

# The Alaska Nurse

The Official Publication of the Alaska Nurses Association  
Vol. 70, Issue 6 December 2019 / January 2020



## Orthopedic Care

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The Alaska Nurse is produced in Anchorage, Alaska and published six times a year by



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## From our President



In this issue we are going to learn more on orthopedic care and bone health. Even if you're not a fan of ortho topics, don't yawn yet! I have a story to tell.

On the first Saturday this May, my husband and I went on a little bike ride. The clouds had just broken up after a large rain storm had passed through, and the sun was shining bright in the sky. It was a lovely evening. We had only gone a block when all of the sudden, I found myself sucked into a ditch with my bike on top of me. Flustered, I exclaimed, "What just happened? Get this bike off of me! WOW, my knee is killing me! Get me up! HELP!" My husband came right over to help me stand and I went down like a rock, with pain shooting through my right knee. He helped me up again and we hobbled home, which took over an hour because the pain in my knee was excruciating.

By the time we got home, I was cold and shivering and diaphoretic. I got into bed, pulled the covers up on me, and asked for a glass of water. My husband then got an ice pack and put it on my knee. Though I don't remember it, my husband said I kept asking for more water, like a gallon of it. I woke up a few hours later to find crutches at the bedside. I couldn't put any weight on my right leg, but of course I didn't go to the doctor because I was fine.

The next day I still couldn't put any weight on my leg, so I stayed on the couch with ice and watched the national Women's Soccer playoffs (I never watch soccer). I couldn't really do anything, but again, I was fine.

Monday, I caved and went to the walk-in clinic at OPA on my crutches. X-rays were taken and – lo and behold – I had a tibial plateau non-displaced fracture. WHAT!? I was supposed to be fine! The orthopedic staff placed a hinged knee brace on me, readjusted my crutches, and taught me how to walk non-weight-bearing on them. For eight weeks I hobbled around on those things straight-legged and kept my leg elevated on ice most of the time. My husband, who is a retired firefighter, taught me how to go up and down stairs, rigged up my crutches with cup holders to hold my cell phone and coffee cup, and kept my cryocuff filled with ice.

At the eight week mark, my knee was healing on schedule so they let me 30 percent weight bear and start physical therapy. I

was free! I started to drive again, I went out to the greenhouse, planted my tomatoes and cukes, and played in the dirt. Then I started PT. Boy was my leg weak and wobbly. Luckily, my injury qualified me to go to pool therapy. I loved pool therapy!

After four weeks at 30 percent, I was allowed to ditch the crutches and full weight bear with the brace.

I went to the grocery store all by myself! I was able to sit on a crate in my garden and weed, pull the hose around the yard to water, and go up and down the stairs almost normally. I was going to be just fine.

At week 16, OPA said I could take the brace off, walk normally, and go back to work. YEAH! Well, after one 12-hour shift on that concrete floor, I hobbled home, put my leg up on ice, and cried. My knee hurt so much and was super swollen. The next day, I made some phone calls and back on short-term disability I went. I told my PT what had happened and they adjusted my therapies to start focusing on strength, endurance, and balance. What a huge difference that made. I hadn't realized that simple things like balancing on one leg for 30 seconds had become so difficult.

In all, I was off work for a total of four months. How crazy is that! My knee still became swollen after each shift and I had to ice it after work, but the next day it would be fine. I'm 100 percent recovered now. No more ice and only the occasional Advil if I happen to overdo it. And sadly, my last day of pool therapy came at the end of October.

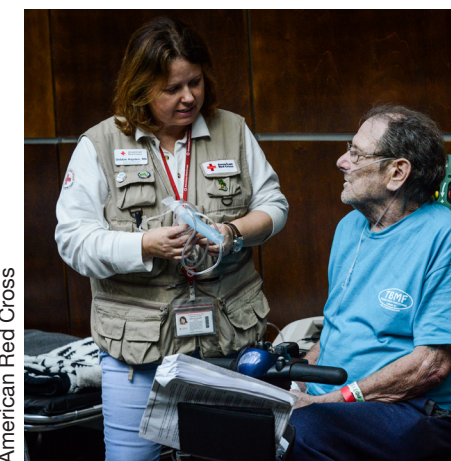
That's my ortho story! I want to thank my doc at OPA and my physical therapists for getting me back to my original self. I learned a lot about the knee, its supporting structures, and all the muscles connected to it and how to work them. I also learned a lot about balance. I'm going back to yoga for sure.

As always, write to me at [jane@aknurse](mailto:jane@aknurse) with your comments, your ortho story, or questions.

*Jane Erickson*

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

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American Red Cross

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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](mailto:Andrea@aknurse.org).

# SAFE WORK, SAFE CARE:

## Health & Safety News for Nurses

### SAFE PATIENT HANDLING: A MUST FOR NURSES AND FACILITIES

BY STACEY SEVER, BSN, RN, CCDS AANA HEALTH & SAFETY TASKFORCE CHAIR

As nurses, we give of ourselves emotionally and physically to our profession. We share in the joys and sorrows of our patients as we care for them. We also share in their accomplishments as they work to overcome their physical setbacks in order to get back to a safe level of activity. However, in trying to assist our patients to reach the end goal of physical independence, nurses can get injured. Work-related musculoskeletal disorders (MSDs) are the leading occupational health problem affecting the nursing workforce. The risk for musculoskeletal injury secondary to manual patient handling crosses all specialty areas of nursing. As such, no nurse is effectively clear from risk (A.B. de Castro PhD, 2004).

Nurses face a multitude of workplace hazards while performing their routine duties: Walking, bending, stretching, standing, and often lifting and moving patients. Other hazards include coming into contact with potential hazardous substances such as drugs, diseases, radiation, and accidental needlesticks. Over the years, addressing workplace hazards to make healthcare facilities safer has been put under the OSHA umbrella. The Bloodborne Pathogens Standard and Needlestick Prevention requires precautions when dealing with blood and other potentially infectious materials and requires the employer to make immediately available a confidential medical evaluation and follow-up to an employee reporting an exposure incident. Safe patient handling has come to the attention of OSHA due to the sheer number of MSDs as hospitals have high rates of nonfatal occupational injuries. In 2013, hospitals recorded 6.4 work-related injuries for every 100 full-time employees compared with 3.3 per 100 full-time employees for all U.S. industries combined (OSHA). Most concerning are back injuries, which can be severely debilitating and career ending for staff. Other types of musculoskeletal injuries can involve additional body parts such as the neck, shoulders, wrists, and knees, which can also affect the nurse's ability to perform patient care or require them to step away from the

bedside. While it may not be one significant event, nurses suffer a disproportionate amount of MSDs related to the cumulative effect of repeated patient handling events.

For many years, nurses and other healthcare workers were trained on the use of "proper" body mechanics to prevent injury. While this may work for moving boxes or other inanimate objects, proper body mechanics doesn't necessarily work with patients. Patient height, weight, body shape, and condition can become significant factors in patient handling. Assisting the movement of a post-surgical patient in the ICU with multiple IV lines/central lines and mechanically ventilated can be a just as much of a challenge as an elderly obese medical patient that has chronic pain and dementia. In addition, the environment in which patients are cared for can also have an impact on how effectively patients are mobilized. Nursing staff must work within the constraints of the physical area to perform their duties such as limited floor plan and multiple pieces of equipment and furniture requiring staff to stretch to reach for needed items. Studies have shown that a higher work pace and emotional demands were significantly associated with MSD. In addition, completing a patient handling task without equipment when equipment was prescribed, and perceived lack of suitable equipment, space, environment, skills or knowledge affecting patient care were also significantly associated with MSD (Boocock, 2018).

Nursing and other healthcare workers are well aware of the research and evidence-based practice literature that is available about the benefits of early mobilization of patients for increasing muscle strength, functional independence and reducing hospital length of stay. Having the tools and training in order to provide safe patient mobility while limiting exposure to musculoskeletal injuries for the staff is a major component of a safe patient handling and mobility (SPHM) program. Implementation of a SPHM

program is a significant undertaking for any facility that can be years in the making. Each department and each patient type must be taken into consideration during the planning stages as well as ensuring that there is enough available equipment for all departments and all patient types. OSHA's website has links to tools and resources that assist healthcare facilities to develop and implement safe patient handling assessments, policies, procedures, programs, training, and patient education. But to make this significant leap requires a culture shift which includes administration down to the staff at the bedside. Healthcare facility costs incurred from an in-patient work-related patient-handling injuries can range from \$114 000 to more than \$800 000 annually. Injuries can add to staff shortages due to lost work days and restricted work days not to mention those that have to end their healthcare career related to their injury. Indirect benefits of an effective SPHM program include: reduced turnover and improved staff and patient satisfaction (Kanaskie, 2017).

In order to achieve success in patient mobility and safe handling, every stakeholder must be involved in the improvement initiatives around patient safety and health-care worker safety. The goals of a SPHM program should include: The frontline staff having integrative solutions that facilitate patient mobility while protecting the patient's skin from shear and pressure, preventing falls through improved patient conditioning, and providing the health care staff with the safe patient-handling tools to achieve in-bed and out-of-bed mobility. With comprehensive solutions, healthcare facilities can successfully achieve safe mobility for acutely and chronically ill patients in order to assist in decreasing hospital lengths of stay, reduced pressure injuries, and for ICU patients, shorter time on mechanical ventilation (Black, 2018).



ErgoNurse, Safe Patient Handling on Facebook

[www.nursingworld.org/ojin](http://www.nursingworld.org/ojin)

<https://www.bls.gov/opub/mlr/2018/article/occupational-injuries-and-illnesses-among-registered-nurses.htm>

[https://www.osha.gov/dsg/hospitals/patient\\_handling.html](https://www.osha.gov/dsg/hospitals/patient_handling.html)

## Getting Certified as an Orthopedic Nurse

Nurses can gain their orthopedic certification through the Orthopaedic Nurses Certification Board (ONCB). The ONCB was established by the National Association of Orthopaedic Nurses (NAON) in 1986 in order to promote the highest standards of orthopedic nursing practice through the development, implementation, and coordination of certification for orthopedic nurses.

The ONCB offers three credentials – two for registered nurses, and one for nurse practitioners. The most commonly obtained credential is Orthopaedic Nurse, Certified (ONC). In order to sit for the ONC certification exam, one must have two years of experience practicing as an RN with a minimum of 1,000 hours of work experience in orthopedic nursing practice within the past three years. The ONCB accepts a wide variety of orthopedic experience for this requirement – including critical care, outpatient clinics, oncology, home health, med-surg nursing, administration, OR, and pediatrics. Nurses must also have a current unencumbered license.

The ONC exam contains 150 questions. Of these, 135 are scored; the remaining 15 questions are pilot items, and the candidate's performance on those questions will not be reflected in the exam score. A raw score (number of questions answered correctly) of 97 is needed to pass the examination. Successfully passing the exam earns a five-year certification. Both the ONCB and the NAON offer exam prep resources.

Alaska currently has 31 registered nurses who hold the ONC credential, and is one of many states without any advanced practice registered nurses who have obtained the Orthopaedic Nurse Practitioner, Certified (ONP-C) credential by the ONCB. Recently, the ONCB has begun offering a second certification for registered nurses: the ONC-A, an advanced orthopedic credential obtained through a portfolio assessment process. More information about orthopedic nursing certification is available at [www.oncb.org](http://www.oncb.org) and [www.orthonurse.org](http://www.orthonurse.org).

# TRENDING TOPICS IN NURSING CONFERENCE HELD IN ANCHORAGE



BY ANDREA NUTTY, AANA PROGRAMS DIRECTOR  
 PHOTOS BY KRISTA KANDRICK, BSN, RN, CCRN, TCRN  
 WWW.KRISTAKANDRICKPHOTOGRAPHY.COM

On October 10-12, the Alaska Nurses Association put on the 7th Annual Trending Topics in Nursing Conference at the BP Energy Center in Anchorage. Nurses came from all over the state of Alaska to attend presentations by local and national experts. The keynote session on Friday gave unique insight into one of our state's most pressing concerns: homelessness. Our speakers, Dick Mandsager with the Rasmuson Foundation, Lisa Sauder with Bean's Café, and Melissa Hernandez with the Anchorage Coalition to End Homelessness outlined the causes and risk factors of homelessness, discussed how it's being addressed in our communities, and called for a more integrated and holistic approach to the

issue. The ultimate goal? Homelessness should be rare, brief, and one-time.

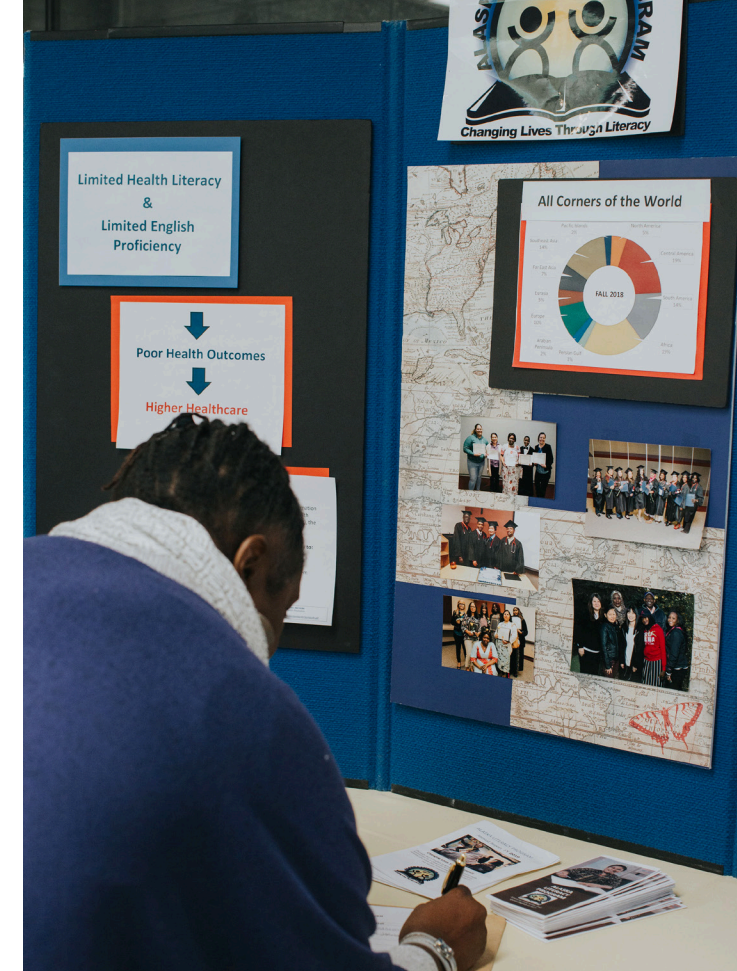
Attendees also enjoyed a presentation from Captain Sean Case of the Anchorage Police Department, who spoke on the law enforcement response to workplace violence and crime committed at healthcare facilities. AaNA attorney Haley Rosenthal provided a detailed look at workers' rights in unionized and non-unionized workplaces, as well as tips for employees facing disciplinary interviews, in her presentation entitled "Hey! The Boss is Calling Me into the Office! What Now?" The CEO of the Montana Nurses Association, Vicky Byrd, MSN, RN, traveled to Anchorage to address another important topic affecting nurses: the Nurse Licensure

Compact. Other topics covered throughout the conference included communication to reduce healthcare disparities, adolescent mental health, non-ventilator hospital-acquired pneumonia, and traditional health-based practices.

We had incredible sponsors and exhibitors that added great support at the event. A huge thank you to our sponsors Alaska Regional Hospital, the Alliance of Nurses for Healthy Environments, the U.S. Army Nurse Corps, and Arctic Chiropractic. One of our sponsors, the Alliance of Nurses for Healthy Environments, even provided a free dinner event at Kinley's Restaurant (with additional contact hours!). They're a great organization, so be sure to check them out online at [www.enviRN.org](http://www.enviRN.org).

We were also pleased to hold our first volunteering expo during the conference this year, in which local organizations offered attendees information about volunteering opportunities for nurses in Alaska. Thank you to Alaska Community Action on Toxics, Healthy Futures and PLAAY, Alzheimer's Resource of Alaska, the American Red Cross, Faith Community Nursing, Alaska Literacy Project, and Commission of Graduates of Foreign Nursing Schools. We are so thankful for all of the support we had this year that truly helped make our conference so successful!

CONTINUED ON PAGE 9



# A Win-Win-Win for All

## Mission Nursing Abroad and at Home

By Shelly Burdette-Taylor, PhD, MSN, RN-BC, CWCN, CFCN

Medical Service Trips also known as Mission Nursing is alive and well. The United Nations (UN) defines Medical Service Trips (MSTs) as individuals (usually medical providers) who volunteer from High Income Countries (HIC) and travel to Low or Middle Income Countries (LMIC) to provide healthcare over a period-of-time ranging from one day to eight weeks. The organization sponsoring the travel may or may not be faith-based. Medical providers and team members usually consist of physicians, pharmacists, nurses, physician assistants, dietitians, dentists, and dental hygienists. It is common to have individuals from military and academia organizations.

The UN defines volunteering as an act of free will that results in benefits for others outside of, or in addition to support given to close family members or vulnerable populations. Long-term commitment is defined as a minimum of one hour per month on at least two occasions in order for volunteering to impart a plausible and sustained impact over a period of time, usually months or years.

Our society has been and more importantly must consider the inequalities and inequities, especially among the most vulnerable populations such as Alaska Native, American Indian, Elders, Disabled, and Mental / Substance Use Abuse individuals. Our economic, social, political, and psychologic climate is at an all-time low and more complicated now than ever.

The building of the “Big Society Policy” calls for low cost, sustainable interventions. It invites people to participate in their local

communities to improve social capital and community engagement. The University of Alaska Anchorage, College of Health has made a “call-out” to faculty to develop and implement interprofessional academic service-learning opportunities for students and faculty. They are working side-by-side in an effort to improve learning by incorporating community-engaged opportunities. At the same time, while individuals are volunteering they are servicing the most vulnerable populations and reducing social injustices.

### **Why volunteer? Why participate in a MST? Why care about others that are vulnerable?**

- Margaret Mead once stated that “Never underestimate the power of one individual or a small group of committed people to change the world. In fact, it is the only thing that ever has.”
- Florence Nightingale was an advocate for all people and stated in 1856 that “Everyone, everywhere deserves to heal and be well.”

These women were onto something. Now we know through the evidence that there are significant health reasons to volunteer, to give of yourself for the betterment of the community and society-at-large. The physical health benefits are an increase in longevity, happiness, relationships, self-esteem, sense of mastery, strength and well-being and a decrease in physical impairments. The mental health benefits are improved cognition, significant decrease in mortality, stress, and depression.

Knowing that, there is a fine line between volunteering too little and too much. No more than 10 hours per month is recommended to avoid risk of the volunteering becoming another task or job, which increases stress and depression.

Medical Service Trips are and have been very popular among healthcare providers. With the exception of Antarctica, MSTs have been conducted on every continent. Most of the trips have been conducted in Africa, South and Central America, and southeast Asia. The financial magnitude is significant with mean cost of \$20,000 to \$40,000, and an average of 225,000 surgical and other procedures conducted per year.

Healthcare providers participate for multiple reasons. Some of the major reasons is provider shortage, to promote diplomatic relations, religious or spiritual, and personal and professional development. Individuals who volunteer and or conduct medical service trips are emotional benefits, personal connections, and feelings of value or being useful.

On a personal and professional note, I have been conducting medical service trips for over a decade in San Pedro Sula, Honduras and recently in Hanoi Vietnam. As a foot and wound care nurse and community health associate professor, my service revolves around foot and wound care rounds, education, and developing policies, protocols, and procedures for

institutions taking care of wounded patients. As a nurse focused on global health and the global burden of disease it is natural to provide simple interventions that can have an enormous impact on health care in LMIC.

In Anchorage, I lead a team of faculty, students, and community providers to offer a sustainable foot and wound care clinic for the homeless. By partnering with Central Lutheran Church, Beans Café, Brother Francis Shelter and Anchorage Faith and Congregations Together (AFACT) we have offered this grant supported activity for four years.

The impact has been on the faculty involved, students who participate, and community members who volunteer. The project is now replicated in other areas of Alaska and with other vulnerable populations. Offering a sustainable foot and wound care clinic that can be replicated is a Win-Win-Win for all. Faculty and students learn through interprofessional service-learning, community partners are facilitating care for community members through community-engaged projects, and recipients of care are receiving much needed physical, emotional, and psychological care.

Medical service and volunteering have enormous physical and mental health benefits. If you would like more information please contact me at [mrburdettaylor@alaska.edu](mailto:mrburdettaylor@alaska.edu) or 907-330-9928 (mobile for text or call).

CONTINUED FROM PAGE 7

Thank you to all who attended the 7th Annual Trending Topics in Nursing Conference! Be on the lookout for a 2020 Save-The-Date – we hope you’ll join us for another great year! If you would like to receive sponsorship information for next year’s conference, please contact our office.



# 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.

## AFTER HOSPITAL DISCIPLINE, NURSES REFUSE TO BE SILENCED

Jennifer Donaldson wanted to update nurses at the University of Cincinnati Medical Center about ongoing negotiations over nurse recruitment and retention, so she launched a six-minute Facebook Live video during a break from her job as a labor and delivery nurse. Even though she was exercising her legal right to communicate with members of her union, Donaldson was fired. Michelle Thoman, a medical-surgical nurse at the hospital was not on duty that day but, acting in a union capacity, helped Donaldson record the video. Thoman received a final written warning for her participation. Before this incident, neither nurse had prior disciplines on their record. The Ohio Nurses Association says the discipline was unlawful and an attempt to silence the union's voice. The nurses say the medical center's actions to stop their momentum are alarming be-

cause their advocacy is focused on positive changes to the hospital. The tactics employed by the hospital have only added fuel to the fight.

Check out how the nurses are fighting back: [www.aft.org/news/after-hospital-discipline-nurses-refuse-to-be-silenced](http://www.aft.org/news/after-hospital-discipline-nurses-refuse-to-be-silenced)

## VICTORY FOR STUDENTS AND EDUCATORS IN CHICAGO

In 1995, Chicago educators were stripped of their bargaining rights and their voice to affect learning and teaching conditions. The city's students, especially minority and special needs students, lost resources and even some neighborhood schools as a result. Fighting to make up those losses, the Chicago Teachers Union, AFT Local 1, went on strike in October. After 11 days on strike, the CTU won a new contract which secured historic victories for Chicago students and educators – including a nurse and a social worker assigned to every school with a staffing



pipeline that covers \$2 million in tuition and licensure for nurses.

Learn what this contract means for Chicago students: [www.aft.org/news/tentative-agreement-provides-path-real-change-chicago](http://www.aft.org/news/tentative-agreement-provides-path-real-change-chicago)

## WASHINGTON STATE NURSES VOTE TO AUTHORIZE STRIKES

After a year of negotiating without contracts, registered nurses at two hospitals in Washington state have voted to authorize strikes. Nurses at Providence Sacred Heart Medical Center in Spokane held their vote Oct. 24 and 25, and nurses at Kadlec Regional Medical Center, a Providence-affiliated system in Richland, voted on Oct. 29 and 30. The nurses, who are represented by the Washington State Nurses Association, object to Providence's plan to cut their benefits even though the multistate nonprofit hospital system is collecting record profits and giving extravagant raises to executives. They also want Providence to commit to safe staffing and improved working conditions that will allow them to give the very best care to patients and their families.

See one Sacred Heart RN's journey to becoming active in her union: [www.wsna.org/news/2019/my-journey-to-becoming-an-active-member-in-wsna](http://www.wsna.org/news/2019/my-journey-to-becoming-an-active-member-in-wsna)

## AFT CIVIL RIGHTS CONFERENCE INSPIRES ACTION

Surrounded by Montgomery, Alabama's rich history of civil rights, participants at the AFT Civil, Human and Women's Rights Conference Oct. 18-20 pledged to persist in the fight for equity, justice and democra-

cy—for everyone, including and especially our most vulnerable populations. "We are on hallowed ground," said AFT President Randi Weingarten, addressing a crowd of demonstrators at the Alabama state Capitol building. "While we stand on the shoulders of giants, we must not just stand. We must show up, we must fight, we must care and we must vote. ... While none of us can do everything, every one of us must do something."

Read more about the conference: [www.actionnetwork.org/petitions/keep-the-promise-of-public-service-loan-forgiveness/](http://www.actionnetwork.org/petitions/keep-the-promise-of-public-service-loan-forgiveness/)

## OREGON NURSES USE COMMUNITY SUPPORT TO WIN CONTRACT

Nurses at Columbia Memorial Hospital in Astoria, Ore., successfully reached a tentative contract agreement with hospital administrators in October. The agreement came after months of negotiations, an informational picket, a community town hall and a rally supported by the Oregon AFL-CIO. The Oregon Nurses Association represents the 135 registered nurses at CMH. The nurses say it was the strong community support that helped their efforts. "We could not have reached this deal without the overwhelming support of our community," says Kelsey Betts, a registered nurse at CMH and ONA negotiations chair for the bargaining unit. "This contract is a big step up. It helps ensure CMH will continue to be staffed with skilled nurses, especially as the hospital looks to grow in the coming years."

Here's how the nurses gained community support: [www.aft.org/news/aft-volunteers-return-us-virgin-islands-year-and-half-after-devastating-hurricanes](http://www.aft.org/news/aft-volunteers-return-us-virgin-islands-year-and-half-after-devastating-hurricanes)





# MEMBERS PASS RESOLUTIONS FOR COMING YEAR AT 2019 GENERAL ASSEMBLY

Members of the Alaska Nurses Association who attended our General Assembly on October 12th introduced and passed resolutions during the annual membership meeting. The members' resolutions act as a guide for the Alaska Nurses Association's programs, outreach, advocacy, and priorities over the coming year. The following are selected portions of impactful resolutions passed by AaNA's membership during the General Assembly, and complete resolutions are available to read at [www.aknurse.org](http://www.aknurse.org).

## Resolution to Expand Professional Membership to LPNs

AaNA recognizes the vital role of LPNs in providing quality patient care to Alaskans, particularly to some of our most vulnerable populations in a wide variety of practice areas such as long-term care and community-based settings.

AaNA will expand our professional association membership to LPNs and will work to actively recruit LPN members in order to build a stronger nursing community.

## Resolution to Support Just Culture in Healthcare

AaNA opposes the criminalization of errors in healthcare and supports the concept of "just culture," which is a fair and open learning culture oriented toward constant improvement and recognition of system failings in order to improve patient safety.

AaNA supports a full and confidential peer review process in which errors can be examined so that both system improvements and corrective and educational interventions can be established to mitigate errors in healthcare.

## Resolution to Address the Student Debt Crisis

AaNA will prioritize combatting the student debt crisis to help our members, their families, and communities through methods including providing student debt clinics to educate our members about income-driven repayment plans and Public Service Loan Forgiveness, bargaining for student debt relief and tuition assistance, supporting policy and pro-

grams that reduce and eliminate student loan debt, and advocating for the protection and expansion of federal student loan debt relief programs.

## Resolution to Oppose Nurse Licensure Compact Legislation in Alaska

AaNA affirms our position that licensure for nurses working in Alaska should be under the jurisdiction of the Alaska Board of Nursing.

AaNA will intensify our efforts to educate Alaskan nurses, legislators, and the public on the dangers of joining the Nurse Licensure Compact and will mobilize our members in opposition to Nurse Licensure Compact legislation in Alaska.

## Resolution to Educate Alaskans to Stop the Bleed

AaNA will support the goals and national implementation of the Hartford Consensus, which aims to train every American in basic bleeding control techniques through the American College of Surgeons' 'Stop the Bleed' curriculum and place bleeding control kits in every public venue.

AaNA will encourage all nurses to complete the Stop the Bleed curriculum and will encourage nurses to take a leadership role (including becoming instructors) to help deliver the course to every member of the public in Alaska in order to stop life-threatening bleeding and save lives in our communities.

## JOIN US!

ENRICH YOUR OWN LIFE AS YOU  
HELP OTHERS IMPROVE THEIRS



**1st Choice Home Health Care** is dedicated to providing compassionate, high-quality home healthcare.

Caring for our team is as much of a priority as is delivering fine healthcare to our community and we are always looking for exceptional employees to join our team.

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1st Choice Home Health Care, Inc is a locally owned and operated Alaskan company that was started in 1995. It is a Medicare certified home health care agency offering a broad range of services to individuals of all ages. The office is located in Soldotna, Alaska and serves Kenai, Nikiski, Soldotna, Sterling, Cooper Landing, Kasilof, Clam Gulch, and Ninilchik areas.

Members Meeting: **Connect - Reconnect - Join**

# RSVP



Theta Omicron Chapter

by January 10, 2020

**Anchorage Membership Meeting**  
BP Energy Center - Brunch  
10 am-12pm • January 18th, 2020

**Fairbanks Membership Meeting**  
Venue - Brunch  
514 2nd Ave  
10am -12pm - February 1st, 2020



Please indicate which event you plan to attend and include current email address when signing up.

If you have any questions, email: [sfcamasi@alaska.edu](mailto:sfcamasi@alaska.edu)  
We hope to see you there!

# Questions & Answers: Knee Replacement Surgery by Dr. George Rhyneer and Dr. Mark Caylor



AS WE GET OLDER, AND OUR FRIENDS AND FAMILY AGE, WE ENCOUNTER PEOPLE CONSIDERING JOINT REPLACEMENT SURGERY. WE MAY EVEN CARE FOR THEM IN THE HOSPITAL OR AS AN OUTPATIENT. MANY PEOPLE TURN TO US FOR ANSWERS. FOR THOSE OF US WHO DON'T WORK REGULARLY IN ORTHOPEDICS, WE OFTEN HAVE QUESTIONS.

HERE, THE ORTHOPEDIC SURGEONS AT RHYNEER CAYLOR CLINIC PROVIDE ANSWERS TO COMMON QUESTIONS ABOUT KNEE REPLACEMENT SURGERY.

## Q WHAT CAUSES THE NEED FOR KNEE REPLACEMENTS?

A. Knee replacements are needed most often due to damage of the knee joint from arthritis – such as degenerative/osteoarthritis which is really just thinning of the cartilage due to age, wear and tear. There are also inflammatory types of arthritis such as rheumatoid arthritis, or post-traumatic arthritis due to injuries from previous fractures or even old ACL tears.

The knee replacement improves motion in the knee and decreases pain thereby improving and maintaining function and a healthy active life.

## Q WHAT CAN BE DONE FOR ARTHRITIS BESIDES SURGERY?

A. Before surgery is considered, we most often recommend non-surgical options. Walking is great for arthritis. Also, other modalities include losing weight to take the stress off the joint, physical therapy, medications like anti-inflammatories, steroid injections, or lubricating injections (such as Synvisc and Euflexxa). Simple arthroscopic surgery for most degenerative/arthritic conditions has been proven not to improve patients long-term, so in general, that is not an option.

## Q HOW DO YOU KNOW WHEN IT'S TIME TO MOVE ON TO SURGICAL REPLACEMENT?

A. When pain, stiffness, or inflammation of the knee limits patients' daily activities—such as walking and using stairs despite the above measures—surgery is usually the next step. We want to perform surgery before contractures and other negative consequences of decreased mobility set in.

Surgery is also recommended when the leg begins to bow at the knee (a varus deformity is more common than a valgus one) as this is a marker of progressive disease.

The goals of knee replacement are to relieve pain, improve knee function and improve quality of life.

## Q WHAT ARE THE TYPES OF KNEE REPLACEMENTS?

A. We generally classify knee replacements into 3 different types:

- 1. Traditional Total Knee Replacement, also known as "total knee arthroplasty" or "TKA."** This is the classic approach that uses a traditional 8-10 inch incision in the middle of the knee that has decades of good outcome studies.
- 2. Partial Knee Replacement, also known as Uni-compartmental Knee Replacement.** This type of replacement is used when only one of the 3 compartments of a knee is worn out. It requires a smaller incision and may offer a quicker recovery. We personally use the Oxford Uni Knee. A partial knee replacement cannot be used in certain situations, but the orthopedic surgeon can let the patient know if he or she is a candidate.
- 3. Knee Replacement Revisions.** These are done for a previous knee replacement that has loosened or worn out, become infected, become unstable, or when there is a fracture of the bone around it. This is a longer, more complex surgery.

## Q HOW LONG DOES IT TAKE TO PERFORM THE SURGERY?

A. From the time an incision is made to the time the incision is closed varies but is approximately 1 hour, unless it's a revision which is approximately 2 hours.

## Q HOW LONG BEFORE PATIENTS CAN WALK?

A. We have our patients up standing or walking with a physical therapist within the first 24 hours.

## Q HOW LONG DO PATIENTS NEED TO STAY IN THE HOSPITAL?

A. Patients often stay overnight for one night, though many go home the same day.

## Q WHAT ABOUT THE PAIN?

A. Narcotic pain medication is often needed for the first week.

## Q HOW LONG IS THE RECOVERY TIME?

A. A gradual progression of mobility and return to full walking occur with a physical therapist. Most patients are back to semi-normal activities in 8-12 weeks, and more active

lifestyle after 3-6 months. Everyone is different and a slower progression is not bad. We look for a general trend of improvement. That is what matters.

## Q HOW LONG DO KNEE REPLACEMENTS LAST?

A. Knee replacements usually last 12-15 years with usual activities, and the newer plastic materials are often lasting longer.

## Q WHAT ARE THE MOST COMMON COMPLICATIONS OF KNEE REPLACEMENTS?

A. Complications include those seen in other surgeries, such as infection, bleeding and blood clots. There are precautions taken to reduce these risks such as varying methods of blood thinners. Each surgeon does it slightly differently as the literature supports a wide range of strategies.

Other complications seen specifically with knee replacements are less common but include prolonged stiffness of the joint (which usually improves with ongoing PT), fracture, malalignment, and peroneal nerve palsy. The latter being more common among patients with diabetes, rheumatoid arthritis, and with severe valgus deformity though still very rare.

CONTINUED ON PAGE 16

# REGISTERED NURSE OPPORTUNITY

RN employment opportunities in Medical Detox and RN Case Management  
for Primary Care, Pediatrics, OB-GYN, and Nurse Family Partnership.

Sign-on Bonus | Relocation Assistance

SCF Recruitment | 888-700-6966  
SCFHRRecruiters@southcentralfoundation.com  
www.southcentralfoundation.com/nursing-opportunities/



Southcentral  
Foundation

*Alaska Native People Shaping Health Care*



**Q WHAT CLINICAL NURSING TIPS DO YOU HAVE?**

**A.** We like to see that the patient gets out of bed every hour for a few minutes and move around. This starts within hours of one's surgery. They can walk the first day and definitely post-op day one. We have PT to assist for longer periods of ambulation. TED hose above the knee is often used for the first week as well.

You may see use of continuous passive motion (CPM) machines, though several studies show that the use of CPM machines after knee replacement do not make a difference in outcomes. Many surgeons no longer routinely use these post-op.

**Q WHAT IS NORMAL IN TERMS OF DRAINAGE FROM THE SITE?**

**A.** The first 1-2 days there will be bloody serous fluid. This is normal. It often can last up to a week. If it lasts longer, then we grow a bit concerned, especially if it goes on more than 10-12 days or so.

**Q WHAT SHOULD NURSING DO IF THERE IS ACTUAL BLEEDING FROM THE SITE?**

**A.** In addition to notifying the surgeon and reinforcing the dressing, cutting back on ambulation can reduce bleeding. Putting the patient back in a knee immobilizer for up to 48 hours often is enough to help seal the bleed.

**Q WHAT DEGREES OF FLEXION SHOULD WE BE AIMING FOR?**

**A.** While we often aim for 90 degrees of flexion in the first week, it's not as important as once thought. We really like to see 45 degrees over the first 2-4 days. Forcing early range of motion too fast can sometimes just increase inflammation and cause increased unnecessary pain and a setback.

**Q IF NURSING NOTES A NEUROLOGIC CHANGE, SUCH AS FOOT DROP, WHAT SHOULD BE DONE?**

**A.** Call the surgeon, loosen the dressing, and put the knee in a small amount of flexion. Sometimes it could be the result of a nerve block so anesthesia may need to be notified.

Knee replacement surgeries are some of the most satisfying surgeries we perform because patients are so grateful for reclaiming their quality of life. We are happy to have well-informed and clinically astute nurses as part of our team.

# 60 hours for 2020 and the American Red Cross, Disaster Health Services



BY JENNIE L. SCHRAGE RN, DISASTER HEALTH SERVICES, REGIONAL ADVISOR/ALASKA NATIONAL NURSING NETWORK, REGIONAL ADVISOR/ALASKA

You hear and see it on the news. Wildfires, home fires, floods, tornados, earthquakes and the Red Cross is there, delivering our mission to "alleviate human suffering in the face of emergencies by mobilizing the power of volunteers and the generosity of donors." What does Red Cross - Disaster Health Services do and who are we?

Disaster Health Service volunteers utilize their skills in unique ways while working with disaster survivors. This includes assisting clients with navigating the healthcare delivery system to replace medications, durable medical equipment or consumable medical supplies. We Disaster Health Services volunteers utilize our assessment skills to perform health assessments on clients and then provide hands on care if necessary and/or guidance on the next steps for a client to follow. Hands on care might involve assisting the client with activities of daily living, wound care or education on client self-care. Providing education about specific disaster-related client protective measures is a large part of the Disaster Health Services role as well. And, we support individuals with disabilities and functional access needs and supplement the community healthcare delivery system if needed.

Our work space varies with the situation. At times we work out of Red Cross offices, other times from home, supporting clients via telephone or wherever disaster survivors or Red Cross responders are. That could be in Shelters, emergency aid stations, community outreach and home visits. The Red Cross model for delivering Disaster Health Services (DHS) is a RN-led model. All clinical activities should be supervised by those with an

active, unencumbered RN license.

We are RNs, Licensed Professional Nurses (LPNs), and Licensed Vocational Nurses (LVNs) with full scope of practice. Other health professionals are welcome to join the DHS team; those include APRNs, NPs, PAs, EMTs, MD, DOs. Nursing Students and CNAs can volunteer under certain circumstances.

There are both local and national opportunities for DHS team members.

Locally you can provide Disaster Health Services support to disaster survivors in your community, participate in community preparedness activities such as the Home Fire Campaign and help build and strengthen local community partnerships.

If you can travel, you can deploy to a national disaster response through your local chapter or region.

## RED CROSS NURSING

A Professional Activities hours opportunity for Alaska Nurses.

Alaska Nurses who have or are planning to renew their license with 30 contact hours of continuing education and 60 hours of Professional Activities, Disaster Health Services volunteer hours meet the criteria for Professional Activities as per the Board of Nursing.

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[ so it won't stop you ]

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 Will you help Alaska women by reminding them to get their regular breast and cervical cancer screening?

Alaska Breast and Cervical Services

## FAQs

### Are the required training courses eligible for CEUs?

Not at this time. Training courses are free and most are web-based online.

### What is the time commitment?

There is no required time commitment. You decide how much time you can give.

If this is not a good time for you to volunteer with the Red Cross, remember that if there is a significant disaster in your local community, you may also be able to volunteer with the Red Cross for as little as a day or two as an Event Based Volunteer.

### How would volunteering affect my job?

You let the Red Cross know when you are available so your job does not need to be affected. You decide when and if you can take time for local involvement or a national deployment.

### How do I sign up?

Follow the below steps to join the Red Cross Disaster Health Services team:

- Visit [redcross.org](http://redcross.org)
- Click Volunteer, then click Apply Now to create a Red Cross ID
- Complete a volunteer application
- Respond to contact from your local chapter and discuss DHS volunteer options
- Complete Red Cross Disaster Health Services training courses

### How does Red Cross know who renews their license with 30 contact hours of continuing education and 60 hours of Professional Activities?

- We don't. Currently there is no data base with that information. We rely on word-of-mouth and referrals of friends and colleagues. Pass it on.



**BECOME A RED CROSS NURSE FOR DISASTER HEALTH SERVICES. IT'S A WIN-WIN FOR YOU AND FOR THE RED CROSS MISSION.**



## The Nurse Licensure Compact: A Bad Fit for Alaska

By ANDREA NUTTY, AANA PROGRAMS DIRECTOR

After looking closely at the Nurse Licensure Compact pros and cons, the Alaska Nurses Association strongly feels that the compact would be a bad fit for Alaska. At first pass, joining the compact might sound like a great idea, something that would bring more nurses to our state to practice and fill the open jobs in communities in need. After a closer look, we've broken down some key reasons why staying out of the compact will make Alaska a better and safer place to give and receive healthcare.

### What is the Nurse Licensure Compact?

The Nurse Licensure Compact was created by the National Council of State Boards of Nursing, a private, non-regulatory, non-governmental trade association. The compact acts as a multistate license, allowing nurses licensed in compact states to practice in all other compact states under one license. If Alaska became a compact state, anyone licensed in other compact states could practice here without obtaining a separate Alaska license. Sounds like an intriguing idea, right? Let's take a closer look at why this could actually be a bad idea for Alaska, Alaskan nurses, and Alaskan patients.

### Loss of state sovereignty

Under our current system, local experts right here in Alaska get to make local decisions that are best for our state. Under the compact, Alaska would lose the ability to establish rules that cover all nurses working in the state. This means that nurses operating under the compact license wouldn't have to abide by all of the rules and regulations set forth by our state, which weakens our standards overall. These lowered standards for nurses will result in worse care for patients.

Imagine going to work and realizing that you and your coworker are working under completely different sets of expectations. It would make it hard to get the job done or know what you need to do. One example of this is in the scope of practice that various states allow their nurses. Each state has its own Nurse Practice Act that defines what a nurse can or cannot do. In Alaska, registered nurses cannot dispense medication or perform examinations. Every nurse in Alaska has to be familiar with these rules. Under the compact, there would be no way to enforce or verify that compact nurses are aware of these practices, causing needless confusion and disagreement for nurses working side by side caring for a single patient.

Bottom line, there's no question that Alaskans know what's best for Alaskans. Handing over important decisions to out-of-state agencies is not what's best for our state.

### Threat to public health and safety

This is a big one. The purpose of the Alaska Board of Nursing, which currently administers Alaska nursing licenses and oversees regulations, is to protect the health and safety of Alaskans. Under the compact, we would

have no way of tracking or monitoring nurses who come into our state to work.

Past experience shared by the Alaska Board of Nursing tells us that it is not uncommon for nurses to try to come practice in Alaska. To date, the Alaska Board of Nursing has been able to use its ability to enforce Alaska's high standards for quality nurses and to deny licenses to unqualified nurses. Allowing nurses from other compact states to practice here means we lose the ability to enforce those high standards.

One of the most important functions of the Board of Nursing is to investigate complaints for nurses working in the state and take action on a nurse's license if there's been unsafe or inappropriate conduct. Under the compact, Alaska would have to investigate complaints for all nurses working here, regardless of where they are licensed, but wouldn't have the ability to discipline compact nurses. Instead, issuing discipline would be left to the nurse's home state, and there are worrisome inconsistencies between states in relation to how discipline is handled:

- Each state has different criteria for disciplinary action.
- Each state is able to make its own case-by-case determination of whether a criminal misdemeanor conviction is related to the practice of nursing, and to decide whether – and what type of – disciplinary action should be taken.
- Felony offense statutes are not standardized across states. What constitutes a misdemeanor in Arkansas may arise to the level of a felony under Alaska law, yet the State of Alaska would no longer have the ability to bar that nurse from coming to Alaska and caring for patients in our state.

In fact, we decided to do some research to see just how differently states treat discipline for nurses. We looked for similar cases – where a nurse was accused of patient abuse – in three states. Here's what we found:

- In State #1, a nurse was angry, raised her voice, and spit at a patient. The nurse received a public reprimand, was ordered to complete additional education within 30 days, paid a \$3,000 fine, and had her license put on probation for one year. This discipline was issued just 2.5 months after the incident.
- In State #2, a nurse pushed an elderly patient to the ground. The nurse received a public reprimand and was ordered to complete additional education within 6 months. The nurse did not pay a fine, and their license was not put on probation or suspended. This discipline was issued 12 months after the incident.
- In State #3, a nurse placed a disabled toddler in

CONTINUED ON PAGE 21

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# Accidents Happen:

## Tips on Surviving Your Child's Fracture

By ANDREA NUTTY, AANA PROGRAMS DIRECTOR

I'll admit it. Until very recently, I had no idea what I was going to write about for this issue of The Alaska Nurse. Then, with such convenient timing, I found myself immersed in the orthopedic world. You see, my 8-year-old son decided to sign up for an afterschool basketball program that was starting up at his elementary school. Great: a new sport! I am all for anything that will keep my son physically active, particularly in the winter when more of our time is spent indoors.

As my son strolled out the school doors on the afternoon of his first practice, I noted that he looked upset. When he got into the car, I asked him what was wrong. He didn't want to talk about it. After a bit of prodding, he told me that he twisted his ankle during basketball.

My son suffered a Salter-Harris Type I physeal (growth plate) fracture of his distal fibula. This type of fracture separates the bone end from the bone shaft and completely disrupts the growth plate. In adults, the ligaments are the weakest part of the ankle, and so a twisted ankle often results in a sprain. In children however, the ligaments are strong and the physis, which has not ossified, is the weakest point – making a fracture more likely than a sprain.

Many parents have been in my shoes before; childhood fractures are common, with one recent study putting the overall childhood fracture incidence at just under 1 in every 5 children. So, since it seems the odds are good that something bad (a fracture) will happen, here's a few tips from my family to yours so you can survive (with your sanity mostly intact) when your kid is stuck in a cast:

### 1. Don't wait to get medical attention

Sometimes, fractures aren't obvious. Also, fairly or unfairly, nurses have earned a reputation for not always being johnny-on-the-spot to get medical care. If it's not bleeding and you're still breathing... When my son broke his ankle, I didn't take him to get checked out until the next day because I wrongly assumed he had a mild sprain. Physeal fractures in particular need to be taken care of promptly because they carry a risk of problems with future growth. And since soft growth plates tend to heal very quickly, that means physeal fractures can very quickly heal incorrectly if not addressed right away. So err on the side of caution and get your child's injuries looked at right away.

### 2. Crutches are great, but get a wheelchair, too

What does Halloween have in common with waxy drug store floors? A wheelchair is needed. My son's fracture happened just two days before Halloween, and I knew there was no way we were hitting all the houses on the block for trick-or-treating with him on crutches. So I rented a wheelchair, decorated it with cobwebs and flashing lights, and spent the evening collecting Halloween treats and some extra sympathy candy. But the wheelchair came in handy for more than just that! A week later, while at a drug store, my son's crutches flew out from under him and he crashed to the ground. Twice. The culprit? Extra waxy floors, a hazard I'd never had to consider prior to having a mobility-challenged child. You can bet the next time we stopped in, we used the wheelchair. Using crutches can be tiresome, especially for younger kids, so we ended up using the wheelchair for trips to the grocery store and some family outings as well.

### 3. A hair dryer is your new best friend

It turns out that hair dryers become quite useful multi-purpose tools when you have a kid with a cast. Casts can cause itching, which can often be relieved with gentle tapping. But if that doesn't work, trying using a hair dryer to blow air into your kid's cast. Another problem with kids in casts is that they are notorious for managing to get their casts wet. My first tip is to simply place the entire child in a large plastic bag for the duration of their fracture treatment, but if they won't comply... you're going to need that hair dryer. My son, who I believe must be secretly training for the crutch speed racing Olympics, managed to trip and dip his casted foot into a rain puddle, soaking the bottom of it. I spent half an hour slowly drying his cast in order to make him more comfortable until we could get a replacement cast the next day. This technique can also be used if a cast gets only a few drops of water on it. Just remember to keep the hair dryer on the cool and low settings in order to avoid burns.

### 4. Modify activities

A fracture can be a real bummer for kids, as it might mean the end of a sports season, having to temporarily give up a favorite hobby like drawing or playing piano, or not being able to participate in a classmate's birthday

party at the trampoline park. But a broken bone doesn't have to equal boredom. Work with your child to figure out modifications or alternate activities they can still participate in. Can't play basketball? Become the coach's helper. A broken dominant hand? Host a family competition to see who can draw the best (and worst) picture with their non-dominant hand. Need to stay inside to escape the rain or snow? It's okay to be a temporary couch potato. Time for movies, books, word searches, and board games. Sitting at a table can be difficult for some injuries, so have a family picnic on the floor or deliver breakfast in bed.

### 5. Stock up on supplies and comfy clothes

Dragging a kid with a broken limb around to run errands can be a total pain – for the child and the parent. Try to plan ahead so you have to make as few trips to the store as possible. There are a few items every parent should have on hand to make life with a broken bone easier. First: baby wipes. Showering or taking a bath can be difficult with a cast, so baby wipes and washcloths will serve a vital role in keeping your kid clean while minimizing the chance of getting the cast wet. Comfy, loose clothes

are also a must. Many of my son's pants were not loose enough to fit over his cast, so we got a couple pairs of oversize sweatpants from the store. Zip-up tops and sweatshirts can work wonders for arm casts, and slip-on or Velcro shoes make life much easier for kids with leg casts, as bending down to tie shoes is sometimes impossible. A final purchase: get a lap desk so your child can rest comfortably while completing homework, making arts and crafts, or playing with small toys. These can often be found at large retailers, craft stores, and online for \$10 to \$20.

### 6. Be patient

With a kid in a cast, everything – from getting dressed to school pickup to getting in and out of the car to setting up an activity – will take much longer. Breathe and be patient. Many children become whinier and clingier during their recovery time, which is draining for parents. Breathe and be patient. Lean on friends and family if you can so you can grab groceries alone or take time to recharge. Then breathe, be patient, and be content with the knowledge that this is only temporary.

CONTINUED FROM PAGE 19

scalding bathwater, causing severe burns to the patient. The toddler died two days later. The nurse was originally charged with second-degree murder, but eventually reached a deal to instead plead guilty to felony assault and serve four years in prison. The nurse did not receive any discipline for this incident, continuing to hold an unencumbered license that eventually lapsed without license action being taken.

In addition to concerns about disciplinary action and criminal offenses, we have concerns about the nursing education programs and continuing education requirements for compact nurses. Of course, the Nurse Licensure Compact does have minimum licensure requirements, but they are less stringent and robust than Alaska's requirements, which were set in place by our policymakers who determined what was necessary to protect the public. Alaska requires nurses prove their continued competency to renew their license by making sure they complete continuing education, continue to work as a nurse, or spend time using their nursing expertise to volunteer.

Many states do not have these renewal requirements. Alaska requires that nurses have graduated from a nationally accredited school, the compact does not. This means that under the compact, Alaskans could be taken care of by new nurses who have received subpar education and have little hands-on experience with patients.

### Loss of revenue and increased burden to Alaska nurses

Since compact nurses working in our state wouldn't have to pay for an Alaska license, the Alaska Board of Nursing would see a significant loss of revenue, making it harder for it to carry out its duties and potentially forcing it to increase Alaska licensing fees, already among the highest in the nation. Calculations show that fees would increase by \$46-\$83 at renewal periods for Alaska nurses.

### Compact will not solve workforce needs or improve access to care

On the surface, it seems like joining the compact would bring a flood of nurses into the state, but it is important to note that there is no evidence to suggest that joining the

compact would bring more nurses to Alaska. The nursing shortage is not a uniquely Alaska issue and joining the compact will not suddenly or magically create a pool of nurses to fill staffing vacancies at needy facilities. Nurses who want to practice here already do so because Alaska is a great place to work, and it's a dream travel destination for many. Licensing costs for travel nurses are covered by nurse staffing agencies and other employers, and the Alaska Board of Nursing is able to issue licenses in a timely manner, even expediting the licensing process if needed, or granting temporary licenses or courtesy licenses in times of emergent needs.

The Alaska Nurses Association remains committed to working with the Alaska Board of Nursing and others on effective regulatory measures that are workable and realistic, that offer real solutions, and that respect state sovereignty. None of this, unfortunately, describes the Nurse Licensure Compact. The compact would harm Alaskans. We can and must work toward better approaches that put Alaskans first.

# VOLUNTEER WITH THE DIVISION OF PUBLIC HEALTH!

Are you looking for volunteer opportunities to meet the recently changed continuing competency requirements for license renewal? Look no further than the Division of Public Health, Section of Chronic Disease Prevention and Health Promotion!

The requirement of professional volunteer activities changed this year, increasing from 30 hours to 60 hours now needed for renewal. There are three methods available to meet the renewal requirements for continuing competency, and you must complete at least two of the three methods: (1) 30 contact hours of continuing education, (2) 60 hours of participation in uncompensated professional activities, and (3) 320 hours of nursing employment. Regulation 12 AAC44.620 has the details as to how to document the professional activities to fulfill this option.

The opportunity for committed nurse volunteers exists at Division of Public Health, Chronic Disease and Health Promotion. If you have a strong passion in reducing the incidence or effects of cancer, diabetes, tobacco use, sugary drinks, and injuries while increasing the consumption of healthy foods, breastfeeding, and physical activity through constant policy work, Chronic Disease and Health Promotion would love for you to become a volunteer nurse with us. There are many professional activities to accomplish to move the needle on public health. Contact Dawn Groth at dawn.groth@alaska.gov or 907-334-5966 to inquire about your opportunities. We promise the work to be fun, engaging, and rewarding. Resume and completed application needed before you will be contacted.

## Calendar of Events

### AaNA

#### UPCOMING MEETINGS

<b>AaNA Board of Directors Meeting</b> 4th Wednesday each month	4:30-6pm	<b>RNs United of CPH</b> Contact for times: 907-252-5276
<b>AaNA Labor Council Meeting</b> 4th Wednesday each month	6-7pm	<b>KTN – Ketchikan Registered Nurses (PHKMC)</b> Contact for times: 907-247-3828
<b>Providence Registered Nurses</b> 3rd Thursday each month	4-6pm	

### Education and Events

#### Alaska Comprehensive Forensic Training Academy

In-person training session  
December 10-12, 2019 – Anchorage, AK  
alaskanurse.litmos.com/online-courses

#### AaNA's Holiday Open House

December 12, 2019  
AaNA Office – Anchorage  
Come out for festive treats, merrymaking & help wrap gifts to bless the homeless in our community!  
RSVP to chanti@aknurse.org  
www.facebook.com/AlaskaNurses

#### Mental Health First Aid

January 7, 2020  
BP Energy Center – Anchorage  
www.aktclms.org/training/class/103091

#### 2020 Sex Trafficking Conference

January 10, 2020  
BP Energy Center – Anchorage  
Earn 5.5 contact hours  
Pricelessalaska.org/event/2020-conference/

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

#### Caring for Victims of Violence with a Multidisciplinary Approach

January 8-9, 2020  
Featuring National & Local Experts  
Earn 14.0 contact hours  
Attend in-person or online!  
Anchorage, AK / Online  
Register at [uaa-coh.asapconnected.com](http://uaa-coh.asapconnected.com)

#### TUESDAY TALKS - Dementia and Delirium

Tuesday, January 21st @ 6 PM  
Presented by Nan Magrath, PGC, ANP, PMHNP-BC, CNS-BC  
AaNA Office – Anchorage  
Attend in-person or online!  
FREE CE: Earn 1.25 contact hours  
RSVP to chanti@aknurse.org  
www.facebook.com/AlaskaNurses

#### TUESDAY TALKS - Stop the Bleed

Tuesday, February 18th @ 6 PM  
Presented by Krista Ralls, BSN, RN, CEN, TCRN  
AaNA Office – Anchorage  
Attend in-person or online!  
FREE CE: Earn 1.25 contact hours

Want to list your event in The Alaska Nurse Calendar of Events and at [www.aknurse.org](http://www.aknurse.org)? Send information to [andrea@aknurse.org](mailto:andrea@aknurse.org)

# Read. Learn. Earn

We're pleased to announce that each issue of The Alaska Nurse will now include a free CE offering!

**READ** – Enjoy this issue of The Alaska Nurse

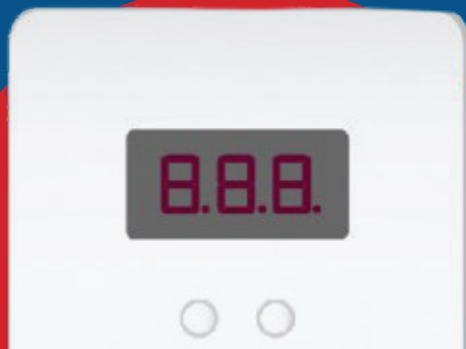
**LEARN** – Discover new information and gain knowledge

**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](http://alaskanurse.litmos.com/online-courses)) and find the CE offering for this issue (Dec. 2019 / Jan. 2020 – 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.



## Install and test carbon monoxide (CO) alarms at least once a month.

CO is called the “invisible killer” because it’s a colorless, odorless, poisonous gas. Breathing in CO at high levels can be fatal.

U.S. Fire Administration



FEMA



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