

The Alaska Nurse AaNA

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The Pandemic

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From our President



Well, I don't know how all of you feel about summer being upon us, but I'm ecstatically over the moon that it's finally here! I was super busy this spring starting my vegetables, transplanting, and watering. Green beans and melons transplanted into 4" pots are in the greenhouse along with tomatoes and peppers. A friend gave me sweet pea starts last year and I grew them along the fence line of my garden. They smelled so sweet; I had forgotten how easy they can grow here and their profuse blooming and aroma. It was lovely whenever I had to weed, and I'm looking forward to the same this season.

As soon as the ground warms up and all danger of frost is past, my garden goes in. Cucumbers, radishes, and zucchini will be in the raised beds; broccoli, cauliflower, green beans, peas, lettuce, beets, carrots, and potatoes go into the garden. Nasturtiums and marigolds will be everywhere. I will look forward to hearing from all of you as to what you planted and the results.

Our cover story is about the COVID-19 pandemic and how it has affected our society and the effects it had on us as nurses. It impacted me greatly in the beginning as it did all of us because there wasn't a vaccine to protect us. The great lengths we went through to protect our families, the new way of donning and doffing of PPE out of the room instead of in the room, the constant use and reuse of N95s, and the constant threat of not enough PPE due to supply chain issues. We'd never had to reuse N95s or droplet masks, or gloves for that matter. Then we learned to keep the IV machines outside the

room, making it easier to troubleshoot the alarms and treat the patient. Then we learned to prone in hopes of saving a life. We all knew how, technically how, to prone, but to do it to 8 patients twice a day for weeks at a time, always hopeful it might save a life, but to have only a very small percentage survive, was hard. Incredibly hard. We learned to make sure to support the other patients while their nurse was in a COVID room, we learned to use the Papr hood like pros, we learned to breathe in a N95 for 12.5 hours, we learned to clean like germaphobes, and we learned to live with COVID.

Then the vaccine came and we all lined up. Slowly, ever so slowly, the pandemic has eased. We have very few patients in the hospital with COVID and they are not as sick. My hope is the curve will forever flatten and we can get back to some kind normalcy in taking care of our patients.

If you have a story to share, please send me an email at jane@aknurse.org. I would love to hear from all of you!

As always, get outside and exercise. Eat your fruit and veggies. Plant a garden and plant flowers, and tell me how your garden grows!

Warmest Regards,

Jane Erickson

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

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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.

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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.

AFT CHEERS REFORMS TO PUBLIC SERVICE LOAN FORGIVENESS

AFT President Randi Weingarten applauds the U.S. Department of Education’s reforms to the Public Service Loan Forgiveness program. “The Department of Education is taking real and meaningful steps to help the thousands of borrowers who, through no fault of their own, were for years cruelly denied the relief that they were owed,” says Weingarten. “These changes will allow them to regain their footing and start to heal the broken bipartisan promise of PSLF.”

Explore PSLF: www.aft.org/press-release/aft-cheers-department-educations-reforms-public-service-loan-forgiveness

MINNEAPOLIS TEACHERS AND STAFF WIN BIG

Teachers, school staff and the community stood together against an intransigent administration to demand improvements in Minneapolis public schools. Their three-week strike led to an agreement that limits class size, retains teachers, pays education support professionals a livable wage (\$35,000, up from \$24,000) and provides mental health supports for students. Watch and celebrate.

Watch and celebrate: www.youtube.com/watch?v=75Em0Gw_XME

AFT HELPS FLEEING UKRAINIAN STUDENTS, TEACHERS

AFT President Randi Weingarten visited Poland this week to meet with Ukrainian students and teachers displaced by Russia’s war on Ukraine. Offering solidarity and support, Weingarten visited Polish classrooms that have taken in Ukrainian students. The AFT was invited by the Polish teachers union ZNP as part of the global labor movement’s commitment to help the region’s educators. We raised \$100,000 through our relief fund to give to ZNP, the Ukrainian teachers union VPONU, and other humanitarian and labor groups. These funds, as well as children’s books and educational supplies, were delivered Monday.

Read about their efforts: www.aft.org/press-release/afts-weingarten-visits-poland-ukraine-border-meet-teachers-children

OREGON NURSES SHOW SOLIDARITY TO RAISE HEALTHCARE STANDARDS

Hundreds of frontline nurses who work in Oregon’s Providence health system took part in an informational picket on March 15 outside Providence St. Vincent Medical Center in Portland to



call for better healthcare standards and a fair contract. The nurses, represented by the Oregon Nurses Association, want Providence to improve patient care by addressing staffing and other issues. “Nurses are the foundation of the healthcare profession, and we deserve safer working conditions, affordable healthcare and a contractual commitment to staffing that provides rest periods and takes patient conditions into consideration,” said Jamie Aguilar, an ONA member and home health nurse at Providence.

See what nurses are doing: www.aft.org/news/aft-among-coalition-unions-calling-permanent-covid-protections

LET’S CHANGE THE NARRATIVE AROUND WOMEN’S HEALTHCARE

Andrea Riley, a nurse and AFT Connecticut member, believes that healthcare corporations have an opportunity to change the narrative about women’s healthcare, and she’d like to start in her hometown of Willimantic, Conn., where the only hospital recently closed its maternity ward. In her AFT Voices post, Riley writes about why the loss of the maternity ward will be detrimental to the community. She urges healthcare corporations to consider all options before closing hospital units and putting communities at risk.

Learn about the problem: aftvoices.org/lets-change-the-narrative-around-women-s-healthcare-7c3975618c7e



FOR THE LONG HAUL

MY JOURNEY WITH COVID-19

By Lucy Johnson, RN

My COVID-19 journey has been one of fear, uncertainty, frustration, and impatience. In October 2020, COVID-19 was still relatively new. Physicians were not seeing patients and immunizations were being developed. Most medical offices were closed, and virtual screening was just beginning. There were no diagnostic tools and those that required hospital testing did not happen unless you were hospitalized.

After I tested positive for COVID-19, the following 10 days could be best described as flu-like symptoms combined with a hangover. Despite feeling unwell, I got a lot of cleaning done and was somewhat thankful for the time off work.

The next two months however, produced a journey that I can't even fully recount without the aid of my diary, recordings, and family members.

I lapsed into severe respiratory distress and fatigue. I remember crawling to the bathroom or sleeping on the floor because I didn't have the energy or enough air to make it back to bed. My practitioner was pleading with me to go to the hospital, but I knew the only thing the hospital could offer was intubation. I also knew I didn't need a tube at this point, and I wasn't going to be locked up and isolated. I had the tools I needed at home: inhalers, nebulizers, steroids, fluids, liquid proteins, and of course, my stubborn nursing disposition!

It was often difficult to get anything nutritious into my body. Battling a lack of desire and loss of energy contributed to nutritional and hydration challenges. I was fortunate that my practitioner was supportive and came to visit me. We had virtual screenings routinely once or twice weekly for months.

Six weeks into my illness, gabapentin was added to multiple courses of steroids and medications. The ever-present fatigue seemed to welcome strange body pain that kept me awake at night, exacerbating my exhaustion. By this point, the emotional toll of not being able to care for myself or return to work seemed to welcome depression, anxiety, fear,

and uncertainty. These emotions were inflamed by the paucity of medical knowledge and lack of a disciplined plan of care within the medical community. Practitioners shrugged their shoulders stating, "I don't really know what to do," as medication after medication was suggested or prescribed.

My long-lasting severe symptoms placed me into an unfortunate group of pandemic survivors: those with post-acute sequelae of SARS-CoV-2. Also known as long haulers, long COVID, and post-COVID syndrome, sufferers experience persistent health issues long after the active COVID-19 infection has left their body.

Four months into my illness, respiratory progress was being made and body pain was tolerable, but fatigue could be overwhelming at any moment. I had to learn to not listen to my body. The signals of heaviness, lack of energy, and calculated minimalistic moves could not be trusted. I decided that unless I could validate these signals, I had to ignore the desire to just make it to the next place to sit down and begin to challenge myself to move more.

It was at this point I had an epiphany: no one knows what to do. I realized that in order to escape the vice grips of this illness, I had to make a concerted personal effort. I needed to define health goals and focus on wellness for myself. I needed to start the road to recovery my way, because no one had the answers. Physicians could only offer more meds, research was scattered and without clear medical direction, diagnostics couldn't predict an outcome, and everyone's long hauler's journey was uniquely personal.

I set up a nutritional plan focused on healing and hydration, a sleep time that was strictly adhered to, a daily activity (limited only by respiratory compromise), and a reduction of stress that also maximized happiness. This was the beginning of my recovery from COVID-19. I started walking from my front door to the back door, then the parking lot, then one block, then six. Things seemed to be progressing until the arrival of cardiac challenges: palpitations,

pressure, shortness of breath, and elevated blood pressure. More symptoms! I was so tired of new symptoms; the effects of long COVID seemed limitless.

Multiple visits, diagnostics, and three cardiologists later, I was able to place a hold on the defibrillator that had been ordered for a thickened heart muscle. My cardiac condition improved as my long hauler's recovery progressed, but not before I added more specialists and two additional medications to my repertoire.

Twelve months into my illness, the ever-present "COVID fog" required intervention. I would lose track of a conversation, displayed repetitiveness, experienced expressive aphasia, got lost in familiar places, and forgot important dates, to mention just a few symptoms. The diagnostic neurological outcome demonstrated white matter changes that supported the complaints I had about executive functions and forgetfulness. Fortunately, post-COVID brain fog is more akin to a traumatic brain injury versus dementia diagnosis and offers greater potential for improvement. Loss of taste (ageusia) and smell (anosmia) still plagued me despite months of cognitive stimulation and olfactory training.

Long COVID has been a strange and challenging experience. It was very odd to be in the middle of a pandemic, experiencing the long-lasting effects without the benefit of science, focused research, medication, or an established medical model. I was, and still am, living it real time. I grasped with retrospective awareness, the cyclic nature of body pain, hair loss, flaky nails, rashes, and increased palpitations. This may eventually be diagnosed as fibromyalgia or other autoimmune disorders as an outcome. Only time will tell.

Eighteen months into surviving COVID-19, I accumulated four practitioners and six medications for body pain, fatigue, neurological, and cardiopulmonary support. Ageusia and anosmia remained. I had the desire to complain and to wallow over the loss of my spontaneity and dynamic energy. However, I was quickly reminded of those more impaired or deceased from this unpredictable and virulent virus.

It has been a lonely journey. I was usually the only one aware of my deficits and challenges. It didn't serve much purpose to whine in the middle of a pandemic; everyone had stressors and other issues to which they had to attend. It was frustrating and at times humiliating to face a practitioner that was

disinterested or questioned my symptoms while having no understanding of long-term COVID effects, no interest in learning, and no opinion for interventions. I arrived at specialist medical appointments armed with current research and thoughts about a plan of care that fell upon deaf, uninformed ears. I did not expect answers, but the journey would have been more palatable and less stressful if the physicians were more of a partner than an observer.

My provider, a nurse practitioner, was a godsend, offering unwavering support and a strong desire to understand this thing that was ravaging my body. The differences in medical and nursing models could not have been more evident. Instead of focusing on validating symptoms scientifically from an illness model, my provider launched a plan of care from a holistic, whole body, wellness model. This was the navigation I needed to chart my way out of the COVID-19 abyss.

There have been positive effects that have helped pave my way forward. A sharper focus on the future developed and I prioritized the valuable people, pets, and places in my world. My career, which was once something I'd never leave, was replaced with plans for retirement. Busy days of volunteering, helping others, and general distractions were minimized, replaced by daily walks in the forest and more time for self-care. I learned how to appreciate food for its texture and color and discovered my brain would tell me how it tastes. Smell was another thing... I miss smelling babies, my wet dog, great food, or burying my face in a beautiful flower and slowly inhaling its essence.

My journey continues...

About the Author

Lucy Johnson has spent 45 years in nursing, spanning 10 hospitals, 8 states, and 4 countries. Her career has included military service, risk management, administration, and revenue integrity, as well as roles as a business owner, adjunct professor, expert witness. Lucy has worked in all areas of nursing, with ICU and ER being her specialty. She is currently assigned to telephone triage at Providence Alaska Medical Center, where she has worked for the past 22 years.



LICENSE RENEWAL



2022 Deadline & Requirements

By Tessa Walker Linderman, DNP, RN
Executive Administrator, Alaska Board of Nursing

As the new Executive Administrator for the Alaska Board of Nursing, I wanted to provide an update on requirements and deadlines for the upcoming RN license renewal cycle; but first, I want to thank all of you who are working so tirelessly as we continue to navigate the challenges of COVID-19. I know these last few years have been difficult, so on behalf of the Board of Nursing, I want to extend my deepest gratitude and appreciation for all the hard work you do every day to care for Alaskans.

RN license renewal will open this September with a renewal deadline of November 30, 2022. For renewal, RNs and LPNs must complete two of the following three methods for maintaining continuing competency:

- Completion of 30 contact hours of continuing education since December 1st, 2020.
- Completion of at least 320 hours of employment as a practical nurse or registered nurse since December 1st, 2020.
- Completion of at least 30 hours of participation in uncompensated professional activities since December 1st, 2020. (This is in the process of being decreased from 60 hours.)

For nurses concerned about not being able to obtain 30 professional activity hours for this renewal period, I want to encourage you to attend an online Board of Nursing meeting. We hold our meetings quarterly in February, May, August, and November and your attendance counts towards your professional activity hours. Additional information regarding professional activity hours can be found on the following page.

In lieu of the above requirements, a nurse may meet continuing competency requirements by completing one of the following since December 1st, 2020:

- A nursing refresher course approved by the board; or
- Successful completion of at least six academic credits in courses required for a degree or nursing certificate beyond the education requirements for the nurse's original license; or
- Passage of the NCLEX exam.

There will be no fee increases for the 2022 renewal cycle. It will cost \$200 to renew your license.

For APRNs with controlled substance prescriptive authority and DEA registration, you will need to submit verification that you

have completed two hours of continuing education in pain management, opioid use, and addiction. If the course you took does not have those three topics listed in the name of the course, please submit a course description that identifies all three topics were covered. You may use multiple courses to cover the three required topics.

For the most up-to-date information and to complete your license renewal, please visit nursing.alaska.gov. Please note, you will not be able to renew your license until we open the renewal cycle in September 2022. To receive notification when the renewal period has opened, information on upcoming board meetings, and regulations changes, please subscribe to our email listserv at <https://list.state.ak.us/mailman/listinfo/commerce-nur>.

Please do not hesitate to reach out if you have any questions or concerns regarding your renewal.

About the Author

Tessa Walker Linderman is the Executive Administrator for the Alaska Board of Nursing. Prior to this role she held various positions within Alaska's Department of Health and Social Services, most notable leading Alaska's COVID Vaccine Task Force. A career highlight was being selected for the Nurse Fellow Program at the Centers for Disease Control and Prevention where she assisted on the 2014 Ebola virus outbreak. Tessa is a lifelong Alaskan and received both her BSN and DNP in public health nursing from the University of Washington.

LIST OF APPROVED UNCOMPENSATED PROFESSIONAL ACTIVITIES

Professional Activities means activities, performed without compensation, that use nursing knowledge & contribute to the health of individuals or the community. If you are unsure whether an activity counts toward the requirement, contact the Alaska Board of Nursing. Regulations & complete list of approved professional activities available at nursing.alaska.gov.

A summary by the Alaska Nurses Association

Approved Activities:

- Work with a professional nursing or health-related organization
- Authoring or contributing to an article, book, or publication related to healthcare
- Presenting before a professional or lay group on a nursing subject
- Conducting a research study related to nursing and healthcare
- Volunteering as a nurse (i.e. overseas, as a camp nurse, at a school, at a skills fair or lab, at a needle exchange program or HIV/AIDS clinic, at a health fair, with organizations such as Peace Corps, American Red Cross, or Volunteers of America)
- Helping with activities at assisted living or nursing homes
- Volunteering as a special needs assistant
- Volunteering as a doula
- Providing respite care
- Providing end-of-life comfort care
- Providing comfort to families anywhere in a hospital, hospice center, long-term care facility, or home. These cannot be your own family members.
- Attending Board of Nursing meetings
- Attending professional nursing association meetings
- Volunteering in quality or infection control services with data entry or record-keeping duties
- Giving injections such as flu shots, vaccines, insulin
- Utilizing assessment and treatment plan skills
- Taking vital signs, heights, weights
- Providing first aid
- Reviewing medications
- Providing health information (i.e. diabetes education)

Unaccepted Activities:

- Working with a therapy dog
- Working as a medical assistant
- Working as a receptionist

VOTE NO

ON A CONSTITUTIONAL CONVENTION

By Cathy Giessel, MS, RN, APRN, Fellow-AANP

Imagine 55 Alaskans, from all walks of life, citizens with different political affiliations, meeting together respectfully and productively. That's what happened at the University of Alaska, in College, Alaska, in November 1955. During three months that Interior winter, these territorial citizens completed the writing of our Alaska Constitution.

Their unifying passion was statehood and Alaska's future. When differences of opinion arose, their shared aspirations for an expanding and prosperous state kept them focused on that mission, making debates productive and compromise negotiable.

Could this kind of collaborative work, a mission of love for our state, be accomplished today?

The folks who gathered in 1955 represented all aspects of Alaska's citizenry. They remembered World War II. Many were veterans but, as citizens of a territory, they were unable to vote in US elections. Many were fisherman and miners. There were a handful of women and one Alaska Native person. Only 8 of the delegates had been born here; the rest came from other states and even other countries.

The constitution they created brought together "best practices" for this guiding document, making it brief, broad, and

empowering for self-government. It put the people of the state in charge through a strong representative legislative branch. It gave the executive branch effective authorities to lead.

Could a document this balanced, future-oriented, and democratically focused be produced today, in three months?

While it's not perfect, Alaska's Constitution represents a time-proven solid foundation for our state. It has carried us through turbulent political times and continues to do so.

You will be asked on the November 8, 2022 General Election ballot: Shall there be a constitutional convention? As a part of the Defend Our Constitution Coalition, I believe the resounding answer is no.

A constitutional convention is unnecessary, expensive, and dangerous. The risks clearly outweigh the rewards.

A convention is unnecessary. Alaskans have resoundingly rejected a convention in the past, recognizing that the constitution we have is strong and has served us well over the last 60 years.

A process to make specific, targeted changes to our constitution exists now. Forty times, constitution changes have been proposed. The ideas have been deliberated by the Legislature and put before Alaska voters

Editor's Note: In April 2022, the Alaska Nurses Association adopted a resolution in opposition to the constitutional convention. Find out more at www.aknurse.org.

for their opinion. Twenty-eight times Alaska voters have agreed with those changes by voting yes; twelve times voters said no. This amendment process is tried and true, and exists today.

A constitutional convention is expensive. Estimates place the cost in the range of \$17 million, but that assumes a 75-day convention. Our legislative sessions go well beyond 75 days and could hardly be expected to accomplish a re-writing of a state constitution in that time frame.

A constitutional convention is dangerous. The convention would have no limits and would open a Pandora's box of problems. Special interests and dark money would flock to our state, attempting to reshape our constitution to fit certain interests. Economic instability and uncertainty would prevail during what would likely be very contentious deliberations. There is no guarantee that a final document would even be produced.

Election of delegates would likely be existing legislators or other elected people. The uncertainty and instability created during

contentious deliberations would cripple our economic and business sectors. Citizens would wonder which existing rights will be changed or eliminated, and how their freedom of life choices may be affected.

The principles contained in our current constitution, such as common use of our natural resources, sustained yield management, public domain, access to fisheries, mineral and water rights, and access to navigable waters would all be put in jeopardy.

Protecting our current guiding document preserves the balances of government powers and citizens' rights. A "No" vote preserves our Alaska Constitution and maintains stability for today and future generations.

About the Author

Cathy Giessel is a nurse practitioner and former state senator. A born and raised Alaskan, Cathy served 10 years in the Alaska Senate, passing legislation on healthcare costs and access, foster care support, behavioral health treatment access, children with disabilities, resource development, and Arctic policy. She has been married to her husband Richard for 48 years. Together they have three adult children and seven grandchildren.



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ORGANIZING ON THE FRONTLINES



Improving Patients' Care and Workers' Conditions

By Rebecca Kolins Givan

This article originally appeared in the Spring 2022 issue of AFT Health Care and is reprinted with permission. Illustrations by James Taylor.

The COVID-19 pandemic has shined a light on long-festering problems in our health system. Shanon Pereira had taken every precaution to keep herself and her family safe from COVID-19—but as a nurse at Backus Hospital, where the supply of personal protective equipment (PPE) was so inadequate that she had to reuse an N95 mask that she stored in a paper bag, it felt like it was only a matter of time. “Reusing PPE until it’s broken or visibly soiled is the reason that my family and my coworkers became ill,” she said. “We deserve safety, protection, and respect.”

Instead, Pereira got blame. Backus Hospital insisted that the repeated COVID-19 outbreaks among staff were due to lapses in proper use of PPE. It was only the latest in a series of

cascading issues that compromised staff safety and patient care in the years since Backus was bought by Hartford HealthCare and hospital priorities shifted from patients to profits (or surpluses, as profits are euphemistically known in the nonprofit sector). This outside focus on the bottom line meant that wages were dramatically lower than at neighboring hospitals—14 to 16 percent on average—which made it difficult to hire or retain nurses. The resulting chronic staffing shortages left nurses overworked, exhausted, and struggling to care for their patients. Even with these problems and the additional strain of the pandemic, the employer had been dragging its feet at the bargaining table for months, leaving nurses working without a contract.

In October 2020, the Backus Federation of Nurses (AFT Local 5149) went on strike for 48 hours. Just over a week later, they had a new contract with significant pay increases and better workplace protections, which they expect will help with staff retention and patient safety. “We choose to strike only when it becomes a life-or-death situation for our patients,” Pereira said. “I would rather be at the bedside ... caring for my patients ... but we cannot allow unfair labor practices to continue. We will not back down when it comes to protecting safe patient care.”

Healthcare workers like Shanon Pereira have always been our leading experts on the strengths and weaknesses of our healthcare system. For decades, they have sounded the alarm about their struggle to provide patients with the care they need because of the inappropriate distribution of resources and the perverse incentives built into the entire system.

The COVID-19 pandemic has demonstrated that our healthcare system is not fit for protecting public health. We have seen clearly that the system was not built for pandemics, but a larger and more essential point has also emerged: the system was not built to provide needed healthcare to all of us or to improve the health of our society as a whole. Rather, our fragmented, profit-driven healthcare system allocates care on the basis of the patient’s ability to pay (or the system’s ability to profit) and depends on healthcare workers who consistently endure high levels of stress from striving to provide adequate care in the face of dire need.

Nurses working through the pandemic have experienced unimaginable hardships. They have faced high patient mortality rates and have endured mental and physical exhaustion as they race to respond to all patient needs. They have risked their own health and the health of their family members, and they have worked in hospitals and nursing homes that initially had insufficient supplies of PPE. The mortality of healthcare workers due to the pandemic has been high, with death rates amplifying other societal inequities; for example, the large number of deaths of Filipino nurses demonstrates the cumulative impact of structural disadvantages for immigrant workers of color in a system that perpetuates health inequities.

For nurses and other health professionals who had been drawing attention to insufficient staffing levels for years, the pandemic proved yet again that they were right in focusing on the link between staffing levels and patient care—but being right provides cold comfort. The experience of the pandemic has confirmed that the needs of patients are firmly aligned with the needs of healthcare workers: what’s good for one is good for the other.

For years, the immense challenges to nurses and the crises in morale and job tenure have been categorized by observers as burnout. This description, however, elides the longstanding systemic problems in nursing and in healthcare organizations. Among other issues, the shifts in hospital management policies toward lower staffing levels, higher patient loads, and stagnant wages make it nearly impossible for nurses to provide adequate patient care; ultimately, these shifts may drive as many as 40 percent of nurses away from the profession. And yet, we have known for 20 years that sufficient staffing alleviates this “burnout” while also improving clinical outcomes. Sufficient staffing levels may even have a more significant positive impact on job satisfaction and tenure than pay.

More recent analyses have recast the problem of burnout, which occurs on an individual level, as moral injury, the complex psychological and emotional harm that results from working in a system that makes it so difficult to provide the needed level of care to patients. In unsupportive environments, the strain of the moral injury becomes a self-reinforcing, vicious circle. Nurses feel unable to fully care for their patients, in part due to low staffing levels, and their confidence in their employers and their affinity for their own workplaces diminish. To meet minimum staffing requirements, hospitals are spending more and more on travel nurses (as travel nurse agencies make a profit for every hour their nurses work) and have less money remaining to pay their committed nurses.

As stable, permanent nurses are replaced with travel nurses, the strain on the remaining permanent nurses becomes more severe; they are tasked with training the newcomers to their workplaces, all while knowing that these newcomers are taking home much higher wages. As the work environment deteriorates further

CONTINUED ON PAGE 14

and the wage disparity becomes more extreme, the temptation to take a more lucrative contract or a travel nursing job—or to leave the profession entirely for something less stressful—only increases. In this vicious circle, some immediate patient care challenges may be met, but the long-term, systemic problems that cause harm to nursing staff and affect their ability to provide care remain.

It's no surprise to nurses that hiring and deploying more staff improves patient care and in turn prevents moral injury—or that healthcare workers' firsthand knowledge of systemic problems affecting the day-to-day work of patient care makes them uniquely qualified to devise solutions. But what may surprise many healthcare workers is that they have the power to fight back. How? By organizing. As Patricia Pittman put it in the Spring 2021 issue of *AFT Health Care*, "Nurses, along with other healthcare providers, need to elevate the discussion of moral injury to a system-level conversation about solutions. Until the major sources of moral injury are addressed across many different practice settings, a large segment of the nurse workforce will continue seeking to reduce their work hours and even leaving the profession as soon as they can."

While leaving the profession is understandable in the face of these challenges, growing the union movement in healthcare offers a better path forward—one that allows patients and workers to have the care and conditions they deserve. In the terms of classic industrial relations research, workers can choose voice rather than exit if they stay and organize to improve their workplaces. Collective action has the power to address the sources of moral injury both individually and at the system level.

The Union Advantage for Patients

Healthcare unions have always served a dual purpose, advocating for the ability to provide the care that patients need while also providing crucial protections for employees. Even so-called bread-and-butter issues like pay and benefits are directly linked to patient care: when nurses and other healthcare workers cannot afford to remain in their jobs, or when low pay leads to recruitment challenges and

insufficient staffing, patient care suffers. In contrast, a workplace that provides a supportive environment also enables these workers to provide the care their patients deserve. Unions ensure a safe voice on the job so that workers can speak up when they notice a problem without fear of retaliation. Unionized workers tend to stay in their jobs longer, and lower turnover means more experienced nurses are at the bedside every day caring for patients. So, it should come as no surprise that a growing body of research demonstrates that the presence of a union improves the quality of patient care.

Just as it's possible to rigorously evaluate the impact of medication and other clinical interventions on patient health outcomes, it is possible to look at the link between organizational factors and patient outcomes. We know, for example, that better work-life balance for workers can lead to better outcomes for patients. And we also know a great deal about the empirical effects of unionized workers on clinical care, as directly compared with patient care outcomes in nonunion workplaces.

A foundational study examined the link between the presence of a union for nurses and a patient's likelihood of surviving a heart attack. The authors found that the presence of a union increases wages for nurses, which had a positive impact on patient care. And, after rigorously examining other possible explanations and confounding variables, they concluded that registered nurse unionization reduced heart attack mortality by 5.5 percent.

A more recent study looked at multiple clinical outcomes and compared similar hospitals—those with successful and unsuccessful union organizing drives—to analyze the specific ways nurses can have an impact on patients. It found an improvement in the quality of care following unionization. Accounting for the fact that poor patient outcomes may lead nurses to organize a union in the first place, the researchers concluded that "hospitals with successful union elections in California during the 1990s and early 2000s had been experiencing declines in patient health outcomes relative to the average hospital prior to the election. But following the election, hospitals with union victories

performed better relative to those in which the union lost."

In examining the difference between COVID-19 mortality rates in nursing homes in New York state, another study showed that residents of unionized nursing homes were less likely to die during the pandemic. Facilities with unionized staff saw mortality rates that were 1.29 percentage points lower, which amounted to "a 30 percent relative decrease in the COVID-19 mortality rate compared with facilities without these unions."

Taken together, these studies should assuage any concerns that unionized workers prioritize their own needs and interests at the expense of the needs of their patients. It's clear from this growing body of research that unionizing is good for both healthcare workers and patients.

But even in the face of this clear evidence, many employers pump a huge amount of money into stopping their employees from unionizing and, when there is a union, attempt to negotiate contracts that do not prioritize resources for quality patient care. Strong worker voice threatens management's ability to impose unilateral policy changes that protect the bottom line at the expense of both patients and staff. To fight this profiteering, healthcare workers must band together to achieve systemic changes that prioritize patients.

Organizing for System-Level Change

By protecting individual professionals through the enforcement of contractual rights, unions allow nurses and other healthcare workers to exercise professional judgment and provide patients with the care they need. But individual protections cannot bring about systemic change. Through strategic use of their collective power, unionized healthcare workers can bring about broader changes in their workplaces and can also work to transform or at least improve the larger healthcare system. While it is never easy, collective action is the only path to bringing about these changes in the face of powerful, well-funded opposition. And it is the only true solution: frontline workers—not administrators, lobbyists, or policymakers—have the experience, insights, and expertise to understand where and how these systems must change in order to better serve their patients.

Unionized workers have three main types of collective action in the fight for systemic change: bargaining (and sometimes striking) to achieve strong contracts; enforcing the contract by using the grievance procedure; and advocating and mobilizing to achieve legislative changes that may improve all workplaces, not only unionized workplaces.

Each action has strengths and weaknesses. When used together, each of the three can complement and reinforce each other, offering alternative routes to realizing improvements. For example, a strong contract is powerful—in practice it can provide a policy that is more enforceable than a state or federal law because using a contractual grievance procedure doesn't depend on a public agency that may be under-resourced or penalties that may be too weak to act as a deterrent. But bargaining is also limited in its impact; it means achieving improvements one employer at a time, and healthcare workers and patients in nonunionized hospitals do not receive the benefit of these improvements. By advocating for legislation, nurses can use their expertise, their collective strength, and the power of broader alliances and relationships to bring about improvements that reach every healthcare workplace and every patient.

In general, it is most effective when unionized healthcare workers engage in multiple kinds of collective action, as they are mutually reinforcing and require the same kind of organizing. For example, successful bargaining requires smart, long-term organizing in order to build sufficient power to win the contracts patients and workers need. In many cases, this means a willingness to strike—but a strike does not come out of nowhere. Workers must be well prepared to walk off the job on behalf of their patients and their coworkers. Successful strikes often require years of organizing and groundwork, with workers exercising power at the bargaining table before contemplating a strike. Healthcare workers can test strike readiness by embarking on a series of escalating actions through which fellow union members demonstrate their willingness to take a public stand in service of their goals. These actions might include signing public petitions, posting their views on social media, reaching out to

community members and elected officials, participating in rallies, and/or attending public or open bargaining sessions.

All of these actions enhance the union's bargaining position—and can amplify its advocacy initiatives. They also send strong signals to administrators and legislators: If healthcare workers remain unified as their actions escalate, then they are well organized and prepared for a long fight at the bargaining table, on the streets in a strike, or in the legislature. But if workers do not feel able to participate in smaller-scale collective action, they are unlikely to stay out of work for an uncertain period or to engage in sustained advocacy.

The three paths to improvement—bargaining, enforcing the contract, and advocating and mobilizing—can work as complements. No one path solves all the problems in any healthcare workplace, let alone all workplaces. But the collective strength of unionized workers provides a crucial resource for using all three paths to achieve sustainable, systemic improvements to patient care.

Organizing for Safe Needles: A Case Study

Healthcare workers frequently feel frustrated and demoralized, and they may feel that the obstacles to providing the care their patients deserve are truly insurmountable. But collective action can create the confidence to build power and create positive change. The fight for safe needles is a perfect example.

When Peggy Ferro, a nurse's aide in San Francisco, contracted HIV through a needlestick injury, the nurses she worked with knew that if her employer had been willing to pay for safer retractable needles rather than cheaper conventional needles, she would not have contracted this bloodborne disease. Employers were not spending money on these safer devices because they did not have to do so. Ferro testified before Congress about her situation in 1992. She died of HIV in 1998 at just 49 years old.

Ferro's story—and far too many others' stories of HIV and hepatitis—spurred Lorraine Thiebaud, a nurse and member of the Service Employees International Union (SEIU), to devote a decade to fighting for safer needles. To succeed, she engaged in all three types

of collective action: contract enforcement, bargaining, and advocacy.

Thiebaud began her campaign for safer needles by using the grievance procedure in her contract, along with a workplace campaign consisting of a petition, public posters, and public demonstrations. Working with the other unions in her hospital, she and her colleagues eventually won the right to retractable needles in their San Francisco hospital. After achieving this important change, Thiebaud and others pushed to ensure that the same protections were covered in other union contracts throughout area hospitals and clinics.

While Thiebaud's strategies were successful in her workplace and in others with strong unions, they did not reach the large number of California workers in hospitals that were not unionized, so Thiebaud and others took the campaign to the state legislature. With added attention thanks to investigative journalism by the San Francisco Chronicle and support from healthcare giant Kaiser Permanente, a law mandating safety needles was passed in 1998. (Thankfully, Ferro, who was also engaged in this campaign, lived to see it signed into law.)

California's legislative climate tends to be more favorable to workers than that of many other states, so the next step was to achieve federal legislation that would provide the same protections to healthcare workers nationwide. Thiebaud testified before the US House of Representatives that "SEIU and other health care unions, such as the American Federation of State, County and Municipal Employees, and the American Federation of Teachers, believe that the only truly effective way to prevent needlestick injuries nationwide is to pass a law requiring employers to evaluate and use safer devices." Finally, in 2000, the Needlestick Safety and Prevention Act amended OSHA's Bloodborne Pathogens Standard and provided the same protections to all healthcare workers.

The fight for this important safety standard demonstrates the many levels and strategies of union work. Organized nurses were able to use their grievance procedures and their contract bargaining to mandate safer needles in unionized workplaces. But this success did nothing for healthcare workers who had no collective bargaining agreements. By pushing for stronger legislation, the unionized workers

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THE PANDEMIC

Where We've Been

By Stacey Sever, BSN, RN, CCDS
Staff Nurse Director,
AaNA Board of Directors

Honestly, it seems like the COVID-19 pandemic has been occurring for a lot longer than the 27 months since the World Health Organization (WHO) made their announcement regarding a mysterious Coronavirus-related pneumonia in Wuhan, China on January 9, 2020. The number of changes that have occurred in our society and in US healthcare during these 27 months has been profound.

US airports started screening for the 2019 novel coronavirus (as it was known at the time) on January 20, 2020, at three major airports: JFK International, San Francisco International, and Los Angeles International. These airports were chosen because the flights between Wuhan, China and the United States bring the most passengers through them. The next day, a Washington state resident became the first person in the US with a confirmed case of the 2019 novel coronavirus, having returned from Wuhan, China that month. This person was identified through overnight polymerase chain reaction (PCR) testing.

On January 31, 2020, WHO declared a public health emergency based on the rapid spread of human-to-human transmission of the virus. Two days later, global air travel restrictions began in many countries around the world and the US declared a public health emergency on February 3rd.

WHO made the announcement of declaring COVID-19 a pandemic on March 11, 2020, and the US declared the novel



coronavirus a national emergency, which unlocked billions of dollars in federal funding to fight the disease's spread. This also put into motion many public health mandates that came soon after such as quarantines, mask mandates, remote school and work, and the closing of businesses, all of which had the intent to decrease the transmission of the SARS-CoV-2 virus, but also had long-lasting impacts on the US economy and society that may not be fully understood for years to come.

It almost goes without saying that healthcare staff were caught in the middle. Patients that were diagnosed with COVID-19 were filling up hospitals in "hot spots" across the nation. Personal protective equipment (PPE) was in short supply, treatments were being trialed each day to see what worked and what did not work, and the amount of COVID patients

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compared to the amount of healthcare staff and providers to care for them was disproportionately overwhelming. Staff were being instructed to care for patients using infection prevention measures that appeared to contradict what they had been trained to do in the past, which added to the level of confusion and frustration being felt daily.

In looking back, the speed at which scientists and researchers identified the virus, determined its mode of transmission, and developed treatment modalities and vaccines, was impressive; but at the time, it was completely frustrating as the information was changing daily. The intent of keeping the public informed as new details emerged had unfortunately led to confusion, mis- and dis-information, and fear.

Healthcare workers suffered during this time period for they had incredible demands placed on them while being witness to the ravages of the pandemic: patients dying without family at the bedside, the sheer numbers of ill and dying patients, feeling helpless as treatments during the early part of the pandemic did not change the patient's outcome, and the lack of supplies along with staff shortages compounded the whole situation.

Operation Warp Speed lived up to its name and by the end of 2020, COVID-19 vaccines had been developed, trialed, and with Emergency Use Authorization (EUA) by the FDA, were made available and being administered to the public and healthcare workers. As of March 24, 2022, over 4.5 billion people worldwide are fully vaccinated with the US ranking #3 as 66% of the population is fully vaccinated (Hannah Ritchie, 2022).

The Occupational Health and Safety Administration's (OSHA) concern for the danger that healthcare workers faced with the new variants warranted measures of protection against the spread of COVID-19 and the need for protecting healthcare workers (Administration, 2021). On June 21, 2021, OSHA adopted a Healthcare Emergency Temporary Standard (ETS) protecting workers from COVID-19 in settings where they provide healthcare or healthcare support services (Administration, COVID-19 Healthcare ETS, 2021). Many in the nursing profession felt that this OSHA ETS was long overdue. OSHA issued another ETS on November 5, 2021, to protect unvaccinated employees of large

employers with 100 or more employees from workplace exposure to the coronavirus.

In the meantime, the SARS-CoV-2 virus was changing, and variants were emerging around the world. The Delta variant was as deadly as ever for those that were immunocompromised or unvaccinated and the Omicron variant was showing an amazing amount of rapid transmission. Currently the BA.2 variant of Omicron is accounting for more than 1/3 of cases in the Northeast US.

OSHA announced on December 27, 2021, that the non-record-keeping portions of the ETS for healthcare workers — which includes rules regarding ventilation, physical barriers and other safety-related issues — would no longer be enforced, but rules regarding logs and recordings would remain in effect (Administration, COVID-19 Healthcare ETS, 2021).

On January 13, 2022, the Supreme Court issued two landmark rulings on the federal government's power to mandate COVID-19 vaccinations.

In *National Federation of Independent Business v Department of Labor*, the Court blocked an OSHA ETS requiring vaccination, subject to religious or disability accommodations, or weekly testing and masking in businesses with 100 or more employees.

In *Biden v Missouri*, the Court upheld a Centers for Medicare & Medicaid Services (CMS) regulation mandating health worker vaccinations, subject to the same accommodations.

Based on the Supreme Court's ruling in *National Federation of Independent Business*, OSHA withdrew the vaccination and testing ETS issued on November 5, 2021, intended to protect unvaccinated employees of large employers with 100 or more employees from workplace exposure to coronavirus. That withdrawal was effective January 26, 2022. Although OSHA withdrew this ETS as an enforceable emergency temporary standard, the agency did not withdraw the ETS as a proposed rule. The agency started prioritizing its resources to focus on finalizing a permanent COVID-19 Healthcare Standard (OSHA, 2022).

The Centers for Medicare and Medicaid Services (CMS) vaccination mandate, which the Supreme Court upheld in

Biden v Missouri, requires healthcare facilities to establish a policy ensuring eligible workers are fully vaccinated, with exemptions allowed based on religious beliefs or recognized medical conditions. One of the main criticisms of the vaccine mandate was the concern for losing additional healthcare workers in an already fragile healthcare system. The US Senate passed legislation on March 2, 2022, aimed at halting the federal COVID-19 vaccination mandate for eligible healthcare workers at facilities participating in Medicare and Medicaid programs. While some healthcare workers across the nation have resigned due to the vaccine mandate, the feared mass exodus has not been realized (Gooch, Becker's Hospital Review, 2022). The White House said President Biden would veto the measure if it comes to his desk.

In the most recent action regarding the development of a final COVID-19 standard for healthcare workers, OSHA announced on March 22, 2022, that it has partially reopened the rulemaking record and scheduled an online public hearing. The agency is allowing written comments through April 22, 2022, and will begin the online hearing April 27, 2022 (Gooch, 2022).

OSHA has also reopened the rulemaking record to allow for new data and comments on topics such as alignment with the CDC's infection control recommendations, additional flexibility for employers,

recordkeeping and reporting provisions related to the virus, and employer support for workers who want to be vaccinated against COVID-19.

Twenty-seven months and counting. The COVID-19 pandemic is still not finished with humans at this time. Viruses will continue to plague humans as we continue to share this planet. As healthcare workers, we are invested in maintaining the health of ourselves, our families, our patients, and the communities that we serve. Only time will tell us about the long-lasting impacts this pandemic has had on our world, just as past pandemics such as The Black Death of 1347 and the 1918 influenza pandemic are still teaching us today.

About the Author

Stacey Sever has been a registered nurse for 28 years in a variety of roles including flight nurse, emergency department nurse, nurse educator, and clinical documentation specialist.

Since 2019, Stacey has held multiple positions with AaNA, serving on the Board of Directors and Labor Council, as Health & Safety Officer of her bargaining unit, and as Chair of the AaNA Health and Safety Committee.



were able to ensure that all healthcare workers, no matter where they were employed, also had access to safer needles. Some unionized healthcare employers even supported this legislation. After all, if they were going to pay for more expensive retractable needles, they didn't want their competitors to keep their profits up by cutting safety corners.

While the plight of nurses and other healthcare workers in the pandemic has been extreme and in many places devastating, their predicament is not new—it is an amplification of already difficult circumstances. The good news is that we know a great deal about how we can combat challenges like insufficient staffing and unsafe equipment that create these difficult and sometimes untenable

working conditions. Organizing collectively by bargaining, sometimes striking, enforcing contracts, and advocating together for improved regulations and laws can yield concrete changes that allow nurses and other healthcare workers to provide the care their patients need.

About the Author

Rebecca Kolins Givan is an associate professor of labor studies and employment relations in the School of Management and Labor Relations at Rutgers, the State University of New Jersey, and president of the Rutgers AAUP-AFT. She is the author of The Challenge to Change: Reforming Health Care on the Frontline in the United States and the United Kingdom.

UAA PROFESSOR'S WORK INCLUDED IN REAUTHORIZATION OF VIOLENCE AGAINST WOMEN ACT

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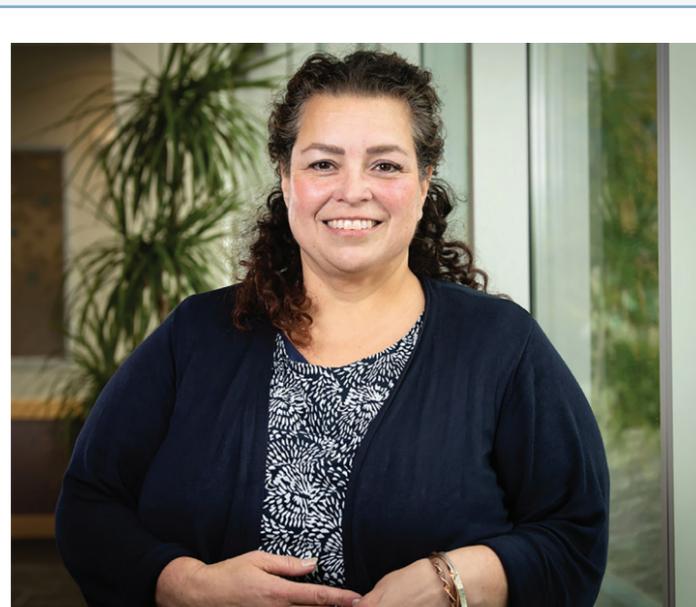
Angelia Trujillo has worked as a forensic nurse examiner, has a doctorate in forensic nursing practice and teaches population health and forensic nursing at UAA. She founded the Alaska Comprehensive Forensic Training Academy. The academy's work was included in the Violence Against Women Reauthorization Act (VAWA) of 2022, which President Biden signed into law on March 17.

When it comes to violence, the statistics in Alaska are startling. Seventy-five percent of Alaskans have experienced or know someone who has experienced domestic violence or sexual assault; an assault in Alaska occurs every hour; Alaska's rate of child mistreatment is 69.3% higher than the national average; the Alaska rate for elder physical abuse is 2.4 times the national rate. Elder psychological abuse is 1.6 times higher than the national rate.

We spoke with Trujillo about her work at UAA and on the national level.

You founded the Alaska Comprehensive Forensic Training Academy (ACFTA). What is the academy, and how did your work at UAA help inform its creation?

ACFTA is a partnership between the UAA College of Health, the Council on Domestic Violence and Sexual Assault, and the Alaska Nurses Association. It's a pilot program that promotes forensic training for nurses and healthcare providers to build capacity for communities to respond to all types of violence.



Research by UAA nursing professor and alumna Angelia Trujillo, B.S. Nursing Science '97, M.S. Nursing Science '04, was included in the Violence Against Women Reauthorization Act (VAWA) of 2022. (Photo by James Evans / University of Alaska Anchorage)

It is very clear to me that violence is a huge issue and we in the healthcare profession are doing a disservice to our patients when we provide dedicated resources to only acute victims of sexual assault and victims of child abuse. There are many others who are victimized by domestic violence, assault, strangulation, sex trafficking and elder abuse.

In my work at UAA, I began doing research around perceptions of providers and interpersonal violence. I wrote about the need for forensic nurses to have a public health and prevention

focus in their practice. The Academy of Forensic Nursing, of which I'm a founding member, gave me support to move towards a focus on generalist care for victims of violence rather than a specific focus on only sexual assault.

I've had the opportunity to lead training around the state to promote forensic healthcare — initially focused on sexual assault, but also domestic violence, strangulation and other issues. In rural communities, I have trained nurses, nurse practitioners, physician assistants and physicians on sexual assault, and they told me they wanted additional, more broad training and providers desired training tailored for them.

In 2018, the Council on Domestic Violence and Sexual Assault asked me to develop a sexual assault nurse examiner training through my work at UAA. It became clear to me that such training wasn't needed — similar training had already been developed. What was needed were more tools for nurses, nurse practitioners, physician assistants and physicians to be able to respond to all victims of violence across the lifespan, using forensic principles to improve the documentation and care for victims. Documentation is important

because of potential investigations by law enforcement and prosecution.

This month, President Biden signed the Violence Against Women Reauthorization Act (VAWA) of 2022. What was included in the reauthorization that originated with your work at the academy?

I worked with Sen. Murkowski's staff (with a big thank you to Anna Dietderich) starting in 2019 to raise awareness of the need for expanded training beyond sexual assault, especially for rural areas. We developed a goal of writing the Ensuring Forensic Health Care for All Victims Act and were able to have the language in that bill added to VAWA.

The Ensuring Forensic Health Care for All Victims Act is based on the work of ACFTA. It's designed to provide grants to institutions of higher education so generalist forensic training can be developed for all levels of healthcare providers to better serve the needs of all victims of violence, regardless of the timing of their injuries. It also has a focus on the documentation needed to support investigations and prosecutions.

This training has the opportunity to benefit rural areas with limited providers that cannot sustain dedicated forensic nurses or SART (Sexual Assault Response Team) programs and urban areas that experience similar issues. I have

heard many times that nurses and providers do not want to be sexual assault examiners but want to provide the best possible care for victims. This training will expand the ability of nurses and providers to recognize violence, care for victims, and document cases using forensic principles.

As someone who works deeply in this space, what makes you hopeful that change is on the horizon?

When people begin to understand the need to move to a general response — that's the first step. We can now talk about needs beyond sexual assault response and provide better multidisciplinary and evidence-based care for all victims.



UAA nursing professor Angelia Trujillo talks with Sara Berkemeier-Bell, policy advisor for Senator Dan Sullivan, about the Alaska Comprehensive Forensic Training Academy (ACFTA) as Berkemeier-Bell tours the Health Sciences Building during a visit to UAA's College of Health. (Photo by James Evans / University of Alaska Anchorage)

NURSES IN THE LEAD



KIM KUCKMAN, RN

Nurses in the Lead is an occasional series introducing you to the elected leaders who govern our association.

AaNA Treasurer Kim Kluckman is guided by two motifs that link the moments of her life, weaving them into the fabric of her story: a genuine love of community and a zest for trying new things. These themes are revealed in our conversations, and it's clear they form the foundation upon which she's built her life.

She grew up in Torrance, California with close family connections, and lived just two blocks away from her grandparents, who watched Kim and her cousins frequently.

At 18, Kim left her hometown for Alaska, following her dad and sister to Anchorage. "I wasn't finding my place in California," she explained as the impetus for her move. She had worked as a lifeguard at a swim school, an escrow officer assistant, and a veterinary technician. Though she didn't enjoy the cat scratches, Kim did enjoy the feeling of helping others.

A conversation with a friend inspired Kim to go into nursing school. She enrolled at UAA and quickly joined as many clubs and activities as possible. She was in search of friends and community, always seeking opportunities and pushing herself to leave her comfort zone. "If I saw a flyer and I had time to go, I went," Kim said with a laugh.

Eventually, Kim got involved in Greek life and helped install a new sorority at the university: the Theta Delta chapter of Alpha Sigma Alpha. She enjoyed serving on the executive board and held a number of positions including technology chair ("pre-Facebook," Kim points out) and recruitment chair. The bonds Kim formed with her sorority sisters are still going strong today.

While she waited for a spot in the nursing program, Kim came across an opportunity to study abroad for nine months in Seville, Spain. The experience helped her come into her own, learning to make good decisions and problem-solve her way out of sticky situations.

Kim became a CNA prior to nursing school and worked at an assisted living facility. There, she bathed residents and helped with feedings in the dining room. She had her first experience with death. Sometimes, she worked two 8-hour shifts in a row.

Following graduation, Kim was ecstatic to become an RN and branch out on her own. She was hired onto an orthopedic unit, working nights. She stayed there for 4 years, until an older colleague she trusted encouraged her to explore other areas in nursing. Kim applied for a fellowship program in the ICU, but didn't get in. The second time, she was accepted.

On the first day of the fellowship, Kim felt sick to her stomach as she entered the critical care unit. The prospect of caring for critically ill patients was intimidating. She threw up in a trash can and rejoined her fellowship group.

It took a long time for Kim to become comfortable working in the ICU, and she says she still doesn't have 100% confidence years later. "There's always something new to learn," Kim shared. It's a challenging, dynamic environment well-suited to her.

For Kim, it all comes down to helping people. She regularly tells patients, "If I can make these next 12 hours better than the 12 hours before, then I've done my job."

Her involvement with AaNA began by attending a union meeting she was invited to

by a coworker. "I didn't understand anything at first, but I just kept showing up," Kim said. "We do so many things. There's a lot to learn about."

Eventually, she decided to join the Board of Directors, first as a director at large, and then as treasurer of the Board and Labor Council. For Kim, working with her union presents an opportunity to work for the greater good. "It's a no-brainer. Of course we're better together than we are apart."

Her advice for nurses who want to learn more about AaNA? Attend a meeting, any meeting. "You're going to feel overwhelmed the first time you dip your toe into the union pool," and that's okay, Kim explains, just keep coming. "Be a voice for your unit. There's so many reasons why our union is important."

When she's not working, Kim enjoys getting pizza and microbrews, walking her dog on the Coastal trail, bee keeping, exploring Anchorage's parks with her two young children, going to Pure Barre classes, and baking breads, noodles, macarons, and much more from scratch.

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

Visit www.aknurse.org for times

KTN - Ketchikan Registered Nurses (PHKMC)

Visit www.aknurse.org for times

Education and Events

Tuesday Talks

Supporting the Immune System

Presented by Sally Coburn, MSN, RD, RN-BC, APRN-BC, CSOWM
Tuesday, June 21 @ 6 PM
[Register at www.aknurse.org](http://www.aknurse.org)
Contact hours available

Tuesday Talks STI Update

Presented by Angelia Trujillo, DNP, MSN, WHNP-BC
Tuesday, July 19 @ 6 PM
[Register at www.aknurse.org](http://www.aknurse.org)
Contact hours available

Tuesday Talks

Roots to Weather the Storm: Reconnecting with our values while the world goes crazy

Presented by Anna Thomas, MSN, RN
Tuesday, August 16 @ 6 PM
[Register at www.aknurse.org](http://www.aknurse.org)
Contact hours available

Pacific Northwest Sepsis Conference

June 6-7, 2022
Seattle, WA
www.sepsisinseattle.com

Alaska Board of Nursing Meeting

August 3-4, 2022
www.nursing.alaska.gov

Wheezin', Sneezin' & Itchin' in Alaska 2022

Asthma & Allergy Foundation of America, Alaska Chapter
September 9-10, 2022
Girdwood, AK
www.aafaalaska.com

All Alaska Pediatric Symposium

September 30-October 1, 2022
Hotel Captain Cook, Anchorage
www.a2p2.org

2022 Trending Topics in Nursing Conference

Alaska Nurses Association
October 6-8, 2022
In Anchorage & Virtual!
www.anaconference.org

2022 AaNA General Assembly

October 8, 2022
www.aknurse.org

Alaska Board of Nursing Meeting

November 2-3, 2022
www.nursing.alaska.gov

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

Remember to visit www.aknurse.org for our current events, updates, and information on local nursing continuing education opportunities and conferences.



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