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AaNA
ALASKA NURSES ASSOCIATION

WORKPLACE VIOLENCE

AaNA

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From our President

As a longtime nurse, I have personally witnessed the rising tide of workplace violence against healthcare workers. Back in the day, when I was a CNA, instances of workplace violence were far less common, and seemed to be perpetrated only by very confused older patients who had no idea what they were doing. Now, as an ICU nurse, I experience a seemingly constant torrent of violence on my unit perpetrated by patients with mental illness, those with substance use disorders, and plenty of patients and visitors who are just plain angry. My personal experiences are confirmation of a sobering fact: Between 2007 and 2017, rates of violence in hospitals grew by 123 percent.

I'm not sure how it came to have evolved that being screamed at, harassed and assaulted at work is seen as "part of the job." Although some conditions may make aggression more likely, there is no excuse to abuse healthcare workers. Workplace violence is NOT part of the job. We should have a safe workplace in which to deliver care to our patients without fear. Unfortunately, healthcare and social service workers are five times more likely to be assaulted at work than the rest of the workforce.

In response to this alarming and unacceptable workplace hazard, the Alaska Nurses Association has based this issue of The Alaska Nurse on workplace violence against healthcare workers. We hope you will read through to learn about workplace violence risk factors, view the results of our workplace violence survey, hear stories of workplace violence from your nursing colleagues across the state, and find out how this horrendous threat is being addressed through state and federal legislation.

I would also like to invite you to get involved in AaNA's efforts to address workplace violence in healthcare settings. Our work is being done through our Health and Safety Taskforce, and we need nurses across the state to take action and participate in order to improve the safety of nurses and healthcare professionals in Alaska. All members of the Alaska Nurses Association are welcome and encouraged to take part in the Taskforce. And if you're not yet a member, you should be! (Yes, I am a little biased.) You can join our professional association and get involved with our workplace violence campaign for just $50 annually. Visit our website at www.aknurse.org or call our office at 907-274-0827 to check your membership status or become a member today.

As always, I'm very interested in you, dear reader! Write me anytime with your thoughts, ideas, and experiences.

Jane Erickson

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

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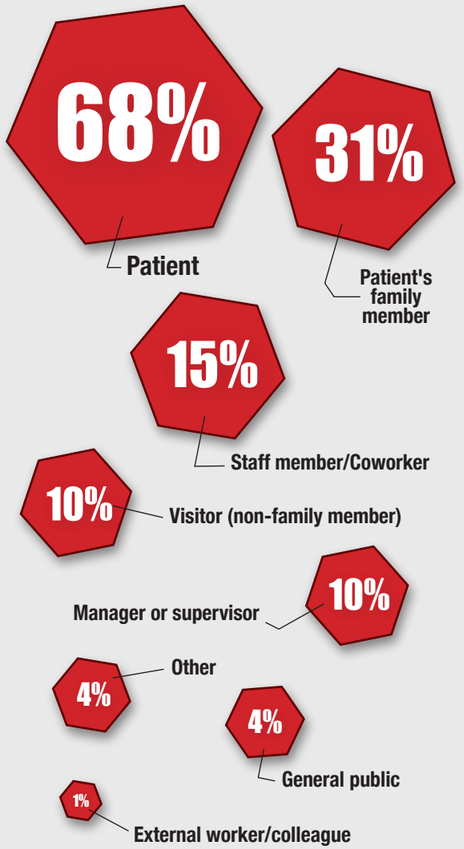
Workplace Violence by the Numbers

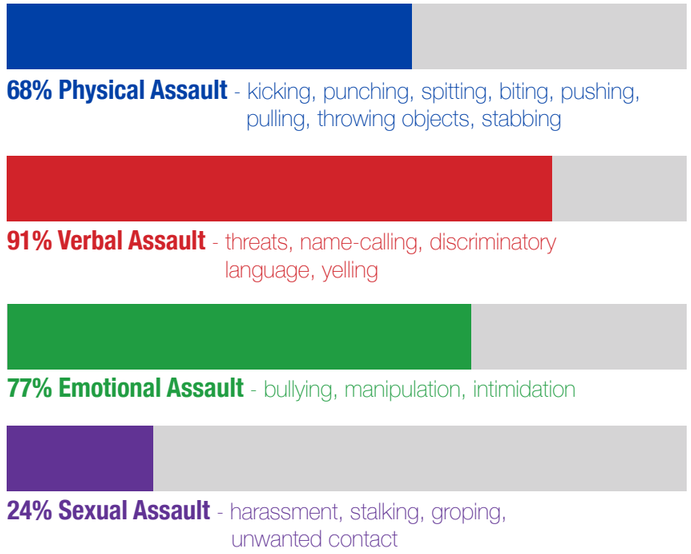
Results from AaNA's Workplace Violence Survey

Workplace violence continues to rise, and healthcare professionals are particularly at risk. We asked nurses across Alaska to tell us about their experiences with workplace violence. Here are the results…

Who is committing acts of workplace violence?



Which types of workplace violence have you experienced while at work?



Only one-third of nurses reported all incidents of workplace violence that they witnessed or experienced within the past year. **27% did not report any of the incidents.**

91% of nurses say they have witnessed or experienced workplace violence

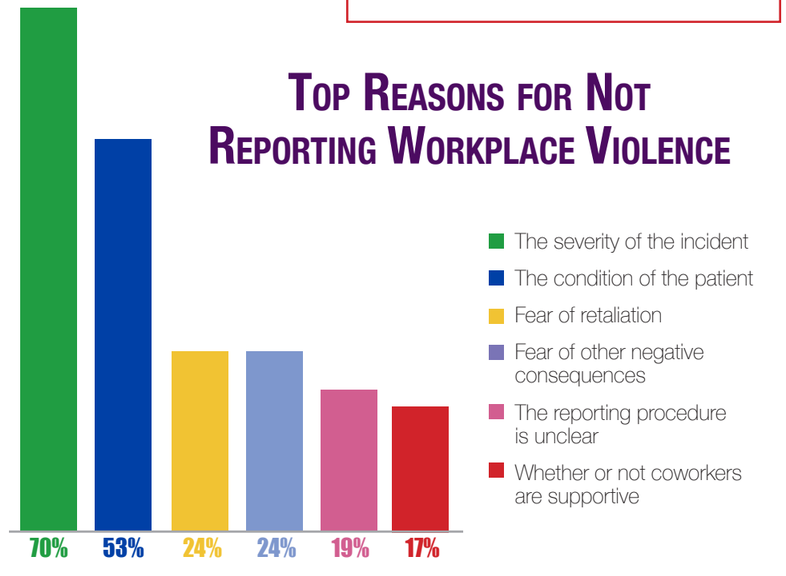
What is workplace violence? Violence finds its expression in physical assault, homicide, verbal abuse, bullying, sexual harassment, and psychological stress. Workplace violence is defined as any assault, threatening behavior, or verbal or emotional abuse that occurs in work-related setting, involving an explicit or implicit challenge to worker's safety, well being or health.

Nearly 2 in 3 nurses are unaware of Alaska's House Bill 312, a new law that relaxed the requirements for assault arrests in healthcare facilities and strengthened penalties against those who assault healthcare workers.

JUST 22% OF nurses report that their workplace offers ongoing training related to workplace violence.

30% of nurses do not know how to report an incident of workplace violence at their workplace.

Top Reasons for Not Reporting Workplace Violence

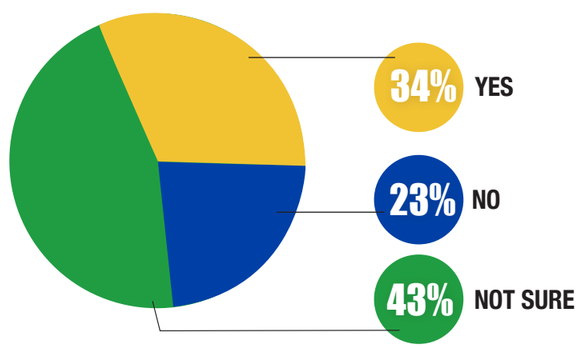


92% OF NURSES ARE WORRIED ABOUT VIOLENCE

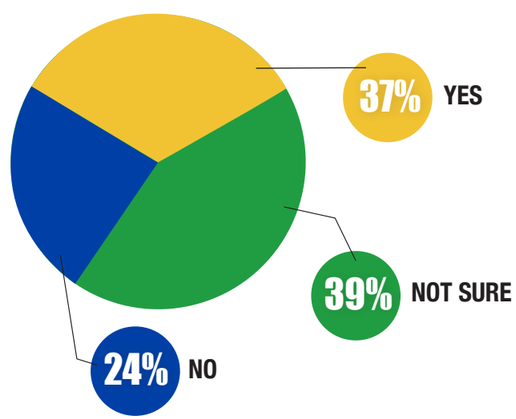
IN THEIR CURRENT WORKPLACE. LESS THAN 1 IN 10 NURSES SAY THEY ARE NOT AT ALL WORRIED ABOUT WORKPLACE VIOLENCE.

1 in 5 nurses have never participated in employer-provided workplace violence training.

Are there clearly established policies, procedures, and expectations for response to workplace violence at your workplace?



Are there clearly established policies, procedures, and expectations for prevention of workplace violence at your workplace?



Changing the Nursing Mindset

By Stacey Sever, BSN, RN, CCDS
AaNA Health & Safety Chair

For those of us that answer the call of nursing, the concept of never coming home after a shift is one thought that does not cross the mind when applying for nursing school. Yet nursing is considered a very dangerous occupation, up to four times more dangerous than other professions (Galant-Roman, 2008).

How has a profession steeped in caring and compassion evolved into such a risky vocation? For decades, research and surveys have been ongoing to understand the factors behind workplace violence (WPV). In 2009, the Emergency Nurses Association (ENA) published a groundbreaking study of approximately 3,500 Emergency Department (ED) RNs outlining their experiences and perceptions of violence in EDs across the United States (Papa & Venella, January 2013). The ENA found that approximately 1 in 4 nurses had experienced physical violence more than 20 times over the previous three years. Nearly 1 in 5 nurses reported that they had experienced verbal abuse over 200 times within that same time frame. The study also found that frequent episodes of either physical violence and/or verbal abuse led to outcomes such as non-reporting due to a perception of violence being "part of the job" and due to fear of retaliation and lack of support from employers (Papa & Venella, January 2013).

Karen Morton, an RN in Soldotna, shares her experience as a victim of workplace violence, "A patient with a mental health condition was brought into the ED in distress. I was hit in the face while security stood by. It resulted in a horrible bruise and I was expected to complete my shift, which I did." Even worse, Karen relates, "I was told by administration that being attacked by a patient 'was just a side effect of the job' and that I 'should just be careful and learn to dodge faster.'"

As nurses, our focus on providing safe and quality care to our patients often puts us at risk for not protecting ourselves (Harris, July 2015). We often are the targets of WPV due to having the most direct contact with patients. Our shifts encompass the 24-hour day, which increases exposure to patients and their families when they are at a breaking point. The night shift and weekends are known to pose the greatest risk. Nursing empathy toward patients and family members expressing anger over situations they cannot control has led to apathy in nurses for their own personal safety.

Workplace culture also influences workplace violence. Growing work pressures and stress related to short staffing result in fewer nurses caring for more, higher acuity patients. In addition, the destabilization of interpersonal relationships with the normalization of bullying within the profession and society (Galant-Roman, 2008) have contributed to the hostile work environment. Additionally,

nurses often do not get the respect that they deserve from other healthcare professionals, particularly from physicians and management due to the perception that nursing is a subservient, inferior profession. Many nurses report having experienced a lack of respect from patients, families and colleagues that leaves them feeling vulnerable, isolated and unsupported (Boafo, January 2018).

Having worked both as a nurse and an EMT, I have noticed that there are some differences in training when it comes to personal safety education. Preparation for both professions offer information on body substance isolation (BSI) and training with protective gear, but only as an EMT was I afforded scene safety education. Any EMS responder who has performed a practical exercise for EMT certification knows that the first two mandatory skills to be completed on the evaluation checklist are (1) ensure the scene is safe before entering, and (2) don protective gear (BSI).

Ensuring the scene is safe is rooted in situational awareness. Being able to capture the clues and cues helps the responder comprehend what is happening (Whitehead, April 2016). When I started in the nursing profession over 30 years ago, the concept of scene safety before walking into a patient's room was unheard of. However, when I filled in on my days off as an EMT on the local ambulance service, approaching the scene of a shooting victim during the night in an area of town known for gang violence would require my partner and me to determine if the scene was safe, and often times meant waiting for the local police to arrive before we treated the victim. While safety cannot be absolutely guaranteed, changing our mindset about our personal safety can help make us become safer.

Nurses are a valuable resource that cannot afford to be wasted. A shortage of 400,000 full-time registered nurses is predicted in the US by the year 2020 (Galant-Roman, 2008). Studies have shown that understaffing is a major contributing factor in staff assaults due to fatigue and lack of patience related to the subsequent overtime. Societal changes including increased violent behaviors, increased substance abuse, the normalization of bullying and a lack of mental health treatment facilities have made hospitals a dangerous place to work.

Nurses need to start actively considering the current risk profile of their environment by doing a risk-benefit analysis. Start by asking yourself questions before entering the room, such as:

- **Does this patient have a history of violent behavior?**
- **Is the patient withdrawing from alcohol or other illicit substances that could lead to verbal or physical abuse?**
- **What will help my dementia patient keep calm while in the hospital?**
- **Do I need more staff with me while caring for this patient?**
- **Is it safe to be alone with this patient?**

Nurses should include scene safety as part of the care plan for patients that are at high risk for violent behavior. Communication between nurses and other staff members caring for the patient is a helpful tool to decrease potential injuries. Discussion and documentation of potential triggers should be available to the care team.

The Occupational Safety and Health Administration (OSHA) issued guidelines for the prevention of violence against healthcare workers in 2004. At its core, the guidelines for preventing WPV advise zero tolerance. Policies should be created and disseminated amongst all managers, supervisors, the healthcare team, patients, and visitors. OSHA suggests that patients and visitors should be able to recognize as they enter facility that there is a zero tolerance policy when it comes to violence.

"Being a nurse is all I've wanted to do, and I love it," Karen Morton adds as she speaks to her experience of workplace violence. "I don't feel that being injured should be 'a part of my job.'" Morton points out that violence in healthcare settings not only endangers workers, but other

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Silent no more

For more than three years, Patt Moon-Updike was unable to talk publicly about the violent assault that ended her career as a nurse. She promised her union, the Wisconsin Federation of Nurses and Health Professionals, that when she was ready, she would do what she could to help other health professionals by telling her story. It was the recent murder of a nurse at the hospital where Moon-Updike's life was saved after her own traumatic workplace injury that moved her to speak up. "It just lit a fire in me," she says.

That fire is what brought Moon-Updike, a psychiatric nurse, to Washington, D.C., on Feb. 27 to testify before the U.S. House of Representatives Committee on Education and Labor's Subcommittee on Workforce Protections, in support of recently introduced legislation that could provide vital safety measures for healthcare professionals.

Rep. Joe Courtney (D-Conn.) introduced the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1309) on Feb. 20 that would require the Occupational Safety and Health Administration to develop enforceable safety standards for frontline healthcare and social service workers, who are five times more likely to be assaulted at work than the rest of the labor force.

"Healthcare and social service workers do important, lifesaving work. The least we can do is ensure that they can come home safe at the end of their workday," said Rep. Alma Adams (D-N.C.), the subcommittee chairwoman during the hearing. "We need to ask ourselves: What is the price of inaction?"

AFT members know the price of inaction all too well.

In her testimony, Moon-Updike told the lawmakers about the assault against her at a county mental health facility by a patient with a history of aggression. He kicked her in the throat, collapsing her trachea, requiring surgery.

"All I remember is sitting in a chair, not being able to breathe, holding on to my trachea for dear life; I just knew if I let go, it would collapse and I would die right there in that hallway," said Moon-Updike. The injury left her with lifelong injuries and post-traumatic stress disorder; she can no longer work in healthcare.

"I loved being a nurse. I do not know what to call myself now," Moon-Updike said. "There is a deep loss when you used to make a difference in the lives of people, in your true calling and passion, and in that place is extreme sadness and fear. The assault that happened to me was not a random or freak event, but a predictable scenario that could have been prevented had there been a plan in place and more trained staff there to assist."

Moon-Updike was joined by fellow AFT nurse members from across the country who came to Washington to share their own experiences with workplace violence.

"It's an honor to be here and to meet people and hear what's happening in the government to help us," said Susan Harper, a member of the Ohio Nurses Association, who was among the group of AFT nurses attending the hearing. Harper has been a psychiatric nurse since 1975. She was attacked by a patient and suffered a concussion that kept her out of work for nearly a month. For Harper, lending her voice to the call for this legislation is about standing up for her family. "I am happy that the union is involved in getting this done, because my children are also nurses," she said. "I just can't imagine why this legislation wouldn't pass."

"It's exciting to be here," said Adrianne Harrison, who made the trip to Washington from Montana. "Taking part in this makes me feel empowered," said Harrison, a member of the Montana Nurses Association. Harrison, a psychiatric nurse, said she has been spit on, verbally threatened and was more seriously hurt in 2014 by a patient who pushed her into a wall. "I've always been involved in my union, but after my assault I got more involved. One of the best things about being part of the union is that you are not alone."

Harrison wants hospitals to be proactive, not reactive, when it comes to workplace violence. "Healthcare workers need those tools. When you're afraid, it affects the way you do your job."

Barbara Walsh, a psychiatric nurse who is a member of Health Professionals and Allied Employees in New Jersey, has been assaulted three times in her 16 years on the job. Walsh was left with long-term injuries, including a traumatic brain injury, loss of range of motion of her neck, loss of vision, memory issues and PTSD. "This bill is a godsend. It's for everyone; every patient would be safer, and that's why I'm here. My story is not an isolated one—but maybe it will be in the future."

For Moon-Updike, the legislation is not just lip service. "It puts protocols in place to provide the equipment, personnel and training we need to do our jobs safely."

Moon-Updike points to a code of silence when it comes to workplace violence in healthcare settings. "You suck it up, and you don't report because the hospital is not going to have your back." But, she said, "We've been quiet way too long, and hospital administrations have benefited from that. They won't change unless we force them to. The violence needs to stop. I'm willing to be the squeaky wheel."

That's why the AFT is one of the loudest voices supporting this bill: Violence should never be part of the job.

"Our nurses and health industry workers care every day for the sick, the elderly and the mentally ill," said AFT President Randi Weingarten, "yet they often feel unsafe or unprotected themselves from the assaults that occur in hospitals and other healthcare-related settings."

"No one should face violence, intimidation or fear for their safety while they're on the job. And as a union of healthcare professionals, educators and public employees, we welcome this effort to finally make federal workplace safety regulations a priority," said Weingarten. "Without a standard to address violence in healthcare, it will continue to go unchecked."

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patients as well. "All patients should feel safe and be protected from violence when they're receiving care. The staff that takes care of those in need should not have to sacrifice their safety either."

Nursing culture is slowly changing to realize that workplace violence truly is not part of the job, and nurses are beginning to recognize the complex nature of acknowledging our own personal safety. Violence can come from patients, families, strangers, physicians, supervisors and coworkers. Nurses are key stakeholders in any program that is designed to address WPV and, as such, should be included in any committee or council that assesses the workplace and develops a violence prevention plan. We must start advocating for zero tolerance with initial and ongoing education and training regarding WPV from both internal (physicians, supervisors and colleagues) and external sources (patients and visitors) at our facilities. Education should include identifying risk factors, de-escalation techniques, clear documentation and communication about patients with a history of violence, as well as reporting workplace violence in a no-retaliation atmosphere, and the inclusion of law enforcement when applicable. Nurses need to send a clear and powerful message that workplace violence will no longer be tolerated.

References

Boafo, I. M. (January 2018). The effects of workplace respect and violence on nurses' job satisfaction in Ghana: a cross sectional survey. Human Resources for Health.

Galant-Roman, M. A. (2008). Strategies and Tools to Reduce Workplace Violence. AAOHN Journal, 449-454.

Harris, T. (July 2015). Personal Safety for Nurses. Minority Nurse.

Papa, A., & Venella, J. (January 2013). Workplace Violence in Healthcare: Strategies for Advocacy. OJIN.

Whitehead, S. (April 2016). Rescue task forces and the scene safety dilemma. www.ems1.com.

In Harm's Way: Risk Factors for Violence Against Healthcare Workers

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

According to research that is available about workplace violence (WPV), nearly every healthcare worker has either been a victim of or knows a colleague who has been a victim of WPV. Some studies have found that up to 80 percent of nurses have reported experiencing violence from patients (Higazee MZA and Rayan, December 2017).

Since health and social services industries account for 48 percent of all non-fatal injuries from occupational assaults, it is important that all healthcare workers be able to recognize specific risk factors in order to either avoid or manage potentially violent situations.

Some common risk factors include those that are behavioral:

- Cognitive impairment due to intoxication from drugs and/or alcohol, dementia, developmental/ behavioral disabilities, or mental illness.

"When it happened, we had a full emergency room and waiting room with several critical patients, resulting in myself and another nurse staying late. A patient was brought in by the police department obtunded with a chronic history of methamphetamine and alcohol abuse. The patient awoke from their stupor and was getting out of bed when I approached them and tried to assist them back to bed. The patient became verbally abusive, shouting obscenities at me, and then proceeded to strike me three times in the chest with both hands. Though I am 6'1" and weigh 215 lbs., the patient struck me with enough force to move me backwards each time.

Apparently striking me was not enough. As other nurses, the physician and security responded, the patient began spitting on me and kicking me. The security officer and I assisted the patient back to bed while they continued to kick and spit on us between screaming more obscenities. The police arrived, the incident was reported, and the patient was discharged in their custody and subsequently found to have three bags of controlled substances on their person when they arrived at the jail."

— Patrick Taylor, RN
Ketchikan, Alaska

- Patients or families in emotional distress or crisis.

"I have been a forensic nurse for over 15 years and have had many experiences caring for sexual assault patients. One experience, though, has always stood out to me because I didn't know how bad it could get and felt I was a hostage to the patient because of that uncertainty. A woman came in who had reported being sexually assaulted. We had a detective and advocate present. The interview began with us all sitting at a round table. The patient was initially calm, occasionally tearful. The case was unfolding much like any other.

Suddenly, the patient became irate, angry and threatening. She started spitting on us, yelling and threatening to hurt us if we 'touched her.' We were in a community-based clinic, away from the main hospital, and this was the middle of the night. She clearly was decompensating following the trauma. There was no separate safe room for her to wait in, so our only recourse was to stay in the room with her and wait for 911 medics to arrive. Although she did not physically touch us, she did verbally threaten us multiple times over about an hour. We were all standing at the farthest points in the room, talking with her to try to keep her calm. She did calm down, but would escalate if we moved closer to her or sat down. It was a very disconcerting situation and it has stayed with me over the years."

— Angelia Trujillo, DNP, MSN, RN
Eagle River, Alaska

Other risk factors can be environmental:

- Limited security, unrestricted public access, and working in high crime areas.

"The first hospital that I worked in was in a high-crime area that had an overwhelming amount of gang activity for a small town of approximately 20,000 people. The employee parking area was surrounded by a 20-foot-tall chain link fence with barbed wire on top, the ED staff had seen a murder take place in a full waiting room, and it wasn't unusual for a drive-by shooting to take place outside the ambulance bay as a rival member victim was being wheeled in for care.

During a healthcare merger, the hospital in the crime-ridden area was absorbed into a bigger facility, which was in another small town about 20 miles down the road and across a river. It basically seemed a whole world away due to its miniscule exposure to crime. After the merger, however, the neighborhood around the larger facility saw an uptick in crime. Hospital lockdowns became frequent due to the gang activity moving across the river to the new location. One evening, a nursing school instructor was the victim of a failed carjacking attempt in the parking lot. She had been stabbed in the neck. Luckily, nothing vital had been damaged and she survived her assault. I sure did miss that 20-foot-tall chain link fence with barbed wire."

— Stacey Sever, BSN, RN, CCDS
Anchorage, Alaska

- Limited lighting is areas such as parking garages and hallways.

A former valet at Froedtert Hospital in Wisconsin was recently charged in the brutal homicide of nurse practitioner Carlie Beaudin in the hospital parking garage in January 2019. Video surveillance shows the suspect was waiting behind a concrete pillar in the parking garage when 33-year-old Beaudin stepped out of the parking garage elevator around 1 am on a Friday. Several hours after the attack, Beaudin was found bleeding and frozen to the ground underneath a vehicle. She was taken the emergency department and pronounced dead.

Additional factors can include situational risks:

- Working alone, transporting patients, or long wait times.

A caregiver working alone was attacked and killed by a patient at Eye to Eye Assisted Living Home in Anchorage in 2015. The patient, a registered sex offender, stated that he kicked, punched and strangled 57-year-old Glenna Whylie because she "made him mad." Two former employees of Eye to Eye spoke out against the ALH, citing previous attacks, having to work alone and other safety concerns as reasons for leaving. A former manager told KTVA that she had been attacked by a patient and quit her job two weeks before the murder. "I had two staff on shift, every shift, nights and days," the former manager said. "And that's when [the owner at the time] said she didn't want two staff working, because she couldn't afford two staff working at the same time."

"That could have been me," former employee Jodie Hiett told KTVA. "I worked nights there, and I know what it's like there. I know how scary it can be by yourself in that house. Just having one more [staff person] in that house, one more, and I really don't think it would have happened."

- Low staffing levels, disproportionately high number of inexperienced staff compared to experienced staff, and lack of proper education/ training for staff.

According to Duncan, et al, increasing the nurse to patient ratios was found to be a significant predictor of violence. Nurses' reported that the most frequent reported change that decreased violent incidences was increased staff numbers (Duncan, 2016).

- Close physical proximity when performing tasks.

"I was working the night shift in the Emergency Department when EMS brought in a patient from a local bar that was 'found down' in the restroom. EMS stated that the patient was uncooperative and extremely combative. In fact, EMS had sandwiched the patient between two backboards and strapped them together in order to stay safe. Completely unresponsive to verbal and painful stimuli as well as to ammonia inhalants, we removed both backboards, placed the patient on the ED stretcher, and I proceeded with my tasks of a full assessment and starting an IV and drawing blood for labs.

Because the patient was unresponsive, the physician had requested that an indwelling urinary catheter be inserted to obtain a urine drug screen as it was suspected that this patient was under the influence of a substance. However, when my colleague placed the end of the catheter into the urinary meatus, the patient immediately sat straight up and started swinging arms and fists around. Luckily, no one was hurt and soon the patient collapsed back onto the stretcher, unresponsive once again. At this point, we put the patient in four-point leather restraints (yes, I am dating myself) and continued on with the task of obtaining a urine sample."

— Anonymous Alaskan nurse

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Violent events can and do happen, and being unprepared is unacceptable. Although it is difficult to completely eliminate violence in healthcare settings, there are many ways to reduce the potential for violent occurrences and to minimize the impact if violence does occur. OSHA recommends that employers establish and maintain a violence prevention program as part of their facility's safety and health program.

As part of a prevention program, employers should:

- Develop and enforce comprehensive policies and procedures against workplace violence.
- Evaluate objective measures of violence to identify risks and risk levels.
- Train staff to recognize the warning signs of violent behavior and respond proactively.
- Encourage all employees and other staff to report incidents of violence or any perceived threats of violence.
- Ensure appropriate follow-up to violent events, including communication, post incident support, and investigation.
- Ensure that the violence prevention program addresses the possibility of gun violence, including active shooters.

Management should be committed to:

- Emotional as well as physical health of the employee.
- Appropriate allocation of authority and resources to responsible parties.
- Equal commitment to worker safety and health and patient/client safety.
- A system of accountability for involved managers and employees.
- A comprehensive program of medical and psychological counseling for employees experiencing or witnessing violent incidents.
- No employee reprisals for reporting incidents.

Healthcare workers should understand that:

- Prompt and accurate reporting of violence will benefit them, and enable management to identify, address, and solve problems.
- No reprisals will be taken by management or employer (OSHA, 2019).

We need to keep in mind that acts of aggression and violence in the healthcare environment are not deserved by nurses or other healthcare workers, even if unintended by the aggressor or as a result of intoxicants or other pathological processes.

Learning and identifying risk factors is an essential step to protect ourselves from workplace violence. However, it is not the only step. Management needs to develop policy that violence, threats, harassment, intimidations, and other disruptive behavior in our workplaces will not be tolerated and that all reports of such incidences will be taken seriously and will be dealt with appropriately. Implementing administrative and work practice controls, such as making patients aware of zero tolerance policies, improving lighting, training staff and providing security escorts can make hospitals safer for healthcare workers and our patients.

References:

Duncan, S. H. (2016). Nurses' experience of violence in Alberta and British Columbia Hospitals. Canada Journal of Nursing.

Higazee MZA and Rayan, A. (December 2017). Consequences and Control Measures for Workplace Violence among Nurses. Journal of Nursing and Health Studies.

OSHA. (2019). **https://www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/viol.html.**

Enduring Trauma: The Aftermath of Workplace Violence

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

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 phys-

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ically 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.

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 it 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.

References

Emergency Nurses Association. (2010).www.ena.org.

Gates, D. G. (April 2011). Violence Against Nurses and its Impact on Stress and Productivity. Nursing Economics, 59-66.

Joint Commission. (2010). Sentinel Event Alert Preventing violence in the health care setting.

Laposa, J. A. (2003). Posttraumatic stress disorder in the emergency room: Exploration of a cognitive model. Behaviour Research and Therapy, 49-65.

Federal Legislation Introduced

to Protect Healthcare and Social Service Workers from Workplace Violence

Since 1996, the Occupational Safety and Health Administration has offered guidance and resources to healthcare and social service employers on programs to prevent violence. Research has shown that these programs can reduce the number and severity of violent incidents. But because the OSHA guidance is voluntary, employers have either failed to adopt comprehensive programs or only partially implemented programs. Meanwhile, between 2007 and 2017, the rates of violence grew by 123 percent in hospitals, 201 percent in psychiatric hospitals and substance use treatment facilities, and 28 percent in social service settings.

Without an OSHA standard, employers have little incentive to prevent workplace violence. Although OSHA may cite employers using the Occupational Safety and Health Act's general duty clause [Section 5(a)(1)], it has not been an effective deterrent. The general duty clause requires employers to establish a workplace free from recognized hazards causing or likely to cause death or serious harm. Citations under the general duty clause must meet a high legal standard and historically have been difficult to sustain.

That's why the Workplace Violence Prevention for Health Care and Social Service Workers Act of 2019 (H.R. 1309) has been introduced in Congress by Reps. Joe Courtney (D-Conn.) and Bobby Scott (D-Va.). This bill will direct OSHA to develop an enforceable standard within 18 months of the bill's passage. The standard will require healthcare and social services employers to implement and maintain comprehensive workplace violence prevention programs with meaningful participation of direct care employees. The bill defines workplace violence as the threat or use of physical force against an employee, regardless of whether an injury is sustained.

The standard will cover most healthcare settings and many social service settings, including general and specialty hospitals; psychiatric and substance use treatment centers; hospital-licensed in-patient or out-patient clinics; skilled nursing homes, hospice, and long-term care facilities; nonresidential treatment or service settings; treatment settings in corrections; community care settings, including group homes and mental health clinics; home healthcare services; and emergency services. It will cover direct employees and contracted workers. Public facilities not otherwise covered by a state OSHA that accept funding for Medicare will be covered.

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Workplace Violence in the Eyes of the Law

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

Healthcare workers can speak to the fact that violence in the workplace is proliferating. Unfortunately, the problem is not so well known to the general public. In addition, the violence is no longer just isolated to certain types of facilities, certain departments within the hospital, or only committed by certain patient populations. All employees throughout a healthcare facility are subject to workplace violence (WPV). Strategies, including legislation to address workplace violence in healthcare settings, have been developed after many years of research looking into the causes, risk factors and the effects of WPV.

Several states, including Alaska, have enacted laws to assist with protecting healthcare workers from workplace violence. Signed into law on June 14, 2018, Alaska's House Bill 312 relaxed the requirements for assault arrests in hospitals and strengthened penalties against those who assault healthcare workers. The new law allows law enforcement officers to arrest and remove perpetrators who commit assault in the fourth degree at a healthcare facility. There must be probable cause for believing that the perpetrator committed a fourth-degree assault (a violation of AS 11.41.230), and the perpetrator must either (a) not be seeking medical treatment at the facility (a non-patient), or (b) must be stable for discharge if a patient. The bill also allows prosecutors to pursue tougher penalties for felony assault when the victim is a healthcare professional assaulted on the job.

When someone is a victim of a physical assault, Captain Sean Case of Anchorage Police Department (APD) describes that one of two types of evidence need to be present: 1) physical injury, or 2) witnesses that can corroborate the assault when there is no physical injury. Assault in the fourth degree, which is a Class A misdemeanor and the only non-felony-level class of assault in Alaska statute, encompasses three types of situations.

The first type of fourth degree assault is when a person recklessly causes physical injury to another person. The key here is the person's recklessness, which means that while they did not specifically intend to harm someone, they were aware of the unjustifiable risk of their actions but consciously disregard the risk, taking the action anyway. This also applies to an intoxicated person who, while perhaps unable to be aware of the risk of their actions while intoxicated, would have been aware of the risk if not intoxicated. The second would be when a person is criminally negligent and causes physical injury to another person by means of a dangerous instrument. For example, when the perpetrator is acting out and throws a chair, not directly at anyone in particular, but that the chair happens to strike another person, causing them injury. The third example would be when the words or threatening conduct by the offender recklessly puts the victim in fear of imminent physical injury.

I recall an episode several years ago when a colleague shared their experience of an encounter with a former patient. This nurse was at a public location and approached by this former patient who started to be verbally assaultive, using offensive language that was followed up with a death threat if the former patient ever saw this nurse again. Another colleague and I encouraged this nurse, who was visibly shaken and crying, to notify hospital security of this incident in case this person were to show up at the hospital. Assault in the fourth degree does not include a conditional threat, such as when a patient threatens to punch a healthcare worker if they don't receive their Jell-O. This is because the conditional nature of the threat eliminates the element of immanency, which must be present to count as an assault.

I spoke with Captain Case recently, who was able to give some history about the changes in law during the last few years. I shared with him that some nurses have voiced frustration about calling law enforcement after being assaulted by a patient or visitor and nothing happening to the offender. He explained that in most lower-level misdemeanor crimes — which includes the most common crimes, such as shoplifting and petty theft — the bail schedule directs judges to release defendants without posting bail. Referred to as the "paper arrest," some law enforcement officers felt increasing resentment of arresting an individual only to have that individual turn around and walk out the door after the arrest report was completed. This led to some officers no longer arresting people for these types of crimes. "What was the point?" was the attitude adopted by some in APD. The bail schedule is set by Alaska's four presiding judges and establishes the amount and circumstances under which a person who is arrested without a warrant can be released from jail before a trial.

Healthcare workers don't always feel comfortable about calling law enforcement when they are victims of violence for a variety of reasons. That may be related to the patient's condition, lack of support from management or security staff, or the misconception that violence is part of the job. Captain Case shares some advice about when the decision is made to contact law enforcement:

1) **Keep the information simple. Frequently, too much information is given over the phone about the circumstances. Give only necessary information such as whether the person is actively violent at the time of the call, if they medically cleared (ready for discharge), and some basic background information on what the responding officers will be "walking in to" when they get there.**

2) **If the person is actively violent and/or there are weapons involved, Captain Case recommends that law enforcement be contacted using 911. The non-emergent number may be used in other situations where imminent danger is not present. Many communities are now using 311 for the non-emergent number.**

HIPAA does permit covered entities (such as healthcare institutions) to disclose protected health information (PHI) about a suspected perpetrator of a crime to law enforcement officials without the individual's written authorization under specific circumstances such as when the report is made by the victim who is a member of the covered entity's workforce (Services, June 2013).

While some may feel that HB 312 doesn't do enough to protect healthcare workers that are victims of WPV (and they would be correct), others feel that this is just one step leading towards developing additional legislation on workplace violence against healthcare workers. With HB 312, at least the public will be aware that hospitals and other healthcare institutions in Alaska are places where violence will no longer be tolerated and that people that are violent towards staff will be held accountable for their actions.

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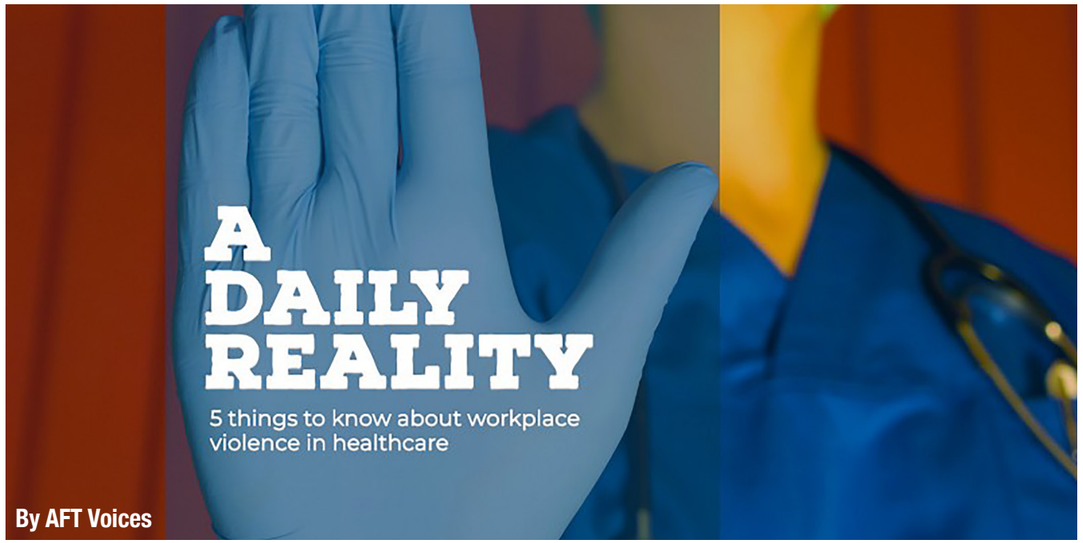
Employers will be responsible for implementation of a plan based on an assessment of hazards in the workplace. Solutions must be site-specific and can include equipment and policies that help to protect workers, such as cameras, panic buttons, barriers and additional exits; posting of additional security staff; preventing staff from working in isolation; flagging patients or clients with a history of violence; and regular training.

Employers must develop a process to report assaults, near misses and threats, and they must respond by investigating incidents in a timely manner. Retaliation against an employee for reporting workplace violence will be prohibited.

OSHA will require employers to keep a log of all incidents of workplace violence. Employers must evaluate the program and send a report to OSHA on an annual basis. They must also post a summary of the log where employees can see it. Employees and their representatives can request copies of the incident log at any time.

All staff, including contract staff, will receive annual workplace violence prevention training—in person from qualified instructors. Workers will have the opportunity to ask questions and request additional training. New employees will be trained prior to assignment, and workers whose job circumstances have changed have the right to additional training. Staff will receive supplemental training after significant violent incidents. Managers and supervisors will be trained to recognize hazards so they can avoid assigning employees to risky situations.

The Workplace Violence Prevention for Health Care and Social Service Workers Act of 2019 will give OSHA a tool to protect healthcare and social service workers from violence. Employers who fail to implement the standard or who retaliate against an employee for reporting violence will be cited. Violence is not part of the job. Prevention is possible—comprehensive prevention programs will reduce the number and severity of future incidents, allowing us to care for our patients and clients.



Workplace violence is a daily reality in healthcare.

Hospitals and other healthcare settings are centers for healing, but inside those walls, the people charged with caring for the sick are often victims of violence themselves—at the hands of patients or their families and friends. Staff in frontline healthcare jobs are five times more likely to be assaulted at work than the rest of the labor force.

Here are five things you need to know about workplace violence in healthcare:

1. THERE ISN'T ONE KIND

In healthcare facilities, workplace violence takes many forms, including verbal abuse, physical threats, or actual physical assault by patients or their families. According to the Occupational Safety and Health Administration, approximately 69 percent of nearly 25,000 workplace assaults reported each year occur in healthcare and social service settings.

2. IT'S ACCEPTED

The perception of many people (workers and supervisors alike) is that violence is part of the job. Studies show that the level of violence in hospitals persists because of the hospital leadership's tolerance for violence.

3. IT'S HIDDEN

People fail to realize the gravity and frequency of incidents because healthcare workers underreport violent encounters with patients. Nurses and other caregivers tend to tolerate a certain amount of workplace threats or violence, attributing it to physical or behavioral issue that the patient cannot control.

4. WORKERS NEED MORE TRAINING

The risk of violence in the workplace increases at healthcare facilities that don't have policies and training for recognizing and managing hostile behaviors from patients, clients, visitors and co-workers. Understaffing and inadequate security also put workers at risk.

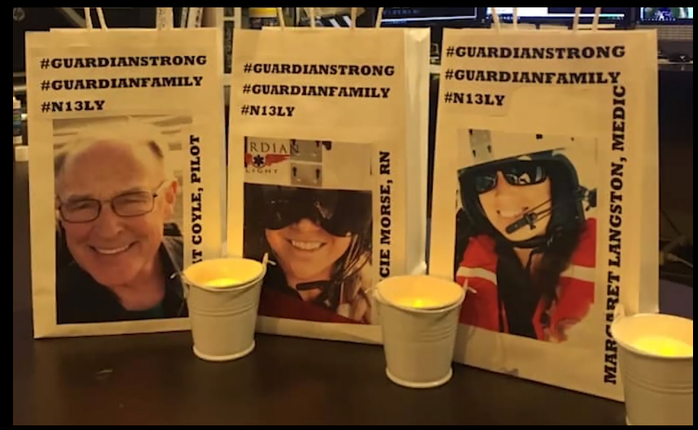
5. THERE ARE NO FEDERAL PROTECTIONS

Right now, there is no federal standard that requires protections against workplace violence, so the AFT and our partners are fighting for legislation aimed at prevention.

Workplace violence is a pervasive issue in American healthcare, but prevention is possible. AFT Nurses and Health Professionals is fighting the perception that violence is just part of the job. Some hospitals have to be forced to do the right thing by their workers, whether it's hiring more security officers, buying technology to monitor hospital occupants or creating programs to identify ways to stop violence before it happens. That's why we're championing the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1309), which will change this once and for all.

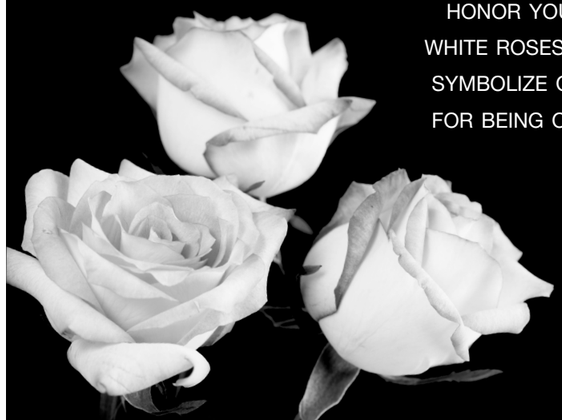
In Memoriam

Honoring Stacie Morse, Patrick Coyle, and Margaret Langston



We honor and remember the lost crew of the Guardian Flight that went missing near Kake, Alaska on January 29, 2019. Our deepest sympathies go out to the family, friends and colleagues of medic Margaret Langston, pilot Patrick Coyle, and flight nurse Stacie Morse and her unborn daughter, Delta Rae. This brave team epitomizes selflessness in the healthcare profession. We honor the lives they lived, in full dedication to their mission to help others in the most dire of circumstances.

Stacie, Margaret, and Patrick, we honor you today and present three white roses and light three candles to symbolize our honor and appreciation for being our healthcare colleagues.



A Union of Professionals

AFT Nurses and Health Professionals News Roundup

ABOUT AFT

The American Federation of Teachers (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.

Casualties of Care

Hospitals and other healthcare settings are centers for healing, but inside those walls, the people charged with caring for the sick are often victims of violence themselves—at the hands of patients or their families and friends. Healthcare workers know all too well that workplace violence is a daily reality in healthcare.

Check out AFT members' stories on workplace violence: *https://aftvoices.org/tagged/workplace%20violence*

Take the AFT e-Learning Course on the Opioid Crisis

"Combating the Opioid Crisis: AFT Responds," is now available on the AFT's e-learning platform, includes video-based content created by faculty and staff experts at Harvard Medical School, and addresses widely recognized training and information gaps AFT members may encounter when dealing with the realities of treating and counseling people about the challenges of opioid use and addiction. The course is free but requires registration.

Take the course: *https://aftelearning.org/*

Union Power is Rising

Schemes to undercut public sector unions—epitomized by last year's U.S. Supreme Court decision in Janus v. AFSCME—have stalled, according to new data from the federal Bureau of Labor Statistics. "It's heartening that working people have seen straight through brazen attempts to destroy our union and other public sector unions," says AFT President Randi Weingarten. "In fact, our union is growing. Union members have sent a clear message: We're sticking with the union."

Find out more: *https://www.aft.org/news/union-power-rising*

Nurses' Donation Erases $8.9 Million in Medical Debt for Thousands

Imagine opening a letter informing you that your medical debt has been canceled. Thanks to RNs represented by the Michigan Nurses Association, that dream became reality for more than 9,000 residents in northern Michigan burdened with medical debt. The announcement was made at a candlelight vigil organized by nurses at Munson Medical Center in Traverse City. The nurses worked with RIP Medical Debt, an organization that uses donations to purchase past medical debt for people facing financial challenges.

Read about their donation: *https://www.aft.org/news/nurses-donation-erases-89-million-medical-debt-thousands*

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Read. Learn. Earn

READ – Enjoy this issue of The Alaska Nurse

LEARN – Discover new information and gain knowledge

EARN – Earn free contact hours when you pass the online post-test

How to Earn Contact Hours:

After you've read this issue of The Alaska Nurse, visit AaNA's online CE center (alaskanurse.litmos.com/online-courses) and find the CE offering for this issue (April / May 2019) - The Alaska Nurse). Add the course to your cart and sign-in or register for a new account. Follow the course instructions to complete the post-test and evaluation. Your CE certificate will be awarded upon successful completion of the course!

The Alaska Nurses Association is an approved provider of continuing nursing education by the Montana Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

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Care Beyond the Bedside

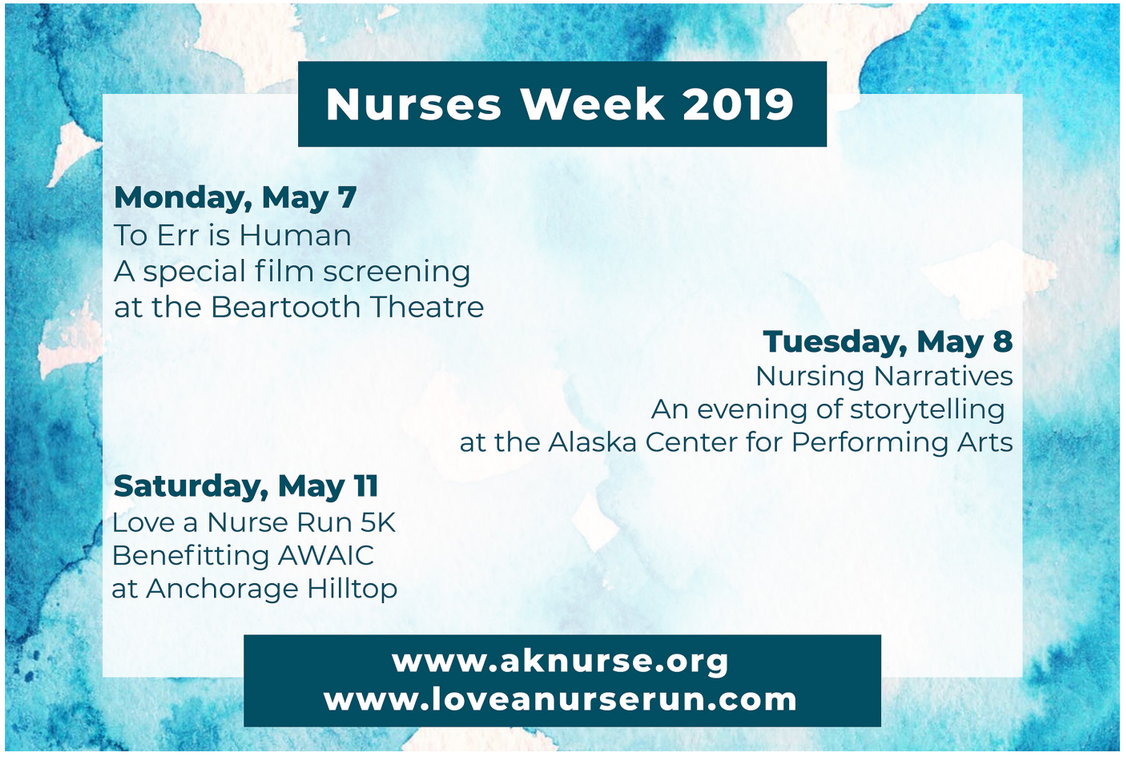
Members of the Oregon Federation of Nurses and Health Professionals didn't let the rain stop them from standing with their community in Portland and distributing hundreds of books in February. For many members, it was the chance to deliver care beyond the bedside. "It's important that people see unions as a part of the community and to connect with people and help them understand what unions stand for," says OFNHP member Rhea Hindemit.

See the story: *https://www.aft.org/news/delivering-care-beyond-bedside*

Everyone Deserves a Secure Retirement

The retirement system that was built for the 20th century is not working for young people today. AFT President Randi Weingarten and Kathleen Kennedy Townsend, director of retirement security at the Economic Policy Institute, lay out a plan so that all Americans can have the security they deserve in their twilight years by saving through guaranteed retirement accounts. With young people mired in student debt or working in the gig economy, it's unrealistic to expect them to save for the future using the same methods as their grandparents.

Learn about the plan: *http://www.baltimoresun.com/news/opinion/oped/bs-ed-op-0207-guaranteed-retirement-20190206-story.html*



Calendar of Events

AaNA

UPCOMING MEETINGS

AaNA Board of Directors Meeting
4th Wednesday each month — 4:30-6pm

AaNA Labor Council Meeting
4th Wednesday each month — 6-7pm

Providence Registered Nurses
3rd Thursday each month — 4-6pm

RNs United of Central Peninsula Hospital
Contact for times: 907-252-5276

KTN – Ketchikan Registered Nurses (PHKMC)
Contact for times: 907-247-3828

Alaska State Board of Nursing

Anchorage Atwood Bldg, TBA May 21-23, 2019
Agenda deadline: April 19, 2019

Anchorage Atwood Bldg, TBA August 7-9, 2019
Agenda deadline: July 14, 2019

Fairbanks or Anchorage November 13-15, 2019
Agenda deadline: October 14, 2019

Meetings of the Alaska Board of Nursing, except for executive sessions, are open to the public. If feasible, executive sessions are scheduled on the second day of the meeting. While we plan ahead, there are, on occasion, last minute changes in the meeting agenda and location. Please call 907-269-8161 to reconfirm if you plan to attend. Audio-conferencing is available. The access number is 800-315-6338 and code 34727.

The Alaska Board of Nursing has a listserv that is used to send out the latest information about upcoming meetings, agenda items, regulations being considered, and other topics of interest to nurses, employers, and the public. To sign up for this free service, visit www.nursing.alaska.gov

Education and Events

Mindfulness-Based Stress Reduction Program
February 6, 2019 – April 17, 2019 (Wednesday evenings) – Anchorage
www.akcfm.com

TUESDAY TALKS
Now in-person AND online!
New Window for Treatment in Stroke Management for Large Vessel Occlusive Disease
Presenter: Diane Lada, MSN, RN, ACNP-BC, SCRN
Tuesday, April 16th @ 6 PM
AaNA Office – Anchorage
FREE CE: Earn 1.25 contact hours
RSVP to chanti@aknurse.org
www.facebook.com/AlaskaNurses

Healthy Student, Healthy World
Alaska School Nurses Association 2019 Conference
April 5-7, 2019 – Crowne Plaza Anchorage
alaskasna.nursingnetwork.com

2019 Alaska Heart Run
Saturday, April 20th
Alaska Airlines Center – Anchorage
Join Team Alaska Nurses!
www.alaskaheartrun.org

Alaska Breastfeeding Coalition Conference
April 25-26, 2019 – Anchorage
alaskabreastfeeding.org

To Err is Human
A Special Film Screening for Nurses Week
at the Beartooth Theatre
Monday, May 7th
www.facebook.com/AlaskaNurses
www.aknurse.org

Nursing Narratives
A Night of Storytelling for Nurses Week
at the Alaska Center for Performing Arts -Tuesday, May 8th
www.facebook.com/AlaskaNurses
www.aknurse.org

3rd Annual Love a Nurse Run 5K
Benefitting AWAIC!
at Anchorage Hilltop - Saturday, May 11th
www.loveanurserun.com
www.facebook.com/AlaskaNurses

TUESDAY TALKS
Now in-person AND online!
Alaska's CDC Quarantine Station
Tuesday, May 21st @ 6 PM - AaNA Office – Anchorage
FREE CE: Earn 1.25 contact hours
RSVP to chantal@aknurse.org
www.facebook.com/AlaskaNurses

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

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

HAPPY NURSES WEEK! - May 6-12, 2019