing rash are circulating: Hand, foot, and mouth disease and fifth disease. Ongoing for months, this has resulted in numerous parent phone calls and letters going home.

Met with a school counselor concerned about a student who has been without some basic services at home. Numerous concerns exist for this family struggling not just financially, but also with tragic loss and addiction. Together we brainstorm strategies to help.

Met with teacher and counselor to identify next steps to help a student with a chronic health condition complicated by neglect. Sadly, a report will need to be made to child protective services.

A student with a chronic health condition requires nurse visits several times a day and is now having major behavioral issues causing instability in the health condition. Increased communications with teachers and parents is happening.

A medically fragile student is now increasing time spent in adaptive physical education class. Additional staff must be trained in management of the health condition. The emergency medication is a controlled substance and the state's nurse practice act stipulates that an RN cannot delegate the administration of a controlled substance. However, the child's parent can elect to delegate this, and the school nurse provides the training. Planning for the training is next.

Two students experienced major seizures. One student required administration of emergency medication. The other required stimulation of an implanted magnetic device to stop the seizure. Must review training and documentation with staff.

A student has been diagnosed with MRSA. This needs to be carefully monitored with ongoing communication with the child's two different households to ensure that the doctor's plan of care is being followed. Need to step up infection control measures in the classroom including communication with the janitorial staff.

Ongoing concussion follow-up for a student who was injured in a school sports program. Need to secure the required signatures on the “Return to Play” form to document that he has been medically cleared to resume activity. This information will need to be communicated to coaches and PE teacher.

CONTINUED ON PAGE 18



CONTINUED FROM PAGE 17

Two students with heart conditions need individualized health plans, which will require communication with parents and securing cardiology reports to determine if precautions need to be in place at school.

An overweight student with a history of high blood pressure is now having frequent headaches. His blood pressure will need to be checked. A call will be placed to parents to report findings and encourage medical follow-up.

Over the course of days, months, years, and entire childhoods, numerous healthcare services are provided to school-aged children by school nurses. These services can make the difference between health and illness, attendance and absences, between academic success and failure. We don't work with all of Alaska's children; but for those we serve, the benefits and rewards are forever. This is why we "catch our breath" and awaken each morning ready to serve again.



What makes the Alaska Nurse?

Who is she or who is he? What makes them tick? Drives them to greatness? Melds their Alaskan independent spirit with the practice of nursing?

Over the past several years, I have had the pleasure of interviewing several of our great nursing icons along with ordinary nurses whose names we have never heard. Without exception, they have all expressed pleasure and humility at having been asked to tell their stories along with wonderment as to why anyone would care to hear their story.

In seeking a cross section of Alaska nurses and after having talked with so many, the

answer has become clear. Great Alaska nurses do what needs to be done, seek out innovative ways to accomplish the care of their patients, and give wholly of themselves in the pursuit of wellness, safety, and the restoration of health for those entrusted to their care.

I am humbled that so many trusted me to tell their stories. I am proud to be one of them. Each of us and all of us who work tirelessly - and often without recognition - in this great state are the Heart of the Alaska Nurse.

- Marianne Schlegelmilch

In 1965, Bernie Wilson began her nursing career with the U.S. Army, which took her to the battlefields of Vietnam. Today, after having survived seven cardiac arrests and a multitude of other health issues, she remains actively licensed and currently sits as the longest serving board member on the operating board of South Peninsula Hospital in Homer, Alaska.

In a soft-spoken, matter-of-fact way that belies her strength and unique nursing experience, Bernie's story begins with her enlistment in the U.S. Army her senior year in nursing school. Having entered at the level of Private First Class for a post-graduation commitment of two years of active-duty service and financial assistance with her studies, she became active duty upon graduation and ultimately achieved the rank of captain while serving in Vietnam. Unlike many of her generation,

Bernie went to Vietnam because she wanted to. She describes her time in Vietnam as a great learning experience, but one with so much emotional stress she is not sure she would want to do it again.

Once she had graduated from nursing school and become active duty, she completed advanced medical and procedural training at Fort Sam Houston, Texas, learning to perform tracheotomies, insert chest tubes, and other specialized emergency procedures. After completion of that training, she was stationed at Valley Forge General Hospital near her hometown in Pennsylvania, even extending her service commitment once until finally achieving her goal of receiving orders to go to Vietnam.

Upon arriving in Long Biên, Vietnam, she learned her orders had been changed from her original assignment due to that area being under attack.

CONTINUED ON PAGE 20

Instead of reporting to the 95th evac hospital in Da Nang, she was re-assigned to the 85th evac hospital in Qui Nhon, where she served from approximately Easter to Thanksgiving in 1968. There she worked MICU and ER, 12-hour shifts, 7 days per week in several of the Quonset huts that served as the wards.

When not working, she stayed inside a compound made of sand-filled window box-like walls that stood about four feet tall and formed the perimeter of the sleeping quarters, which were strung with screens and netting at the higher levels. She and others slept in partitioned areas within that space securely within the compound, protected by soldiers who were committed to keeping them safe.

She recalls the helicopters filled with wounded coming in sometimes non-stop—one after another after another. She describes how multiple helicopters would arrive at the same time, landing only long enough for enormous numbers of injured to be pulled off before immediately taking off again to retrieve more wounded. She remembers many such days, where everyone scrambled to unload the helicopters and tend to the crushing influx of wounded as the helicopters just kept coming in.

Bernie describes working while people were dying all around her. The wounded soldiers bore multiple internal and external injuries of combat—the scene almost unimaginable with some of them having missing limbs, others having facial or brain injuries or all possible combinations of wartime trauma—some arriving dead, others near dead, and yet others with some hope for survival.

It was during the Vietnam war that triage protocols changed from treating the severest injuries immediately to treating those with survivable injuries first—a pivotal shift in the previous standards of priority born of dealing with mass casualties from this guerilla type of war that ultimately took the lives of 58,000 soldiers, who mostly ranged in age from 17-20 years.

With a tone of sadness and resignation, Bernie mentions many times the helplessness she and others felt at being unable to take the time to be with the dying because they were so overwhelmed in caring for the mass casualties they had a chance of saving. She describes this as being the hardest part of the work she did in Vietnam, and it is clear in talking with her that she still bears the scars of that inability to be with those who desperately needed the comfort of human compassion during their last moments.

Several times Bernie steers the conversation to the frustrations of trying to treat injuries so horrible there are not adequate words to describe them. She says that at the evac center the nurses received incoming wounded and immediately stripped them of their clothes before starting large bore IV's and hanging Ringer's Lactate. They used a

felt tip marker to put a T on the forehead of every victim who had a tourniquet so that those could be closely monitored, and then did rapid assessment using a color-coding system to identify the worst of each patient's multiple injuries before passing them down to the next Quonset hut unit (lab, x-ray, surgery, etcetera) where surgeons operated on multiple victims in one large room while standing on floors covered in blood and discarded surgical gloves.

She remembers local Vietnamese working around the hospital and the uncertainty of not knowing who a friend was or who was a foe. She says the Vietnamese working among them during the day might be shooting at US soldiers by night.

She talks of treating Republic of Korea Soldiers (ROKs)—tough and combat hardened allies of the US Army. She says they also treated some civilians and some POWs, who were in a separate secure and guarded building.

During rare down times, she and others would go out into the villages to offer aid, traveling in a jeep that had two gunners on the front and two on the back for security. She saw many cases of Malaria and Tetanus among the civilians, personally seeing five cases of Tetanus that were treated with IV muscle relaxants. Because there were no ventilators, some but not all of them died—usually from paralysis of the diaphragm.

Bernie says she feels the greatest medical advances coming out of the Vietnam war were recognition of PTSD and resulting treatment—the catastrophic effects of mass exposure to Agent Orange notwithstanding—as well as management of mass casualty situations.

The stories from the Vietnam war as told by people like Bernie who were there are compelling. After serving valiantly, honorably and under the most horrific conditions imaginable, how hard it is to accept the reality that after surviving the horrors of war, Bernie and so many others were spit on, derided, and subjected to scorn and ridicule as they returned home during that highly unsettled time in our nation's history.

After returning from Vietnam, Bernie worked in a 250-bed hospital in Philadelphia, working double shifts as house supervisor for two weeks at a time in order to have two weeks off in a row. Half of this time was spent working evening shift and half night shift, while she rotated with another nurse as they filled in for each other to accomplish the same goal.

A serious car accident with a lengthy recovery had derailed plans to visit friends in Alaska and when she finally visited them the next summer, she went back home knowing she wanted to come back to stay. She finally arrived in Alaska to work around Christmas of 1970 and went to work in ER on evening shift at Providence, which at the time

was around 325 beds. It was also her job to cover codes during her shifts.

She describes work in ER at that time as challenging because the ER was not staffed with physicians and they had to be called in from home, leaving her to handle things via phone orders until they got there. She was assisted by an LPN whose thick English accent made her difficult to understand—not so much from the language nuances, but from differences in terminology used to describe procedures and supplies. Still, they worked well together, and Bernie held this job for about two years. To this day and after all these years, Bernie and her English former co-worker worker remain good friends and stay in touch.

By this time, Bernie had married and decided one weekend a month with her new husband was not enough, so she went to work for a physician she had met while working at the hospital, who was now opening his own practice after having finished his military commitment.

Bernie worked with him for five years before moving to Florida to seek a healthier climate for her child afflicted with recurrent ear and respiratory infections. In Florida, she worked in a hemodialysis

center for two years before the family returned to Alaska.

By this time, the physician she had previously worked for had moved to Homer and so, delaying her plan to seek work in Anchorage, she drove down to Homer to visit him only to remain there working for him for another five years, until he closed his practice and left to attend anesthesia school.

A parting story in the local newspaper written by his wife, paid heartfelt appreciation to Bernie Wilson, the nurse who had worked with him for a total of ten years.

After her employment with the doctor ended, Bernie found herself unable to adequately care for her child and work the required rotating shifts at the hospital. It was then she left nursing for a while and went to work for what ended up being thirty-two years in the records management department of Homer Electric Association.

After years of repeated recruitment efforts from several local doctors and others, she was appointed to the operating board of South Peninsula Hospital in Homer—a rather unique position for a licensed

CONTINUED ON PAGE 22





Besides her work on the local hospital operating board, Bernie enjoys her hobbies of cooking for large groups of people, photography and spending time with her three grandchildren (ages, 10, 14, and 16), who live only a block from her home and who she enjoys teaching to do the things she loves but can no longer do herself. She talks affectionately about her love of Homer—the beauty, the abundant wildlife, and the friendliness of the people with its accompanying relaxed atmosphere.

Having lived in the small seaside community for close to fifty-two years, she shares proud remembrances of times spent performing other leadership roles in the community over the years, such as chairing the winter carnival, race marshal for the Homer Musers and co-chair of Homer's fourth of July celebration.

From her pioneering work as a combat nurse to her unique role as a sitting member of a hospital operating board, Bernie Wilson has walked the walk in having the true heart and soul of an Alaska Nurse.

Reference

*AHA Health Care Governance Survey Report, Kevin Van Dyke, MPP, John Combes, MD, Maulik Joshi, Dr. P.H. from Percentage of Hospital Boards with RN Members, <https://campaignforaction.org>

About the Author

Marianne Schlegelmilch is one of the last of the once dominant field of Diploma Nurses. She proudly considers nursing as the biggest part of who she is and credits her long career in caring for others as making her the person she is today. "If I could have found a way to survive financially, I would have done it for free," she writes.



She has written for as long as she can remember and often used writing to deal with the stress of critical care work. She is the published author of eleven books, with fiction being her preferred genre. She credits nursing with giving her the ability to understand people and life and uses her deep nursing experience in bringing characters to life in her books. Marianne lives in Homer, Alaska, where she is inspired by the natural beauty that surrounds her and by the array of genuinely interesting people who live there.

The stories written in this publication are as told to the author by the individuals about whom they are written. The author has relied on the individuals written about for the accuracy of their information and each featured individual has reviewed the final version of their story for accuracy.

CONTINUED FROM PAGE 21

nurse according to AHA Center for Healthcare Governance, who cited a figure of only 4-6 percent of hospital boards being comprised of RNs nationwide in the years leading up to 2014 (Van Dyke-Combs-Joshi 2014*).

Today, as the organizational skills, critical thinking and communication abilities of nurses become more recognized, there are many articles citing the benefits of having RNs on hospital operating boards and new goals are being set to increase their presence with each passing year.

As we talk, I am unsure if Bernie has taken the time to realize the uniqueness of her position or the fact that she was a vanguard in nursing both in her position on a hospital board and in her time serving our country in Vietnam. Like most nurses I know, she just stepped up to the plate to do what needed to be done, taking on positions during her career blending both her interests and the necessity of personal circumstances.

With this in mind, Bernie Wilson, in the innate way that many nurses seem to carve the paths of their careers, has brought a lifetime of skill and acumen to her current position as a leader within her community, even as she enters her advanced years. This seems to highlight the often-said adage among nurses: Do nurses ever really retire?

Calendar of Events

AaNA Meetings

AaNA Board of Directors Meeting

4:30-6pm
4th Wednesday each month

AaNA Labor Council Meeting

6-7pm
4th Wednesday each month

Providence Registered Nurses

4-6pm
3rd Thursday each month

RNs United of Central Peninsula Hospital

Contact for times: 907-252-5276

KTN - Ketchikan Registered Nurses (PHKMC)

Contact for times: 907-247-3828

Education and Events

Tuesday Talks

Electroconvulsive Therapy

Presented by Jennifer Hazen, BSN, RN
Tuesday, September 21 @ 6 PM
[Register at www.aknurse.org](https://www.aknurse.org)
FREE CE: Earn 1.25 contact hours

Tuesday Talks Nurse Burnout

Presented by Jessica Estes, DNP, FPMHNP-BC
Tuesday, October 19 @ 6 PM
[Register at www.aknurse.org](https://www.aknurse.org)
FREE CE: Earn 1.25 contact hours

Tuesday Talks Advance Care Planning

Tuesday, November 16 @ 6 PM
[Register at www.aknurse.org](https://www.aknurse.org)
FREE CE: Earn 1.25 contact hours

Alaska Nurses Book Club

Meets every other month
[Register at www.aknurse.org](https://www.aknurse.org)
FREE CE: Earn contact hours

15th Annual Asthma and Allergy Conference

September 10 & 11, 2021
www.aafaalaska.com

State of Reform Health Policy Conference

September 14, 2021
www.stateofreform.com

Alaska Nurse Practitioner Association Conference

Begins September 17, 2021
Virtual
<https://anpa.enpnetwork.com>

All Alaska Pediatric Symposium

September 20 to October 1, 2021
www.a2p2.org

2021 Trending Topics in Nursing Conference

October 7 to 9, 2021
www.aanaconference.org

2021 AaNA General Assembly

October 9, 2021
www.aknurse.org

Alaska Maternal Child Health & Immunization Conference

February 22-24, 2022
www.alaskamchconference.org

National Tribal Public Health Summit

May 10 to 12, 2022
Anchorage
www.nihb.org

Want to list your event in The Alaska Nurse Calendar of Events and at www.aknurse.org?
Send information to andrea@aknurse.org

Remember to visit www.facebook.com/AlaskaNurses for current events and www.aknurse.org/index.cfm/education for frequent updates and information on local nursing continuing education opportunities and conferences.

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