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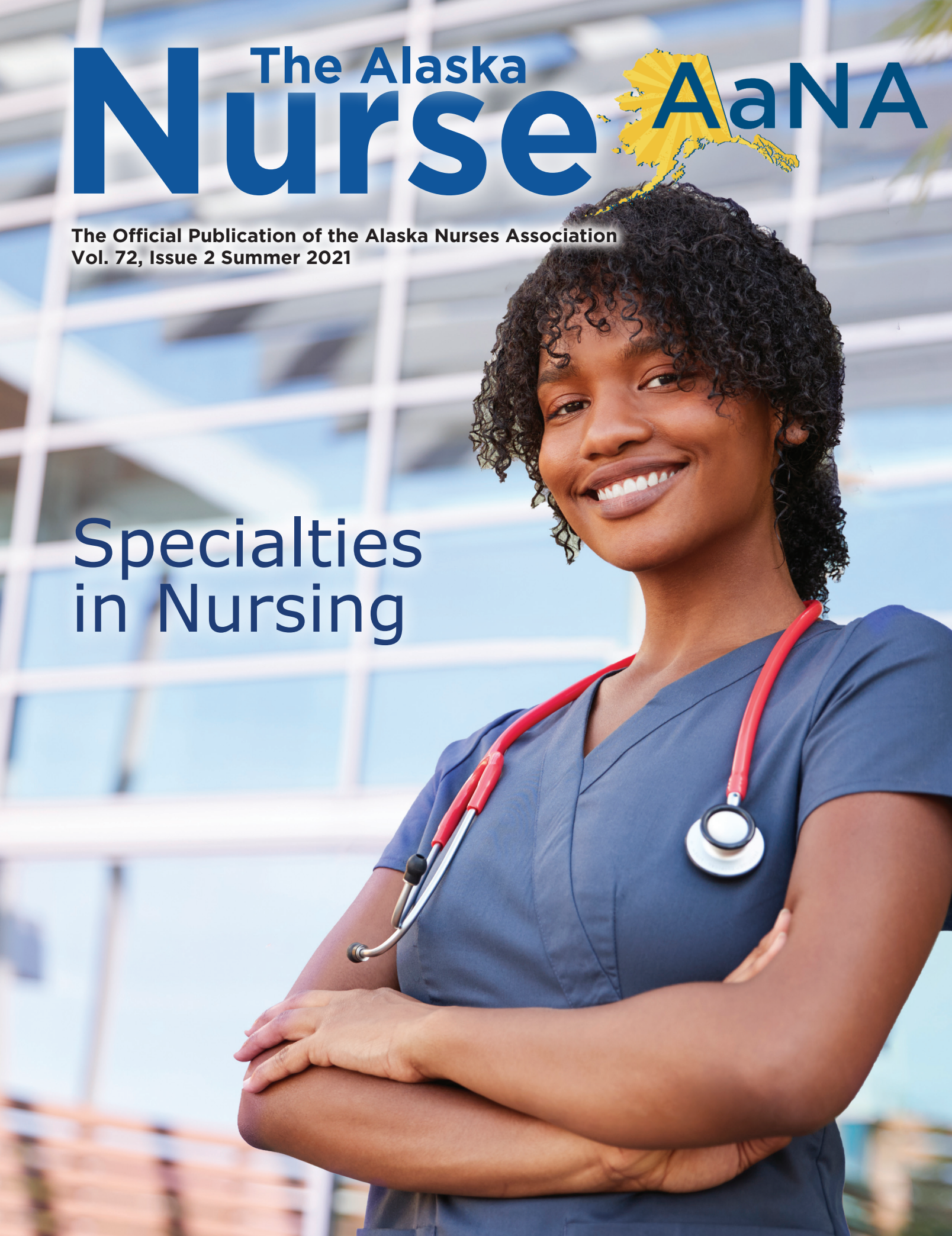

Specialties in Nursing

AaNA Alaska Nurses Association

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From our President

Spring has sprung with a bang! We got three feet of snow in the first two weeks of April, on top of the three feet already in my yard. I do love snow, but I was ready for spring! I did get more snowshoeing in however, up in Hatcher Pass. Spring snow up there and sunshine makes for a perfect day. I did get a little sunburnt though. My nose took a hit. I looked quite funny with that big, red peeling nose. I was thankful for once to have to wear the mask. It hides quite a lot.

Now it is May, and the snow is finally gone. The grass is green, the leaves have budded out, and the plants are in the greenhouse. I have transplanted my tomatoes, as well as the melons and cucumbers. Nothing goes in the ground until the week of Memorial Day. Our weather is just too unpredictable for me to plant anything sooner.

I have been out hiking in the local hills also. The trails are finally dry and the mountains are calling me. It's a good time to brush up on your wildlife safety skills. Be very bear aware! Make lots of noise while hiking so wildlife will get off the trail for you.

I know we are all drained by the pandemic, so it's super important to take some time to focus on you. Get some "me time" to reenergize yourself. During Nurses Week, I was able to take a step back at our Paint and Sip event. I'm not an artist by any means, and in fact, I don't find art relaxing at all. However, Glenys Mee at Palette Pop Up Art did an amazing job as our instructor and I actually had a lot of fun!

For our virtual Love a Nurse Run this year, my hiking tribe walked the Coastal Trail for 8.1 miles. All proceeds from the 5K went to the Foundation for Alaska Nurses, which works to uplift nurses, advance our profession, and make Alaskans healthier by providing educational scholarships and opportunities, supporting Nurse Honor Guard ceremonies, and taking on projects that help Alaska's nurses and patients. I hope all of you out there had a fun time running, biking, hiking, or just walking for the Foundation!

Warmest Regards,

Jane Erickson

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

In This Issue

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

A Career in **Nursing Informatics**

By Pamela Miljure, BSN, RN, MHA/INF

I have been a nurse for over 20 years. It has always been my passion to work in the medical field. After a year of trying the big city life at the University of Colorado, life events brought me back to Alaska where I found a great nursing program and began my career in the nursing field.

While attending the University of Alaska School of Nursing, I spent time with my young son and did my best to be a good role model to him. I spent a few summers participating in externships at the Alaska Native Medical Center to expand my network connections and gain some experience.

Upon graduation from nursing school, I took a few months off to have another child. While my peers were studying for the NCLEX and filling the jobs that I desired, I was enjoying the time with my family. The summer externship that I participated in right before graduation is where I found my first nursing passion: surgical services (OR, Day Surgery, Endoscopy, and PACU). I met a lot of great mentors and lifelong friends there and was grateful for the experience, as it would pave the way for the rest of my career.

When I was ready to return to work, I applied to a position in surgical services. I was hired as the very first new graduate nurse. Less than two years later, I became the Clinical Nurse Manager. During my time in this position, I was an integral player in the selection, design, build, and deployment of an electronic health record (EHR) in the surgical services department. Our department was the first in the organization to go electronic. I didn't know it then, but, this was the beginning of my career in informatics and I loved it.

After ten years in surgical services, I moved to a clinic within the same organization and continued to support the stand-alone EHR that I helped create. I worked with providers that performed procedures in surgical services so I maintained that connection. Three years later, the rest of the campus decided to implement an EHR to handle both inpatient and outpatient services. With my limited EHR experience and newly found passion, I became a super-user and helped train users in my department. From my very first EHR experience, I maintained network connections with those on the original team. I let them know that if they ever had a position on the informatics team that I would be interested.

Three years after the deployment of the campus EHR, it was decided that surgical services would move to the same vendor to allow for better integration of information. They posted a position for an analyst specifically tasked to build and deploy a new solution for surgical services. I knew this was what I wanted to do. I applied and was accepted as a clinical informaticist. After a year of build work and design decisions, we had a successful implementation.

I have participated in a few other surgery implementations, a long-term care solution, and a few other solutions that are integrated via interfaces or stand-alone systems. I enjoy coming to work every day because it is a constant learning experience. I maintain the solutions that I support, act as a general analyst to offer assistance for our support line, and participate with others to collaborate on how to optimize our system, workflows, and our ever-changing healthcare environment.

Nursing informatics gives me the satisfaction of making positive changes and knowing that I am making a difference. It allows me to stretch my innovative side to come up with different ways of doing things. Our organization is unique, as we support many other tribal health organizations on a shared EHR domain. This allows for a continuity of care for all patients within our healthcare system. To be a part of something so enormous can be overwhelming, but the benefits outweigh the potential complications that may arise from varying regulations, workflows, and site-specific needs.

Informatics is a fairly new field and unknown to many. It comes with many challenges and a huge learning curve for nurses coming from clinical practice. Experience in clinical care is a requirement, but the technical knowledge that is required to do this work has to be learned in most cases. Younger nurses are more tech savvy, but more experienced nurses are not accustomed to practicing under the technological advances that we have in our current healthcare system.

An informaticist has to be aware of the impact that any modifications to the system has on the entire system. There are change management processes and tape that we have to go through that can often be time-consuming and frustrating. We deal with the frustration from end-users (especially when they came from another EHR system that worked differently) and do our best to help them so that they can do their job. There are many regulatory issues to keep up with and to accommodate in any EHR solutions (e.g., CMS regulations, TJC for accreditation). There are global events (e.g., COVID-19 pandemic) that drive healthcare changes. When clinical care is impacted, the EHR team needs to be flexible, reactive, and quick to make the necessary change to positions, workflows, and documentation.

If a nurse is interested in moving to informatics, there are a few things that they can do to prepare themselves:

- *Gain some clinical experience and practice nursing skills before moving away from patient care.*
- *Develop some knowledge of how the EHR fits in with their clinical practice and how different applications within that EHR are integrated with one another.*
- *Take some classes specific to informatics to gain an overview perspective.*
- *Understand organizational structure. This helps in achieving organizational goals, but also in knowing how all the players fit together to attain success.*
- *Have some experience in leadership (project management inevitably becomes a part of life as an informaticist). Experience does not have to come in the form of official leadership positions. It can be leading a church group, rallying a group for a common cause, etc.*
- *Work on time management techniques such as task lists, delegation, and prioritizing.*
- *Be prepared to accept change and have the willingness to accept defeat when things don't go as expected.*

In conclusion, informatics is a highly rewarding career where change is inevitable (perhaps desired) and rewards are unrivaled. People often ask me if I miss direct patient care. My reply is this: I feel like I am able to make a greater impact in the position that I am in. There are reasons that our paths are chosen for us. We may not always agree with the trail taken to get to where we are. As nurses we are all in this for the same purpose: to help our patients and to make our healthcare system the best that it can be. I don't regret the path that was presented to me for one minute. I have had many "windows" opened after many "doors" have been closed. I go to sleep at night with a rich feeling of fulfillment. Informatics is a growing field and I would be happy to work with anyone who has the same desire for change and hope as I do.

ELECTROCONVULSIVE THERAPY
A New Treatment Option in Alaska

By Sarah Shuman, BSN, RN

There is widespread ignorance when it comes to electroconvulsive therapy (ECT). It's not just coming from the general population either. It's also coming from within the medical field. Studies have shown that the more one knows about ECT the more they are likely to support it, including nursing (Nestshilema, Khamker, & Sokudela, 2019). I would like to take this opportunity to educate the reader about ECT. How it helps as well as who it helps. I would also like to review the relevance of ECT to the Alaskan population.

What is ECT? Electroconvulsive therapy is a medical procedure that is used to treat severe psychiatric and neurological illnesses (Magid, Kellner, & Greenberg). It is used to treat major depressive disorder, bipolar depression, acute manic episodes, acute psychosis in schizophrenia, delirium, and motor symptoms in Parkinson's disease. In some cases, ECT is a first-line treatment for major depressive disorder (Nestshilema, Khamker, & Sokudela, 2019).

ECT is now a procedure that is done here in Alaska at Providence Alaska Medical Center (PAMC). Historically ECT was done in a designated suite, usually within a mental health facility (Lamont, Brunero, Barclay, & Wijeratne, 2011). More recently (2005) it has been done in an operating room suite in general hospitals. This allows a safer environment for an increasingly older population and adapts to the greater level of comorbidities that require a higher level of monitoring (Lamont, Brunero, Barclay, & Wijeratne, 2011). This also allows the patient to recover in a proper post-anesthesia care unit (Lamont, Brunero, Barclay, & Wijeratne, 2011). One of the downsides to this is the time that it takes to bring the patient from another floor to an OR suite. This has the potential to create a stressful environment for an already anxious patient.

"I absolutely believe that ECT works! I've seen severely depressed patients be able to get off medication completely. I've seen catatonic patients come back to living full lives!"

— Jennifer Hazen, ECT Nurse

Once the patient is in the room the patient is put to sleep using common general anesthesia agents. The patient is not intubated and is suppled oxygen using an oxygen mask. A blood pressure cuff is typically placed around the calf or ankle to prevent the muscle relaxant from reaching the foot. This allows the physician to assess for signs of seizure activity.

The placement of the electrode is dependent on the severity of the disease being treated as well as the diagnosis. The physician will choose either the right temple or top of the scalp. They have found less memory loss with this placement and are used in longer treatment plans (Magid, Kellner, & Greenberg). The bilateral temples are reserved for severe cases of depression (Magid, Kellner, & Greenberg). As well as shorter and more intense treatments. Memory loss is largely associated with ECT. The extent of memory loss can be controlled by electrode placement.

The relevance to this treatment is that people do not know ECT as a treatment option. With that said, people also do not know that ECT is safe. ECT is new to Alaska. The program has been up and running for the past 3.5 years and it's growing (J. Hazen, Personal communication, February 16, 2021). In 2018 Alaska reported a suicide rate of 25.3 per 100,000 (2017). With the national average being 13.5 per 100,000 (2017). This is a statistic that is listed as 'needs improvement' on the State of Alaska Health and Social Services website.

I am establishing the position on the need for more education on the topic of ECT. While yes, mental health is such a large portion of a nursing program. I only remember the topic of ECT being one that is skimmed over and not as informative as other treatment modalities. I recommend nursing programs take more time in introducing this topic and release the idea of this being seen in a negative way. When one hears about ECT all they can think of is Jack Nicholson in "One Flew Over The Cuckoos Nest." Let's as nurses, move away from this idea and move more into education and letting student nurses establish their own views of this treatment modality.

References

Hazen, J. (2021, February 16). Personal Communication [Email]

Lamont, S., Brunero, S., Barclay, C., & Wijeratne, C. (2011, February 11). Login. Retrieved February 10, 2021, from https://onlinelibrary-wiley-com.proxy.consortiumlibrary.org/doi/full/10.1111/j.1447-0349.2010.00725.x#b17

Magid, M., Kellner, C., & Greenberg, R. (n.d.). What is ect? Retrieved February 10, 2021, from https://www.isen-ect.org/educational-content/what-is-ect

Nestshilema, T., Khamker, N., & Sokudela, F. (2019, March 28). Mental health professionals' attitudes toward and knowledge about electroconvulsive therapy at Weskoppies Hospital, South Africa. Retrieved February 09, 2021, from https://onlinelibrary-wiley-com.proxy.consortiumlibrary.org/doi/full/10.1111/ppc.12330

State of Alaska Health and Social Services. (2017). Retrieved February 18, 2021, from http://dhss.alaska.gov/dph/HealthPlanning/Documents/scorecard/2017TrustScorecard.pdf

A Union of Professionals

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.

The moral imperative of healthcare

While the vaccination rollout offers hope, the pandemic continues to expose long-standing inequities in healthcare and accentuates the challenges faced by front-line providers. The new issue of AFT Health Care delves into the severe problem of moral injury among healthcare professionals, explaining what causes it, offering self-care strategies for providers, and discussing the long-term systemic changes necessary for patients and providers to thrive. Also in this issue: the importance of respectful maternity care for women of color, how clinicians can support health literacy and equity through improved communication, and the essential work of nurse practitioners.

Read the latest issue: www.aft.org/hc

AFT health professionals push OSHA for a COVID standard

The COVID-19 pandemic is the most challenging public health crisis the U.S. has seen in decades. In the last year, the pandemic has drastically impacted our members and their families, and our union has lost more than 300 members to COVID-19. For more than a year, nurses and health professionals have strived to provide care for patients while their hospitals and government safety watchdogs have made choices that put them at risk. Now, more help may finally be on the way.

Find out more: www.aft.org/news/afts-health-professionals-push-osha-covid-standard

Workplace violence bill gets new life

Health professionals are one step closer to federal protection from workplace violence with the passage of the Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195) in the U.S. House of Representatives on April 16. Rep. Joe Courtney (D-Conn.) introduced the measure to help workers like Carol Grant, who has been a nurse for 17 years. She is no stranger to dealing with patients or family members who get violent. Workplace violence has gotten worse, especially in the last three or four years, she says. "It is definitely happening more and more in the workplace. You try and make excuses, but it just gets really out of hand sometimes."

Explore the AFT's workplace violence prevention toolkit: www.aft.org/wpvact

After strike, Oregon techs win new contract

AFT President Randi Weingarten is congratulating the 155 therapists, technicians and technologists at St. Charles Medical Center in Bend, Ore., who ratified a momentous first contract in April after 15 months at the bargaining table and a nine-day strike. The hospital staff union, St. Charles United, is affiliated with the Oregon Federation of Nurses and Health Professionals. Weingarten said, "I am so proud of the newest members of the OFNHP and AFT family, who organized for years and fought fiercely at the bargaining table and on the picket line to win a fair first contract."

Learn about the win for workers: http://ofnhp.aft.org/news/after-strike-techs-win-new-contract-and-huge-wage-raises-st-charles

When choosing to be a nurse means choosing student debt

Every day, Melissa Cain, a nurse in rural Ohio, takes care of people at their most vulnerable, inserting IV lines, swabbing wounds, reassuring family members, and more. Like other nurses, she gives so much—yet she is saddled with six-figure student debt accumulated because she was training to be the best nurse she could be. Her story is just one of many arguments for student debt relief.

Hear her story: https://aftvoices.org/when-choosing-to-be-a-nurse-means-choosing-student-debt-fb01aecce247

AFT citizenship clinics change immigrant lives

Last month in Houston, many immigrant workers made significant strides toward becoming U.S. citizens, thanks to a citizenship clinic sponsored by the AFT, Texas AFT and Houston-area AFT locals and featuring help from attorneys from the Equal Justice Center. Volunteers helped lead participants through the complicated naturalization process and handed out free books for families as well. "We know the naturalization process is daunting," said AFT Executive Vice President Evelyn DeJesus. "But we are here—presente—to help."

See how AFT is supporting community members: www.aft.org/news/aft-citizenship-clinics-change-immigrant-lives

AFT offers trauma benefit for members

All working AFT members have access to free trauma counseling to help them in the aftermath of an incident like assault or workplace bullying, or in dealing with secondary trauma, such as the trauma many members have experienced during the pandemic. The coverage is for traumatic incidents occurring both in and outside the workplace. These services are provided by licensed counselors who have undergone specialized training in trauma recovery.

Access the benefit: www.aft.org/members-only

ADVOCACY ACTION

Help Protect Nurses and Protect the Right to Organize

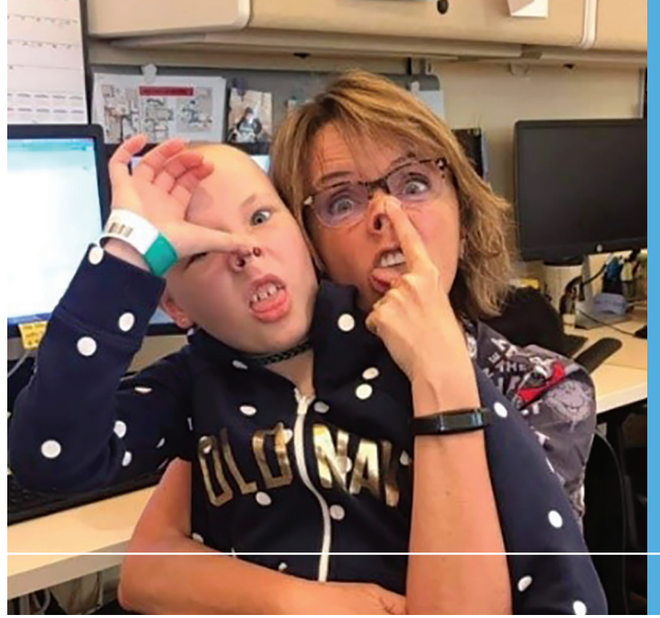
By Quinn Sharkey MA, RN-BC, CCDS, NHDP-BC, AaNA Board of Directors

As we emerge from the pandemic, AaNA continues to advocate for nurses at all levels and we need your help on two issues of national significance.

Workplace violence continues to plague the healthcare industry and AaNA has worked tirelessly to bring change for several years including strong advocacy at the state level resulting in legislation. At time of publication, H.R. 1195: Workplace Violence Prevention for Health Care and Social Service Workers Act has passed the House and showed promise in the Senate. This federal legislation would direct the Secretary of Labor to issue an occupational safety and health standard that requires covered employers within the healthcare and social service industries to develop and implement a comprehensive workplace violence prevention plan. This is the opportunity we have been fighting for. We all saw first-hand what the lack of an OSHA standard for respiratory protection subjected nurses to at the height of the pandemic and this is a critical opportunity to finally compel employers to take workplace violence seriously.

In addition, The Protecting the Right to Organize Act, known as the PRO Act, has also passed the House. In a climate with increasing calls for things like equity, justice, and employment security, people tend for forget that organized labor has done more than anyone to level the playing field in this country for over a century. This act would continue that tradition and has the potential to amend some of the nation's stagnant labor laws and give more workers the right to form a union and have a voice on the job. As we observed Workers' Memorial Day last month to remember those who have suffered and died on the job, we were reminded that a union is the best option for all workers to have a voice, nurses included.

AaNA's advocacy helped get us here but now we need your help. Congressman Don Young took a courageous, bipartisan stance and voted in favor of both these bills, for which we express our sincere gratitude. Now our senators need to hear from you – all of you. Write them letters, email them, advocate on social media. Follow the AaNA website and on social media and do what you can to make your voices heard and strongly advocate for this legislation. We wouldn't be asking if it wasn't that important. The time is now!



(PHOTO USED WITH PERMISSION)

Pediatric Infusion Nursing

By Lisa Friesen, BSN, RN, VA-BC

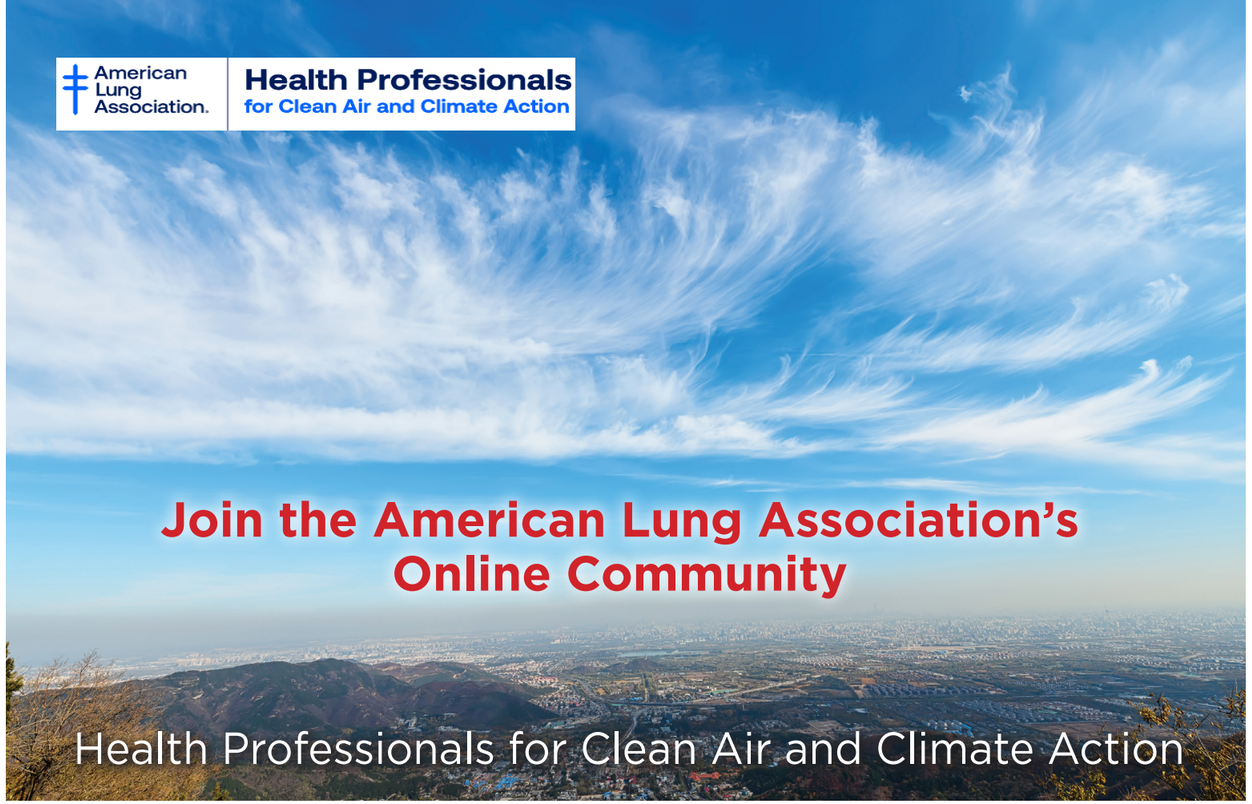
Children suffering from diseases like cancer, anemias, immune diseases, and other illnesses that require infusions spend a lot of time in the hospital for infusion therapies. The goal of pediatric infusion nursing is not only to be an expert in Pediatric IV medications, IV access, and central line care, but also to make the child's frequent visits as pain-free and stress-free as possible. The infusion center should be a place where getting IV medications becomes fun, for the most part.

As a pediatric infusion nurse, my typical day consists of 2 to 6 patients, who may require lab draws, medication infusions, central line dressing changes, and blood product transfusions. Patients frequently have ports or other central access, because the disease they have requires frequent IV access for labs and meds. Each child has a unique way of how they like their port accessed: sitting on Mom's lap, sitting on a recliner, numbing the port site with topical medication or ice, or watching cartoons as they are accessed.

The nurse spends a lot of time developing a rapport with the child and the family. A good rapport with a child makes care easier for all involved. Parents tend to trust a nurse much faster if the nurse takes an extra few minutes to get to know them and their child. Infusions range from an IV push medication to 8-hour infusions. The children getting chemotherapy may often be in the center for all-day infusions and often for 5 days of the week. Many infusions require frequent vital signs, which can be challenging for toddlers. Educating patients and families on the disease process and navigating resources in the community is also part of the responsibility of the nurse.

Pediatric nurses must love children, have a good sense of humor, and lots of patience! On slow days you might be playing a game with a child that is having an infusion. You may have to bribe a child with a prize to get him or her to take their Tylenol. In all honesty, many children who have come to the infusion center for a long time are excited to come for their infusion and may not want to leave.

Caring for children in an outpatient setting is very rewarding. The difficult part of this type of nursing is when a child dies or they are hospitalized and no longer well enough to have their infusion in an outpatient setting. Nevertheless, the rewards far outweigh the difficulties, and pediatric infusion nursing is a very fulfilling career.



Are you involved, or would you like to get involved in efforts to protect the health of the patients and communities you serve from air pollution and climate change?

Climate change is already harming our health in many different ways – from worsened ozone pollution due to warmer temperatures, to more frequent and intense wildfires producing dangerous particle pollution.

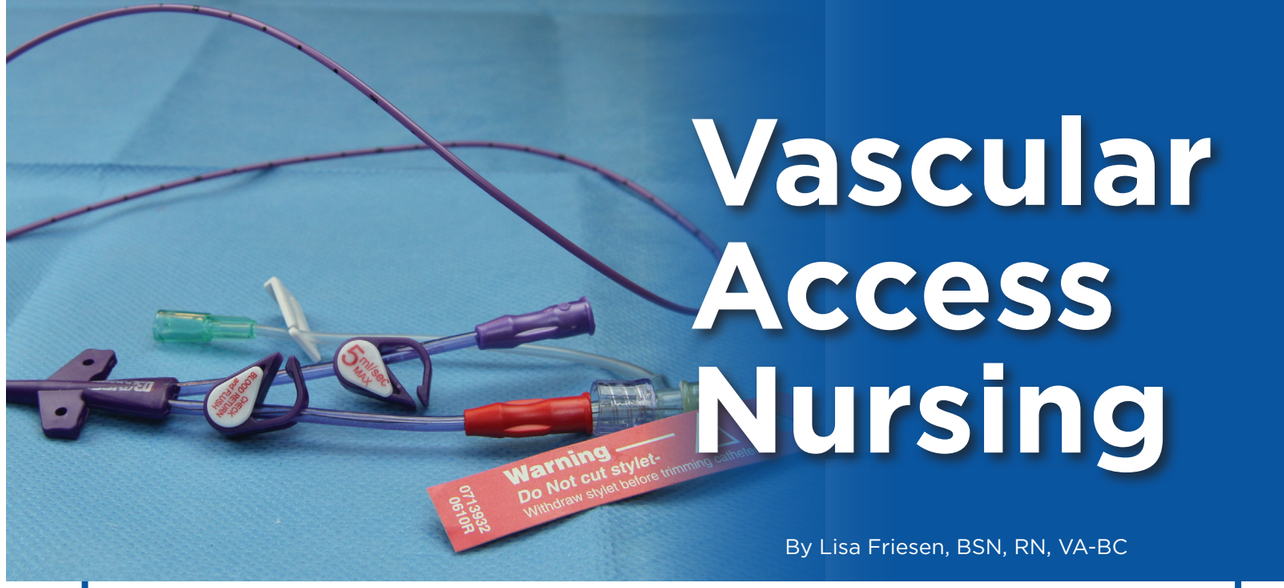
When it comes to rising to the challenge of addressing climate change, leadership from the health and medical community is essential. Nurses treating patients on the front lines are critical to raising awareness of the severe health burdens caused by air pollution and climate change – and to help build public will for solutions.

The American Lung Association's "Health Professionals for Clean Air and Climate Action" is a campaign designed for nurses, doctors, public health workers, and other health professionals to learn more about health impacts of air pollution and climate change, share their story why fighting air pollution and climate change is important, and take action on critical policy issues. The website also highlights physicians and health professionals who are speaking out for strong climate action.

One key action nurses can take is to add their name to the American Lung Association's Health Professionals Declaration on Climate Change. More than 1,500 doctors, nurses, academic and health professionals from across the country have signed this declaration urging elected officials to take stronger action against climate change to protect public health.

Learn more and sign up to receive the free monthly Health Professionals for Clean Air and Climate Action newsletter on the American Lung Association's website at www.lung.org/ClimateChangesHealth.

For more information, please contact Diana Van Vleet, National Director of Outreach and Engagement, Healthy Air Campaign, American Lung Association, Diana.VanVleet@lung.org.



Vascular Access Nursing

By Lisa Friesen, BSN, RN, VA-BC

"Insertion of an IV catheter is an invasive procedure that introduces multiple risks and potential morbidities and even mortality, and should be given the respect it deserves." - Robert E. Helm

A Vascular Access RN or IV Nurse has visions of beautiful, healthy veins in individuals and realizes that it is indeed only a dream! On an average day, a VAT (Vascular Access Team) RN will see at least 25 to 30 patients. All of these are patients are having issues with vascular access. Most patients hospitalized require IV access for treatment and many of them have poor vasculature for this procedure. Patients that are typically difficult to access are the elderly, patients with IVDU, obese patients, and often those with several co-morbidities like cancer, obesity, diabetes, CHF, or renal failure.

Generally, the shift starts off with EMR rounding on all central lines in the hospital. This entails checking the medical record of every patient in the hospital that has central access. VAT is responsible to check all central lines in the hospital. VAT places all the PICCS and midlines (inpatient and outpatient), rounds on them daily, and changes the dressing when needed.

VAT is also responsible to advocate for patients when they need a CVL or if their CVL is not needed anymore. Each RN carries a pager and a phone and can be reached whenever needed between the hours of 0800-2200 for IVs, CVL dressing changes, troubleshooting CVLs, and guidance on medication compatibilities, infiltrations, extravasations and other complications of IVs.

On any given day, the VAT RN will start about 10-15 PIVs, start 1-2 PICC lines, change 2-4 CVL dressings, de-clot a line, and spend time communicating with nurses and physicians. Many times the patients a VAT RN sees have had terrible experiences with IV starts, and the RN strives to make IV access a less painful experience.

Education is also a big part of VAT nursing. VAT teaches the patients about their lines, the nurses how to care for them, and often works with physicians to decide on the right line for the patient. VAT RNs can also become certified in vascular access.

A good VAT RN will be approachable, organized, be able to prioritize, be assertive, and have the skill to insert IVs, use the ultrasound machine, have a good sense of sterile technique, and more than anything, care deeply about each of the patients.

Informatics Nursing

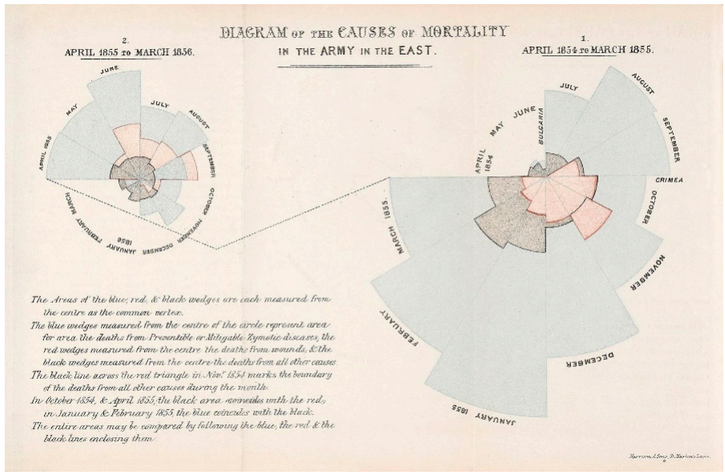
By Quinn Sharkey MA, RN-BC, CCDS, NHDP-BC, AaNA Board of Directors

What is informatics nursing? In essence, it is the intersection of nursing and data. There are numerous definitions, but the American Nursing Association (ANA) has defined nursing informatics as "the specialty that integrates nursing science with multiple information and analytical sciences to identify, define, manage and communicate data, information, knowledge and wisdom in nursing practice."

When we hear the term "informatics" in healthcare today, it sometimes triggers a vitriolic disdain for the some of the electronic health records (EHRs) that the majority of us now use in our daily practice. It can be particularly frustrating when we see how advanced and easy to use so many of our personal devices and software applications are and then compare them to what we are compelled to use in our professional practice areas.

This lack of progress is truly surprising given the fact that EHRs have been around a lot longer than one might think, with their origins going back to the 1960s. Probably one of the first tools that we would consider a modern EHR was developed by the Department of Veterans Affairs. Way back in the 1970s, the VA was visionary when they implemented the foundations for what was to become the EHR called "VistA" (The Veterans Health Information Systems and Technology Architecture), which was a pioneering initiative when most hospitals were still using paper charts.

Florence Nightingale herself was one of the first, if not the first, informatics nurse. Even back then, Florence understood the power of healthcare data to influence change and the importance of visual aids in helping policy makers understand the data she had collected. As an ongoing tribute to her pioneering work, the Data Visualization Society launched a new publication called Nightingale in 2019.



"DIAGRAM OF THE CAUSES OF MORTALITY IN THE ARMY IN THE EAST" BY FLORENCE NIGHTINGALE.

EHRs are here to stay and the analytical power that the data EHRs create can't be underestimated. EHRs, when properly configured and deployed, can revolutionize healthcare delivery. In many cases, patients can now even access their own records through EHR portals. Today, an informatics nurse needs to know a lot more than just how to use the EHR. They need to merge the full gamut of clinical practice with the EHR and then understand how to manage and report out the data that the EHR produces.

The COVID-19 pandemic has put the demand for real-time healthcare data front and center over the past year and that is unlikely to change anytime soon. This was on top of the already ever-increasing number of mandated clinical quality and performance measures such as those that influence Hospital Compare, Leapfrog and other healthcare ranking methodologies that are all EHR-dependent. The pressure to meet these reporting requirements and produce the required data has in many cases created an egregious amount of "clicking" and typing by the entire clinical team, not just nurses. Often compelled to use antiquated and poorly configured EHRs designed by individuals never required to use them in clinical practice, nurses sometimes struggle to meet the demands of both patients and the computer.

How do you get involved? Many hospitals and clinics are always seeking nurses to serve as subject matter experts, committee members, and to become trainers or super users for EHRs. Only with nurses actively participating in these activities, can we influence EHR evolution and ensure they become more user-friendly and effective. Beyond that, there are numerous MSN programs focused on informatics and the American Nurses Credentialing Center (ANCC) offers an option to become a Registered Nurse-Board Certified (RN-BC) in Informatics, which was established back in 1992. If you are looking for a change, or to be a champion of change, informatics might be right for you!

By Heather Hagelberger, Covenant House Alaska, Trafficking Program Coordinator

Human trafficking is prevalent worldwide, and victims of this vile industry tend to be the most vulnerable in society. Based on studies conducted in Alaska, within 48 hours of becoming homeless, one in three children will be approached by a trafficker. In Alaska, the common age of recruitment is 14-16 years old; and once recruited, the average lifespan is seven years. So if Covenant House doesn't find these vulnerable youth first, who does? Traffickers.

In April 2017, Covenant House released a groundbreaking study that shed new light on the link between youth homelessness and human trafficking. In 10 cities studied nationwide, Anchorage had the highest reported prevalence of trafficking.

For this reason Covenant House Alaska has spent years building strong partnerships with many organizations to help our homeless youth in Alaska who are vulnerable to trafficking. We partner with Southcentral Foundation, Cook Inlet Tribal Council, First Alaskans Institute and Cook Inlet Housing Authority, who are all working inside our shelter and alongside us to heal the trauma all our at-risk youth have experienced.

We are also working to address the lack of training among health and law professionals so they can more quickly identify victims of sex trafficking. We partner with the Alaska Native Justice Center and the FBI, as well as Priceless, the anti-trafficking organization, and two local domestic violence organizations, STAR and AWAIC. Together, we serve all trafficking victims who walk through our shelter doors.

As nurses and allies against trafficking, there are red-flag behaviors you can recognize and report.

- Most sexually exploited children have been trained to lie about their age. Sometimes a child's appearance and/or actions can contradict the information they give. Be sensitive to clues in behavior or appearance that could indicate that a child is underage.
- Personal information – such as: age, name, and/or date of birth – might change with each telling of his or her story, or the information given might contradict itself. While this could be a trauma response, it does demonstrate a need for further discussion.
- Has no identification or is not in control of his or her identification documents.
- Evidence of controlling or dominating relationships, including: repeated phone calls from a "boyfriend" and/or excessive concern about displeasing partner.
- Always being seen with an older sister or aunt. These can sometimes be another trafficked individual who is keeping the victim in line for their trafficker.
- Wearing sexually provocative clothing can be an indicator of sexual exploitation. But it should be noted, so as not to rely on stereotypes, that not all children in the commercial sex industry wear such clothing.
- Tattoo with name or specific image, piercing that may be considered branding.
- Frequent ER or health clinic visits for sexually transmitted infections or frequent pregnancies.
- If the age of an individual has been verified to be under 20 in Alaska, and the individual is in any way involved in the commercial sex industry, or has a record of prior arrest for prostitution (or related charges), then he or she is a sexually exploited child.

If you suspect one of your patients is a victim of sex trafficking, first and foremost, believe the child. Then you will need to report, empower, follow up and support. If guidance is needed, contact Covenant House Alaska. We are here as a resource of information and training if needed.

In order to end trafficking in Alaska, it is going to take the effort of all of us. Thank you for your diligence in learning the warning signs, and reporting your suspicions. At Covenant House Alaska, we value the work that you do and always welcome the opportunity to work together on these important initiatives.

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Covenant House Alaska is currently recruiting volunteers who are Alaska Native to work with our youth. At any given time, 50% of the youth that we serve are Alaska Native and they are in need of mentors who can relate to their culture on a deeper level.

For more information on Covenant House Alaska and how you can help, visit covenanthouseak.org.

AaNA CELEBRATES

NURSES WEEK 2021

2021 Art Contest Winners

At the Alaska Nurses Association, we look forward to honoring Alaska's amazing nurses during Nurses Week. This year, our celebratory efforts continued to look a little different due to the pandemic.

With the help of the community, we held our sixth annual Kids Art Contest, asking Alaskan kids to create artwork under the theme "Nurses are our Heroes." Our winners' artwork is featured here, and you can view all the entries at www.facebook.com/AlaskaNurses.

In addition, we hosted two virtual continuing education events and a virtual paint party led by Palette Pop Up Art. And because we so appreciate our members, we had daily prize drawings and gave away crazy fun compression socks as a small token of our thanks.

To round out the week, our Love a Nurse Run again went virtual. Local artist and AaNA member Ashley Seabolt created a one-of-a-kind shirt design for participants, and runners were able to complete the 5K anywhere and anytime they wanted through Nurses Week. Thanks to everyone who participated and raised funds for the Foundation for Alaska Nurses.

It is always a privilege and honor for us to recognize the contributions of nurses in Alaska and to show our gratitude for our nursing colleagues. We hope to see you at our events next year!

Pre-K to 1st Grade

Winner: Taylor T., Kindergarten

Runner-up: Hazel H., 1st Grade

2nd to 3rd Grade

Winner: Camille U., 3rd Grade

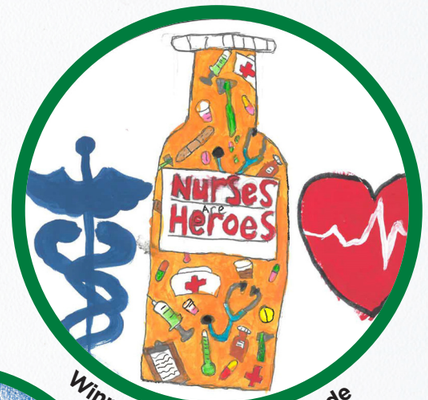
Runner-up: Finley F., 3rd Grade

4th to 6th Grade

Winner: Claire C., 5th Grade

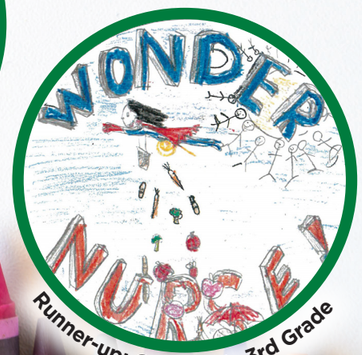
Runner-up: Aura May T., 5th Grade

Overall Favorite



Winner: Claire C., 5th Grade

Runner-up: Peyton L., 3rd Grade



Runner-up: Camille U., 3rd Grade

Heart of the ALASKA NURSE

Marianne Schlegelmilch

By Marianne Schlegelmilch

What makes the Alaska Nurse?

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

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

In seeking a cross section of Alaska nurses and after having talked with so many, the answer has become clear. Great Alaska nurses do what needs to be done, seek out innovative ways to accomplish the care of their patients, and give wholly of themselves in the pursuit of wellness, safety, and the restoration of health for those entrusted to their care.

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

— Marianne Schlegelmilch

It's hard to write your own story, but here goes:

My life as an Alaska nurse began in 1965, when I was accepted into the nationally accredited diploma nursing program at the very hospital where I had been born. Three years later and after passing what was then known as the State Boards, I was licensed as a registered nurse.

I went to work right away in a large hospital in my hometown of Flint, Michigan. It was a 700-bed hospital, and I began on the 3-11 shift on the med-surg unit with a patient load of 20, plus 8 other patients in the physical rehab wards, where I was responsible for their meds and IVS as their regular staff only worked day shift. I would later run into one of those patients long after his discharge and marry him, abandoning my plan to move to Ann Arbor to obtain my BSN and then move to New York City to care for the poorest people there.

During my time at that hospital ICUs were born nationwide and I transferred into ours right away, anxious to learn about this new kind of nursing. Back then they pretty much just threw you in and you learned as you went, usually carrying a patient load of 6-8 patients with the help of a nurse's aide and as time went on, a new field of caregivers called respiratory therapists.

Prior to moving to ICU, I had also worked evening shift OR for 3 years, where we handled emergency cases only—a job much like ER, where there are long periods of quiet and then suddenly a crisis.

After 7 years at that hometown hospital, my husband and I decided to move west, where we spent 6 years and where I worked in large hospitals in Nevada and California. During that time, I worked exclusively in ICU, then CCU—another new and rapidly advancing field. I also expanded my skills and knowledge base and realized there was more than one way to correctly do various procedures as I honed my critical thinking skills.

In those places I cared for many interesting people, some very famous and others unknown—even observing the planning of a presidential inauguration from our unit when a VIP was admitted for "exhaustion"—then a surreptitious diagnosis for high level care in a quiet hospital room.

Once, I received a job offer to be one of the first paramedic level RNs for a medevac service out of Denver, but I passed it on to my colleague and friend, who was more interested in rappelling down cliffs and learning to insert chest tubes and trachs in the field than I was. Sadly, she and the entire crew and their patient were killed when their medevac helicopter went down in a canyon near Hoover dam one night, leaving me with the mixed emotions of feeling grateful I had passed on that job, yet sad and guilty my friend had taken it and died because I did.

In 1981, after hearing Alaska was an amazingly beautiful place, Bill and I moved there sight unseen. I had researched hospitals in Anchorage and sent in my resume and references to Providence, receiving some indication that I should call when I arrived. When they were still being vague about needing nurses after we had holed up with our dog in a Spenard hotel for two weeks, I called them and said if they didn't need nurses with my skill level to please let me know or else I was heading for Fairbanks in the morning. They hired me on the spot.

Like most newcomers, I was assigned to night shift in the unit of my choice, CCU. It would end up being one of the most profound jobs of my career as I worked in that small unit with doctors who would later form the Alaska Heart Institute and who had forged a unique bond and trust with each of us who staffed that unit, allowing me to experience collaboration in ways I had never imagined.

There are so many stories I could tell of those days—about how I finally worked my way to day shift and my favorite, evenings. About all the firsts: first group of Alaska nurses to become ACLS certified, first group of Alaska nurses to learn to run the intra-aortic balloon pump, first group of Alaska nurses to fly to remote locations on a Lear jet and bring injured and sick people into Anchorage for advanced care. In my life as an Alaska nurse, there were so very many firsts—each one exciting and challenging and at a level of performance I had never dreamed I would experience.

And the people I cared for were people my work really mattered to. People brought in from remote areas for things like pacemakers or surgery, or people I picked up on my flights from places as far away as St. Paul Island in the Pribilofs, or a woman in shock from Yakutat whose diagnosis was not the acute pancreatitis they had told us, but instead was a ruptured ectopic pregnancy causing her BP to bottom out as we reached altitude. With no one to call I ran two IVs wide open, which got us to Anchorage where she survived.

It was like that in those early days of flight nursing, flying out in the middle of the night with orders from a doctor you had never met based on an assessment by a village health aid or medic—diagnoses that were almost never what you thought they would be. There was the guy in extreme pain who tried to jump out of the plane every 5 minutes for 800 miles. There was the tribal chief who was so respected that the entire village formed a chain of headlights to guide us into the remote village late one night.

There were scary moments, like when one of the young pilots forgot to turn on the cabin pressure—suddenly remembering as we reached 40,000 feet. Or the time I went deaf on descent and worried how I could possibly take care of my patient, my ears finally popping as the door to the plane opened. There were other moments like insisting to an ER doctor in Barrow I was not willing to try to intubate a patient with a gunshot wound to the neck in a Lear jet—angering him when I insisted he had to come with me or intubate before we left.

There was also great satisfaction in caring for people who were so critically ill you thought they would never make it and later have them come back for something less serious and thank you for making a difference.

I guess it was like the old cliché, "It was the worst of times and it was the best of times . . ." as I grew and learned as a nurse. I did things like study flight physiology on the side. I created a 2- sided, 3-page long flow sheet to document every aspect of a patient's care for each 24-hour period—designed to be detailed, concise and be an effective tool for each nurse and each doctor—a project put into a committee of nurses and doctors and later into practice in our unit long before today's computer charting technology existed.

Later I would move briefly to 3-11 IV nurse in a job that had me running between two towers all shift long, even prompting me to wear a pair of roller skates one evening that I had found at a garage sale. All you did was push a button and the wheels came down as needed. I can still see myself trying them out on the balcony between the two towers there at Providence, but of course I never really

Continued on page 22

Continued from page 21

wore them during actual patient care.

I worked in Sitka for only one year, but it, too, had a profound impact on me as I cared for 18 patients on night shift with the help of one nurse aid in the old hospital and helped move from the old hospital to the new Sitka Community Hospital, which itself now no longer exists.

Like flight nursing, you learned to be prepared for anything working on an island, when weather could sock you in for three days or more leaving you sometimes with a very critical patient waiting for the weather to clear so you or a peer could personally medevac them on a commercial flight to Seattle.

It was small town living, where you knew everyone. A place where I learned how to cook herring roe from two Tlingit men, who brought some in on a spruce bough as we took the one floor elevator ride to the patient floor. A place where our 3-day bear hunting trip turned into a life-threatening situation, and where a patient I had just treated miraculously appeared and guided us with his seiner back to safety during a storm 100 miles into the remote Inside Passage.

From Sitka we left for Michigan, longing to return almost the moment we left. It would be 10 years later, though, before we would find our way back and end up in Palmer, where I was hired to be the manager of the first satellite center for the Blood Bank of Alaska. My territory—the entire vast and then sparsely populated 23,000 square mile Mat-Su Valley.

I met great people on that job and once again learned as I went. I did things like asking Iditarod founder Joe Redington for help with marketing and got it. I held blood drives in places none had ever been held. Places where community members would bring us lunch or give us lodging, or where a private pilot would volunteer, like the one who picked up a couple of coolers full of blood from our team after landing his plane on a gravel bar in a wild river near Healy.

Bill and I spent a couple of our anniversaries in such locations, as I would try to turn remote collection sites into adventures for the other staff members and their spouses as we sought to expand our outreach for much needed blood.

I'm proud to say that my center passed every federal and national inspection with high ratings. We all worked hard for that to happen in the tightly regulated blood collection industry. We had big challenges but also lots of satisfaction and fun in doing it—like on 9/11 when the CEO came in and worked as the receptionist as we raced to collect blood from people lined up around the block.

So, as I said in the beginning, my life as an Alaska nurse really began at the hospital where I was born and from where I launched my nursing career. I like to believe it was that solid grounding that gave me the foundation for growth and my marriage to an adventurous man, who gave me the courage to tackle anything and everything new and exciting I could find in the world of nursing.

In writing my story, I was worried about how it would come across. How would I sound to others as I told my own tales and gave it my own spin? To that end, I reached out to a couple of people I had worked with way back in those first days and months at Providence and I asked them what they would say about me as a nurse if someone ever asked.

One of them wrote: You were always very professional, helpful, good IV starter with a quick sense of humor.

Another promised to send me paragraphs, summing things up by writing: You were the best, you know. You were the best!

I'll take that. Back at ya, fellow nurses!

I officially retired from nursing October 5, 2018—50 years, 6 months after I began. It was one of the hardest decisions of my life.

About the Author

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

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

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

Calendar of Events

AaNA Meetings

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

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

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

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

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

Education and Events

Tuesday Talks
Nurse Licensure Compact presented by Sara Massmann, RN and Shannon Davenport, RN
Tuesday, June 15 @ 6 PM
Register at www.aknurse.org
FREE CE: Earn 1.25 contact hours

Tuesday Talks
Topic TBA
Tuesday, July 20 @ 6 PM
Register at www.aknurse.org
FREE CE: Earn 1.25 contact hours

Tuesday Talks
Topic TBA
Tuesday, August 17 @ 6 PM
Register at www.aknurse.org
FREE CE: Earn 1.25 contact hours
Alaska Nurses Book Club
Bad Advice by Paul Offit
June 29 at 6 PM
Register at www.aknurse.org
FREE CE: Earn 3.0 contact hours

15th Annual Asthma and Allergy Conference
September 10 & 11, 2021
www.aafaalaska.com

2021 Trending Topics in Nursing Conference
October 7 to 9, 2021
www.aknurse.org

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

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