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The Missouri Nurse encourages readers to submit articles and information for publication. Contact the Missouri Nurses Association (MONA) office for submission requirements and deadlines. The Missouri Nurse reserves the right to edit manuscripts. MONA reserves the right to utilize published articles in a variety of formats and for the purpose of the organization. Photographs, if included, should be of crisp and clear quality. Materials should be sent to: Editor, The Missouri Nurse, P.O. Box 105228, Jefferson City, MO 65110.

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I recently read an article titled “Is Nursing Really Recession-Proof”? This is a topic of concern for many nurses in Missouri as several are facing job layoffs, mandatory furlough time, reduced retirement contributions, etc.

People will always get sick and need care, but will this make nursing a recession-proof career? The answer is as complex as the recession. Yes, people will always get sick and need care despite the economic status. Yes, the population is aging, more obese and, in general, demands better care.

But can people afford healthcare in a recession? With nearly 50 million Americans presently without any health insurance, it is more likely they will opt to make the mortgage payment and not seek medical care unless it is absolutely essential. So while this can mean a cutback in the number of patients being seen or cared for, it also means those who are seeking care are often sicker than usual.

For those who are insured, the new calendar year has most likely brought higher co-pays, higher deductibles and out-of-pocket expenses as well as other changes in coverage for beneficiaries. These changes will affect the level of care Americans seek. And given a choice between paying the medical bills, buying food, or paying the mortgage, medical bills will more than likely be put on the bottom of the pile. This will impact the providers.

A leading indicator of a recession to health care industry professionals is the rise in the number of knee replacements and gum surgeries according to an article in the March 28, 2008, issue of Business Week. As Americans face possible layoffs and loss of health insurance, they often rush to have elective procedures done. On the other hand, many will forgo even necessary care for fear of losing their jobs for taking time off from work.

As hospitals, clinics, and other providers face financial losses associated with these factors, nurses and other staff will be affected. Some hospitals and other facilities have already instituted hiring freezes and a few have laid off staff. The nursing shortage isn’t going to go away because we are in a terrible economic crisis. Between 2006 and 2016, the BLS estimates that we will need 23% more RNs.

The really bad news is that economic situation is not expected to get better until it actually gets worse first. It is estimated that an additional 4.2 million Americans are likely to lose their health insurance coverage before the economy recovers.

Illness doesn’t take economic factors into account. The population today is older, more obese and more prone to chronic diseases. Those who face cancer, heart disease and emergency medical situations will need care whether they can afford it or not. Many will be sicker because they have put off seeking care until absolutely necessary which will tax the system even more. Should there be an epidemic or medical crisis during this recession, it could turn into a real medical mess!

Nurses are likely to find themselves placed in a precarious situation of being leveraged with the heavy hand of administrators threatening them to take on increased patient ratios or face layoffs themselves. This is going to be a time when nurses need to unite and stand strong in the face of adversity to not lose the small amounts of ground we have gained in this fight so far.

As the economy recovers, history has shown with past recessions that patients will rush the health care industry and it can be difficult to build back staff quickly enough to keep up with the demand. Because of the growing shortage of nurses, it is important for more people to continue to become nurses. There may be a shortage of jobs for new nurses for awhile, but as the economy recovers, this situation will improve and new nurses will once again find multiple options.

The nursing profession is not entirely recession-proof, but nurses are certainly positioned to be less likely to be laid off than many others. Will they be affected by the recession? Without a doubt.

Reference: SupportForNurses.com
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MONA CALENDAR

APRIL
30th  Membership Call (12:00 Noon)

MAY
8th   Holiday (Office Closed)
13th  District President’s Call (12:00 Noon)
13th  Nursing Practice Call (2 p.m.)
20th  MONA Foundation Call (3:30 p.m.)
25th  Holiday (Office Closed)
29th  Nursing Practice Update, Kansas City, MO

JUNE
4th   Bylaws Meeting (10 a.m.)
10th  District President’s Call (12:00 Noon)
10th  Nursing Practice Call (2 p.m.)
12th  Med/Surg Conference, Joplin, MO
26th  Membership Call (12:00 Noon)

JULY
3rd   Holiday (Office Closed)
8th   District President’s Call (12:00 Noon)
8th   Nursing Practice Call (2 p.m.)
17th  Nursing Practice Update, St. Louis, MO
22th  APRN SIG Meeting (12 - 4 p.m.)
23rd  Finance Committee Meeting (1 - 4 p.m.)
23rd  Executive Committee Meeting (1 - 4 p.m.)
24th  MONA Board Meeting (9 a.m. - 5 p.m.)
FROM THE PRESIDENT
Mary Berhorst, RN, BSN, BC, CMSRN

RIVER CITY
A Nurse’s Year in Vietnam

NURSE

Nurture:
Encourage someone or something to flourish, grow, develop, thrive and be successful

Utilize:
Make use of or find a practical use for something

Rest:
Stopping of work or activity; a period of refreshing and freedom from exertion

Supplement Substance:
Physical reality that can be touched and felt

Exercise:
Physical movement or action, designed to make the body stronger and fitter

A nurse needs to do for herself before she can care for others. She needs nurturing by pampering, taking time for a spa, a day off or even a deserved vacation. If she does not have time to rejuvenate, she becomes burned out. I know. I have been there.

A nurse needs to utilize her profession. She needs to be involved in her professional organization which monitors her nursing practice and issues that are important to her career, such as health care reform. She needs to utilize continuing education opportunities whether it means going back to school to advance her career or taking a certification course.

A nurse needs proper rest. We simply cannot work seven days a week, twelve hour shifts without it. When I entered the workforce thirty-three years ago, a work week was forty hours, five eight-hour shifts. The nurse must balance career, family, school and volunteer time and still be able to get adequate rest. For some of us, that remains very difficult.

A nurse must receive substance nourishment. During a busy day, a nurse will miss lunch or their break to obtain nourishment. There are those of us that do not eat before going to work hoping to get a break early in the shift. How then do we nourish ourselves – junk food or the food pyramid?

A nurse must exercise to keep his/her body fit and in shape. A nurse needs not only to be able to move patients but equipment as well.

Patricia grew up the eighth of fifteen children in a poor Minnesota farm family and worked her way through nursing school and anesthesia training. In 1967, she volunteered to serve a civilian in a Vietnamese hospital in Danang, caring for people caught in the crossfire. When she arrived at the largest casualty handling facility in South Vietnam, she found a primitive hospital whose medical supplies were mostly diverted to the black market. To keep in operation, the staff had to beg supplies from the American military and use the blood they discarded as too old.

Patricia fell in love with a Marine who was killed at the start of the Tet Offensive and her back was injured, but she continued to work in pain because of the heavy load of casualties and her unwillingness to leave her colleagues and patients. RIVER CITY a nurse’s year in Vietnam, chronicles the dedication, self-sacrifice, trials and triumphs of practicing combat medicine. It is a unique view of war through the eyes of a woman, a close up perspective on civilians caught in the middle and the effect on those caring for the carnage. The first chapter, additional information and pictures are available on the web at patriciawalsh.com. The 303-page, $14.95 trade paperback can be ordered at barnesandnoble.com/amazon.com and bookstores.
CORRECTIONAL NURSING:  
Using Evidence to Guide Nursing Practices for Aspirin Administration in Acute Coronary Syndrome

By Pamela Melvin RN BSN, C. Jo Riggs RN PhD, and Janice Putnam, RN, PhD - University of Central Missouri

Cardiovascular disease is the leading cause of death in the United States (Agency for Healthcare Research and Quality [AHRQ], 2000). According to the AHRQ, a national priority continues to be researching the causes, progression, and treatment of acute myocardial infarction (AMI). In order to address treatment and prevention of AMI, research must be focused on the early diagnosis and treatment of a spectrum of cardiovascular diseases collectively identified as acute coronary syndromes (ACS). The American Heart Association (AHA, 2005a) explain that acute coronary syndrome includes unstable angina (UA), non-ST segment elevation myocardial infarction (NSTEMI), and ST segment elevation myocardial infarction (STEMI). AHA notes early identification and treatment of ACS has been shown to result in decreased morbidity and mortality in this group of patients.

Not only is cardiovascular disease the leading cause of death and a major cause of disability in the United States, the U.S. Centers for Disease Control and Prevention (CDC) report cardiovascular disease also results in substantial health-care expenditures. In 2007, cardiovascular disease was estimated to cost 151.6 billion dollars in direct and indirect costs (CDC, 2007). In the United States, prisoners’ annual healthcare costs averaged $3350 or 12% of the total cost of incarceration (Awofeso, 2005). Correctional health care is becoming more difficult to fund due to ever increasing prison population, greater health care needs among inmates, and limited budgets. Awofeso notes that data from research, surveys, and clinical practice should be used more effectively to identify inmates’ core health needs, current healthcare practices, and cost effective methods to bridge identified gaps in services. Ensuring that the prison population is receiving the best care according at the best practice guidelines is imperative for both improving health outcomes and reducing long term health care costs of ACS.

Nurses in clinical practice are increasingly being challenged by the expectations of patients, patient organizations, and other healthcare organizations to provide clearly measurable care of the highest quality. In order to achieve this, EBP is of key importance, and the nurse’s role is to ‘bridge the divide’ between research and practice via improvement of clinical care on the basis of the evidence regarding best practice (Hollem, Eiens, van Vliet, & van Achterberg, 2006, p.703). Penz and Bassendowski (2006) note advanced practice nurses have the opportunity to act as facilitators of EBP, encouraging the questioning of current common practice and ways of thinking in order to improve the clinical outcomes of patients. APNs can help identify which practices are likely to help a facility make the best decisions regarding patient care delivery and are experts in the implementation of the practice.

EBP is an integration of the best research evidence combined with clinical expertise, patient values, and patient preferences (Rycroft-Malone, Seers, Titchen, Harvey, Kitson, et al., 2004). The Iowa model notes two reasons for undergoing an EBP endeavor; those related to a problem-focus trigger and those related to a knowledge-focused trigger. Polit and Beck note that using research to improve practice “involves a series of activities and decisions” (2004, p.687). These steps include 1) deciding whether a topic or potential problem is a priority for further exploration for the institution, 2) conduct a review of the literature to assess the state of knowledge on the topic, and 3) decide whether a change in practice is warranted. If the review of literature shows evidence to support a change in practice, “assessing for transferability, feasibility, and cost/ benefit of the innovation” prior to implementation is then warranted (Polit & Beck, 2004, p. 690).

Based on a knowledge-focused trigger, it has been determined that there is a need to validate the current guidelines and indicators for the use of aspirin with ACS for prison populations. The specific indicators of inquiry currently being used in Missouri are as follows:

1) AMI-Aspirin upon being sent out
Monitor the percentage of offenders having a principle diagnosis of acute myocardial infarction that were given an anticoagulant (clopidogrel [Plavix"] or aspirin [ASA]) post cardiovascular event prior to referral to the hospital. Individuals with contraindications to aspirin are excluded.
2) AMI-Aspirin at return to facility
Monitor the percentage of offenders having a principle diagnosis of acute myocardial infarction that were given an anticoagulant (clopidogrel or aspirin) post cardiovascular event upon their return arrival to prison. Individuals with contraindications to aspirin are excluded.

Evidence is ranked according to the strength or rigor of the research studies utilizing an evidence hierarchy (Wyatt, 2003). Research hierarchy ranking system means that evidence from the top of the hierarchy should have greater impact in clinical decision making than those of lower level observations, because the higher ones provide more “strength of evidence” (Polit & Beck 2004, p.678). The system presented by Stetler and his associates (1998) relates the following levels of hierarchy from strongest to weakest:

i. Meta-analysis of controlled studies - random clinical trials (RCTs)
ii. Experimental studies
iii. Quasi-experimental studies
iv. Non-experimental studies (includes qualitative studies)
v. Program Evaluations, research utilization (RU) studies, quality improvement (QI) projects, and case reports

In this hierarchy, random clinical trials (RCTs) would provide the strongest evidence as these studies show more reliability and validity. Opinions of experts would be considered the lowest or weakest strength.

To identify interventions with potential application in treatment of AMI related to use of aspirin, a review of the literature was conducted related to AMI and ACS. Pertinent articles and papers were found by searching the databases MEDLINE® and CINAHL, using the keywords ‘acute coronary syndrome’ and ‘AMI’, ‘aspirin’ and ‘ASA’. The search produced a total of 57 articles from MEDLINE, and 55 articles from CINAHL. These searches were narrowed to peer-reviewed journals in English language within the past five years. From this list a manual review of the abstracts was conducted, looking for the most current research related to aspirin use both in initial treatment and management of ASC.

A literature search of the search engines Google and Ask.com was also made, using keywords ‘practice guidelines for myocardial infarction’ and ‘ASA’. This search showed the American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines. Another link was the 1998-2007 National Guideline Clearinghouse (NCG). From the NCG web site, a search of ‘cardiovascular disease’ resulted in 325 guidelines. The search was then narrowed to ‘myocardial ischemia’ resulting in 31 guidelines. These guidelines were manually reviewed for the most current and relevant standards of care related to the use of aspirin in ACS. This integrative review is aimed to find and evaluate the most current available evidence on best practices related to use of aspirin with ACS.

According to the AHA, effective interventions for patients with ACS are extremely time sensitive. Effective initial stabilization of an ACS patient has significant impact on patient outcomes (AHA, 2005a). Houssholder-Hughes (2006) explains that aspirin blocks platelet activation and aggregation and has been shown to reduce the incidence of death or AMI in patients by approximately 50% in clinical trials studying UA. The AHA’s pre-hospital guidelines for aspirin with suspected ACS recommend that dispatchers advise the patient with suspected ACS, and without a true aspirin allergy, to immediately chew a single dose, 160 to 325 mg, of aspirin (AHA, 2004, 2005b). Studies have shown that administration of aspirin in the field is safe and that the earlier aspirin is given, the greater the reduction in risk of mortality (AHA, 2005b). Although some trials have used enteric-coated aspirin for initial dosing, more rapid buccal absorption occurs with non-enteric-coated formulations (AHA, 2004).

According to the European Society of Cardiology (ESC) Medical Specialty Society, pre-hospital and/or early hospital class I recommendation includes 150 to 325 mg chewable aspirin. The ESC notes that if aspirin is not tolerated, clopidogrel 75 mg is the recommendation.

The Institute for Clinical Systems Improvement (ICSI) recommends that a patient complaining of chest pain should immediately receive oxygen via nasal cannula and a 324 mg loading dose of aspirin, preferably chewed on arrival in the emergency department (ICSI, 2006). Use of aspirin and clopidogrel, or if aspirin allergic, clopidogrel alone, is recommended upon presentation. ICSI recommends avoiding clopidogrel if cardiac surgery is anticipated.

The American College of Cardiology/American Heart Association (ACC/AHA) guidelines for the management of UA and non–ST-segment elevation myocardial infarction (NSTEMI) were published in September 2000 and revised in 2002, and the 2004 ACC/AHA guidelines for the management of patients with STEMI report antiplatelet therapy is a ‘cornerstone in the management of UA, NSTEMI, and STEMI’ (AHA, 2002, 2004). All chest pain patients should receive 162 to 325 mg of aspirin, chewed, unless contraindicated. Antiplatelet therapy should be initiated as soon as possible after presentation and continued indefinitely. Clopidogrel should be administered to hospitalized patients who are unable to take aspirin because of hypersensitivity or major gastrointestinal intolerance (AHA, 2002).

Hospitalized patients with UA or NSTEMI in whom an early non-interventional approach is planned; clopidogrel should be added to aspirin as soon as possible on admission and administered for at least 1 month (AHA, 2002). In patients who have undergone
MI, stroke, and death are greater for patients with a history of AMI and established coronary disease than for patients without known coronary disease (Wodlinger & Pieper, 2003). Thus, all patients who have had ACS require the administration of antiplatelet (Wodlinger & Pieper, 2003). Based on the evidence, it is recommended that patients with a history of ACS receive a daily aspirin in a dose range of 75 to 325 mg indefinitely, unless there is clear contraindication to aspirin such as active bleeding, major coagulopathy, or true aspirin allergy. Clopidogrel 75 mg per day is recommended as the antiplatelet of choice for patients with contraindications to aspirin.

The review of literature also reveals guidelines addressing the use of both aspirin and clopidogrel simultaneously. The acute treatment of UA and NSTEMI recommends the addition of clopidogrel to aspirin as soon as possible on hospital admission and administered for at least 1 month post discharge. For patients after percutaneous coronary intervention, clopidogrel 75 mg per day in combination with aspirin is recommended for up to 12 months. In addition, patients who have undergone percutaneous coronary intervention with stent placement should initially receive higher-dose aspirin at 325 mg per day.

Review of current literature showed no new additional findings that would suggest a change in practice from the established AHA/ACC guidelines for the use of aspirin in ACS.

Although health problems inside prisons are often similar to those outside prison, inmates have a much higher rate of chronic conditions compared to in the outside community (Dale & Woods, 2002). What makes prison nursing challenging is the setting in which it takes place and also the role expectations of the nurse to meet the unique health needs of the correctional population (Dale & Woods, 2002). Challenges in correctional health care often include inadequate funding, staffing shortages, issues of custody-medical interfacing, legal matters and ethical concerns, and caring for inmates who have greater health concerns and needs than those of the general population. Ensuring the prison population is receiving the best care according to the best available evidence is imperative for both improving health outcomes and reducing health care costs of ACS.

Upon the first signs of ACS, inmates should receive chewable aspirin, in a dose range of 150 to 325 mg, as soon as possible prior to referral to the hospital, unless contraindicated. If contraindicated, the offender should receive clopidogrel upon arrival to the emergency room. Upon return to the prison facility, offenders with the diagnosis of ACS should be given either aspirin or clopidogrel, or a combination of the two as warranted, unless contraindicated. Thus the quality indicators are pertinent and should continue to be monitored to ensure the best health care for inmates with ACS.

The risk of coronary heart disease events including recurrent
Did you know that today’s nurses will care for more adults who are over 65 years of age than any other patient population? It’s true. Part of the reason is that older adults use approximately 44% of the total days of hospital care, they comprise 80% of all home care patients, and 93% of all nursing home residents. Of older adults living in the community, 90% of those over 65 have at least one chronic disease and this increases to three chronic diseases in those over 75. This increase in chronic diseases, combined with physiological and functional changes of aging, increased medication use, and the interrelationship between these factors makes caring for older adults far more complex than most of today’s nurses ever learned in school.

To provide future nurses with the knowledge and skills needed to care for this growing population the Hartford Foundation funded a series of Geriatric Nursing Education Consortiums (GNEC) developed by the American Association of Colleges of Nursing (AACN). The fourth GNEC was held in St. Louis, on October 14-16th. Two more institutes are planned for next year at different locations. To date, 532 faculty representing 290 nursing schools from 46 states have attended. At the St Louis GNEC alone, a total of 118 attended, with 20 faculties from 10 different Missouri nursing schools. At the GNEC institute faculty received advanced educational preparation in the care of older adults and in teaching strategies for integrating geriatric content into the nursing curriculum. The overall goal of the project is to educate faculty in the nursing care of older adults and provide teaching strategies and resources faculty can use to integrate this content into their nursing programs.

At the institute, evidence-based modules on critical thinking, interdisciplinary care, critical care, mental health, cancer, diabetes, heart disease, dementia/delirium, and incontinence were reviewed. The presenters emphasized the complexity of health care needs, the tendency for older adults to present with atypical presentations, and the need for student nurses to explore the complexities of care of older adults through a variety of learning activities. The GNEC project developed and distributed educational resources that faculty can use in teaching students including case studies, PowerPoint presentations, and scholarly papers which address the module topics. You can find further information about these resources and future GNEC institutes at AACN’s web site, www.aacn.nche.edu.
10 Tips For Perfecting A Nursing Interview

By Carolyn Moore, Communications Strategist, The Communications Doctor.

According to the 2008-2009 Bureau of Labor Statistics, in the next ten years, almost 587,000 new jobs will open up in the health care field. Acing an interview is the gateway to the many opportunities that await you. Follow these ten tips for better interviewing and you’ll be on your way to landing your dream job.

1. Go the Extra Mile on Your Resume.
Your resume is the first impression a prospective employer has of you. Don’t blow it by submitting one that is incomplete. Make sure your resume is free of grammatical and spelling errors. Have a friend proofread your resume before your interview. Also, even if it’s not required, show you’re willing to go the extra mile by sending a cover letter along with your resume. Cathy Ivers, a nursing recruiter at Harborview Medical Center, one of the top hospitals in the nation according to the U.S News and World Report, also recommends including clinical or employment performance evaluations, as well as references and letters of recommendations from managers. “We want applicants to list out their clinical rotational experiences because it’s nice to see that they’ve had experience handling unique challenges at a place comparable to our environment,” she said.

2. Explain the Gaps.
Employers want to see a logical progression in your career. It shows that you are reliable and committed. If you have gaps in your resume, explain them in your cover letter and then later in your interview, even if your employer doesn’t ask. This keeps you from appearing like you are hiding anything.

3. Role-play.
Before the big day, practice what you’re going to say by staging mock interviews with family and friends. Practice answering common interview questions such as:
- Tell me a little bit about yourself.
- What would you say are your strengths?
- Your weaknesses?
- What do you know about this organization?
- Why are you interested in working here?
- Why should we hire you?

If given a choice, schedule a mid-morning interview. This ensures that both you and your potential employer are fresh and have had enough time to let the morning caffeine kick in.

Arrive on time. “There’s no reason to arrive early but don’t be late,” Ivers said. She also recommends being prepared to spend two to three hours at an interview because you may be asked to meet with multiple staff members that day.
The day before, check out the area and find the best place to park and best door to enter. This way, you won’t feel pressured to arrive too early because you are scared of being late.

Make sure to get a good night’s sleep and to eat a healthy breakfast. Walk in confidently and introduce yourself, making sure to clearly articulate your first and last name. Offer a positive attitude and a firm handshake.

While you can’t predict every question you’ll be asked during an interview, it may ease your mind to know that certain questions are off limits. According to a 2007 White Paper published by the HR Specialist, these include personal questions such as:

- Are you married? Divorced?
- If you’re single, are you living with anyone?
- How old are you?
- What is your family situation like?
- Do you have children? If so, how many and how old are they?
- Do you plan on having a baby within the next few years?
- Have you ever been treated for drug addiction or alcoholism?

5. Put A Positive Spin On It.
So things at your last job were not perfect. Your boss was overbearing, you were always short-staffed and your colleagues never worked as hard as you. “An interview is not the time to air your dirty laundry,” said Charles Cheek, Clinical Manager at Wake Med Hospital. Present yourself as a positive professional by talking about what you can do, what you are willing to do and what you have done.

Your positive attitude will help you avoid bringing any negative energy into your new future.” Cheek said, “Focus on you and what skills you bring to the table and you’ll make the impression you want.”

Many interviewers purposefully ask tough questions to see how you’ll respond under pressure. Your future employer wants to know that if there’s an emergency, you’ll be able to keep your cool and maintain composure. When answering tough questions, keep your responses brief, following up with “did that answer your question?”

7. Show Your Interest.
Companies want a committed and motivated employee. Make sure to express your enthusiasm for the job throughout your interview.

Also, do your homework. Research the company by studying their Web site. Know what the exact qualifications are for the position and be prepared to demonstrate how you have exemplified them in the past. Make sure to point out any extra certifications you’ve completed. This demonstrates that you’ve actively taken steps to improve your potential.

Cheek shared an experience he had when searching for a job as a sales representative at a medical device company. “What do you know about our company?” was first question he was asked. Luckily, Cheek had researched the company in depth and had created note cards, which he studied for three weeks prior to the interview. Cheek knew not only the president’s name, but also was able to accurately identify the leader of each division. The response? The board saw that Cheek had done his homework and gave him the job.

8. Stay Focused
Leanne Marchiano, Human Resources Generalist at CSPI Health Facility Resources, encounters many candidates who get too comfortable in the interview and end up sharing too much information. “I recently interviewed a woman who worked at a well-renowned facility and I asked her why she was leaving her position. She told me she was on her third corrective action and she needed to get out before she got fired,” said Marchiano.

Beware of sharing the juicy details as they can hinder your professional credibility.

You are a stranger when you walk into an interview. The only information the interviewer has about you is from your resume. This is why interviewers feel more comfortable hiring you when someone within their organization can vouch for you. If you’ve worked with someone, ask him or her to give you a recommendation before the interview. Networking won’t get you the job but it will definitely give you a leg up.

10. Follow-up.
Not only is it polite to send a thank you letter, it’s expected. Use the thank you letter to your advantage. Graciously thank the interviewer for taking the time to meet with you. Jog their memory by including some of the topics you discussed, especially anything unique. Express your excitement and enthusiasm for the position. The letter could be the last contact you have with the company before they make their hiring decision. Putting some thought into creating a memorable thank you letter is a great investment of your time.

Land of Opportunity
Get excited. It’s a great time to interview in the field of nursing. Overall job opportunities abound and more hospitals are offering signing bonuses, family-friendly work schedules and subsidized training. Secure these benefits and more by implementing these ten tips for perfecting your next nursing interview.
Cindy Latz, RN, MSN

Cindy Latz, RN, MSN, Kansas City, MO is a nurse at Humana in Kansas City. She has been married to Doug for twenty years and has a teenage son, Bradley.

Cindy has served on the MONA executive, membership and CE Provider committees and as a MONA state director. She has been an active MONA member for seventeen years.

Cindy believes there are many challenges facing nursing today such as safe staffing, nursing and nursing educator shortages, lack of health insurance, lack of emphasis on health maintenance/prevention, a higher acuity level of clients and healthcare literacy levels. She feels membership in the Missouri Nurses Association is a priority as MONA has an active lobbyist promoting the nursing agenda. She also finds comradery and support from other MONA members, has access to a wealth of information and receives a sense of belonging with fellow nurses.

She enjoys time with family and friends, including involvement with her son’s football and baseball teams, working out and shopping. Her long-term goal is to enter into a doctoral program and become a nurse educator.
Bonita Leiber, RN, MSN

Bonita Leiber is a staff nurse on the pediatric Progressive Care Unit at St. Louis Children’s Hospital. She cares for infant thru teenage children who have a congenital heart defect, have had open heart surgery, lung transplant, heart transplant, or are on Berlin hearts for life support while awaiting a transplant.

Bonita has truly turned nursing into an art. She has a passion for caring for patients and it shows in her every action. She is blessed with a wonderful personality of compassion and a sense of calmness, which has helped our medically complex patients heal time and again. Just watching a crying baby calm in her arms when all attempts have failed to bring comfort takes your breath away. It is also overwhelming to hear a patient screech with excitement as Bonita dresses as a princess while throwing a princess party to celebrate a patients discharge after months of hospitalization.

Not only does Bonita make a difference in the lives of our patients but she does the same for her peers. She comes in from home to help out when it is an extremely busy day and will even come in to help cover patients so others can participate in hospital-wide committees to improve patient care. She is warm-hearted, caring and an absolute delight! Working with Bonita during the holidays is like being home away from home for both patients and staff. She brings costumes for all occasions and creates a fun atmosphere for everyone.

Bonita was a finalist for the “Clinical Care” 2008 Nursing Spectrum Excellence Awards for the Midwestern region.

Suzi Wells, RN, MSN

Suzi Wells is the Nurse Manager for the Answer Line and After Hours Programs at St. Louis Children’s Hospital. She was awarded the St. Louis Children’s Hospital 2008 Leadership Award for the outstanding leadership she displays with her team and in the community.

Suzi’s staff nominated her for the “Leadership Award” for being an outstanding manager. She created a vision for the Answer Line and After Hours programs. Each day she attempts to make her department the best it can possibly be by using innovation, two-way communication, and holding staff accountable.

An example of Suzi’s innovation would be the partnership she created with the manager at Rainbow Babies Hospital to find a better way to handle high call volume. This collaboration resulted in a streamlined process impacting patient safety.

Suzi is also a great communicator. She is open with staff, always honest, and a role model for positive behavior. Gossip and negativity are not tolerated and her staff seems to really appreciate this and believe it comes from the top down.

Suzi’s departments are committed to excellence. One five year Strategic Plan goal lists “Provide a world class caller/patient experience with a focus on quality, safety, and customer service”. Her staff is held accountable in meeting timelines for these strategies, which keeps everyone on tasks to reach goals.

Suzi is aware of the budget, but never lets it impact patient safety. High standards are set for herself and those who report to her. She encourages staff to move from their comfort zone which encourages growth and feelings of pride and accomplishment.

She is honest, hard-working, dependable, and fun. She is a top-quality manager.

The success of the Answer Line and After Hours program is purely a direct reflection of Suzi’s commitment and dedication to caring for pediatric patients and building relationships with the community. She has collaborated with private physicians, families, and other resources to develop a program that meets the needs of our customers and our community. For anyone that has used the Answer Line at St. Louis Children’s Hospital...it is priceless!
MONA Candidates
2010-2012 Term

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Corinne Fessenden – Palmyra
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Maryann Coletti – St. Louis
Dee Esry – Hamilton

SECRETARY
Nelda Godfrey – Liberty
Jaimee Givens – Rogersville

TREASURER
Mary Chaston – Kearney

CORRECTION:
Kathryn Farwell, PhD, RN, CARN-AP, Southeast Missouri State University, received the Nurse Educator of the Year Award at the International Nurses Society on Addictions 32nd Annual Educational Conference in Atlanta, October 2008.

This corrects the article from the last issue of Missouri Nurse, Edition 2, 2008.

Thank You for Your MONA PAC Contributions!

Laurie Beach
Sue Beckering
Georgene Bosaw
Linda Brown
Dolores Drury
Tina Gallagher
Vivian Hall
Janice Jones
Geneva Kilgore
Amy Linn
Stephanie Powelson
Janet Samuels
Angela Selzer
Josetta Wahwassuck
Phil Wright

Thank You for Your Contributions to the Missouri Nurses Foundation!

Laurie Beach Mary Berhorst MONA District #16

In Memory of Helen Pfaff, RN

Mr. and Mrs. Herbert Duncan Carol Pfaff
Ann Krieger Mr. and Mrs. David Sandfort
Elaine Maxwell Mr. and Mrs. Steven Seay
Mary Orf Mary A. Waltman
Bobby Orf

Membership Accomplishments
1st Annual
Nursing Practice Update
What Nurses Need to Know

Too busy to keep up with the latest trends and current events?
• Half Day
• Locations in:
  Kansas City, St. Louis or Jefferson City
• Everything you need to know!

Catch up on current issues and trends affecting your nursing practice in Missouri.

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Location Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas City</td>
<td>Friday, May 29</td>
<td>St. Joseph Medical Center 1-4 p.m.</td>
</tr>
<tr>
<td>St. Louis</td>
<td>Friday, July 17</td>
<td>Missouri Baptist Medical Center 1-4 p.m.</td>
</tr>
<tr>
<td>Jefferson City</td>
<td>Friday, August 7</td>
<td>Capital Region Medical Center 1-4 p.m.</td>
</tr>
</tbody>
</table>

Agenda
Title Protection for RNs
Technical Advisory Committee (TAC)
• Unlicensed Assistive Personal (UAP) Rules
• Safe Staffing
• Safe Patient Handling
• Procedural Sedation
• Electronic Health Record

Legislative Issues
• SB 724 Update
• History of Medicine
• 2009 Proposed/Passed Legislation Related to Nursing

Purpose
This activity is designed to provide nurses updates on current issues and trends affecting nursing practice in Missouri.

Audience
This activity is appropriate for, but not limited to staff nurses, nurse educators, managers and new nursing graduates who desire updated information on nursing practice issues and trends.

Accreditation
The Missouri Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Accreditation as a provider refers only to the recognition of continuing education activities and does not imply Missouri Nurses Association or ANCC Commission on Accreditation approval or endorsement of any commercial product.

Cancellation
MONA reserves the right to cancel an activity if insufficient enrollment occurs. If cancellation of the activity is necessary for any reason, you will be notified by phone or mail and a full refund will be sent to you.

Registration fees, less $25 enrollment/processing fee, will be refunded to participants who cannot attend and notify the MONA office in writing of the cancellation no less than ten (10) business days prior to the date of the activity. No refunds will be made after that date. There will be no refunds due to inclement weather.

Registration Form

Please choose one:
- $250 MONA Members (Member #__________)
- $50 Non-Members
- $20 Students (documentation required)

Name:

Credentials:

Address:

City:__________  State:__________  Zip:__________

Day:__________  Evening:

Phone:__________

Email:

I would like:
- To Contribute to MONA-PAC $__________
- To Contribute to Mo Nurses Foundation $__________
- Info on Joining Mo Nurses Association (MONA)

Payment Method:
- Check Enclosed
- MasterCard  □ Visa  □ American Express

Card #__________  Expiration Date ________

Billing Zip:__________

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Refund/Cancellation Policy: We encourage you to send a qualified substitute if you cannot attend. See inside for details.

If you have special needs, please notify the MONA office at 573.636.4623. Reasonable efforts will be made to accommodate your needs.

Register NOW!
FAX: 573.636.4623
MAIL: MONA, P.O. Box 105228, Jefferson City, MO 65110
PHONE: 573.636.4623, ext. 226
Healthy Living Institute

Successful rural business leadership by female nurses is newsworthy. Healthy Living Institute is a not-for-profit corporation started by Fran Atkins, Ph.D., Psychiatric/Mental Health Clinical Nurse Specialist, R.N., Board Certified. Healthy Living Institute advocates wholistic healthy life styles including mind, body and spirit activities across the lifespan. Licensed mental health professionals include psychologists and psychiatric/mental health clinical nurse specialists in private practice. The newest person joining the team adds to the wholistic services. Dr. Steven Porter, D.N., Doctor of Naprathic Medicine, focuses on nutritional counseling, herbal pharmacology, and bodywork to address connective tissue problems. We dream of adding a psychiatrist to our team to work with Josetta Wahwassuck, Psychiatric/Mental Health Clinical Nurse Specialist, R.N., Board Certified.

Healthy Living Institute was started by Dr. Atkins when she was 64 years old, an age when many persons are planning to retire. Dr. Atkins is a third generation self-employed person. Her paternal grandfather owned and operated the Langford Lumber Yard in Winston, MO at his death in 1944. Her father owned and operated the LaVern (Truckbed and Trailer) Manufacturing Co. in Olathe, KS, from 1953 to 1970. From 1971 to 1997, he constructed log homes (from scratch) and repaired and sold neglected real estate.

“I am a late bloomer. I began private practice in 1999, and I’ve just begun to move from the novice nursing practitioner to the expert, why should I want to retire now? The dream to make a difference in Lafayette County began a couple years before I quit work in 1988 to enroll in graduate nursing school to study mental health for children, adolescents, and families. I worked in psychiatric hospitals intermittently while attending school, finally completing my Ph.D. (in nursing) in 1997. Being present as children and adults heal from stress, illness, and trauma is my way of helping to make a difference where I live.”

Frances D. Atkins, PhD, CNS, RN, BC, Child-Adolescent & Adult Psych/Mental Health

Healthy Living Institute is located approximately 50 miles east of Kansas City in the center of Lafayette County, which is a medically underserved county, also known as a federally designated health manpower shortage area. Healthy Living Institute began serving mental health needs of citizens of Lafayette and surrounding counties on July 1, 2005, under the initiative of Clinical Nurse Specialist, Frances Atkins. By September, 2005, Dr. Leonard, Psy. D., and Dr. Pulcher, Ph.D., both clinical psychologists, began coming to Healthy Living Institute to provide services. Since that time there has been a steady flow of graduate master’s students coming to Healthy Living Institute, providing services in return for the clinical experience required to complete their degrees.

At a time when Missouri state government has announced cuts in the budget for mental health services, Healthy Living Institute is increasing service hours to people of Lafayette County who may not have insurance to pay for services. Increased service hours are available because Healthy Living Institute is a clinical education location for graduate level students who are working for degrees and license in psychology, educational counseling, social work, or psychiatric/mental health nursing. While they are highly competent, graduate level students are not paid for their clinical hours. Therefore, people who have limited resources can benefit from the educational clinical experience of the students.
No Quick Fix, But One Healthy Solution
How internationally trained nurses can help us solve our nursing shortage

Mick Whitley, Managing Director, HCL International

With everything that is going on right now in the economy, the nursing shortage may not be top of everyone’s mind. But with some 35 million Americans admitted to hospitals every year, and 118 million treated annually in ERs, all of them dependent on experienced nursing care, perhaps it should be.

The figures vary slightly, but all are alarming. Already an estimated 10% of the nursing positions in the U.S. are unfilled, and that demand is expected to grow by 2-3% each year. In fact, according to U.S. Department of Health and Human Services (HHS) 2007 research, the U.S. will require 1.2 million new Registered Nurses by 2014 to meet the nursing demand – 500,000 RNs simply to replace nurses leaving the field or retiring, and 700,000 to meet growing demand.

Of even greater concern and potential risk to patients is that the shortages are highest in the areas of critical care, cardiac, and operating room nurses - the hardest jobs to fill (it takes two years to train an effective operating room nurse).

Challenges include an existing aging and retiring workforce; a low number of nursing students; an even lower number of nurse educators to teach them; high turn-over rates; as well as a lack of funding for domestic nursing schools.

New graduate nurses feel apprehensive and unprepared to work autonomously, without the sufficient support and guidance of experienced nurses. And current economic conditions are making it even more difficult for hospitals and nursing schools to recruit and attract people to the nursing field.

Obviously, to this multitude of problems, there is no “quick fix.” It is heartening to hear the nursing shortage occasionally mentioned, in current conversations about healthcare reform. However, the healing process will take years.

Well, there are a number of internationally trained Registered Nurses who are willing and able to do so. Yet, according to news reports, President Barack Obama has expressed alarm over the notion that the United States might have to import internationally-trained foreign nurses. This is misguided.

As evidenced by the figures above, these internationally-trained nurses would not be taking jobs away from U.S. workers. Quality is not an issue either - with some minor variations, RNs entering the U.S. are all required to have successfully passed the NCLEX exam, registered with a US board to practice, and satisfactorily meet requirements of the VISA screen. Add to this language training and enculturation programs and you have a well prepared workforce who wants to come to the US to care for us and our family members. So, at least in the short term, until the United States healthcare system is able to heal itself, international recruitment offers a practical and plentiful staffing solution.

However, the immigration/VISA process currently in place for internationally-trained nurses severely limits our ability to utilize this solution. There are generally three non-immigrant visa options for nurses: H-1C, TN, and H-1B, and two of these are significantly limited by statutory and quantitative visa allotments, as well as legal, regulatory and policy-based eligibility requirements.

The other method for a foreign nurse to come to the U.S. is by applying for a green card, but the current numbers of nurses succeeding through this Schedule A procedure still do not come even close to approaching the levels needed to help alleviate the shortage. Problems include quantitative visa limits, as well as inconsistencies in procedures and processing times. Some nurses, e.g., from India, have been waiting to come here and work for as long as seven years!

Obviously, this recruitment must be done in an ethical and sustainable way. We should not be taking nurses away from countries with shortages of their own. And issues of acclimation, for both the incoming nurses and their US coworkers, must also be considered and carefully addressed.

But a failure to look outside our borders, and to change VISA/immigration procedures to ease the entry of more internationally-trained nurses, could very well prove fatal to the public health system and to patients in the coming years.
The Missouri Nurses Association presents

Medical/Surgical Review Course

8:00 a.m. Registration & Networking
8:30-10:30 a.m. Cardiology
   Donna Bell, RN, CCRN
   This session will discuss risk factors, pathophysiology, primary
   rhythm disturbances, testing & treatments of heart failure and CAD,
   determinants of cardiac output, and describe differences between
   right & left heart failure.

10:30-10:45 a.m. Networking Break
10:45-12:00 p.m. Respiratory
   Donna Bell, RN, CCRN
   This session will discuss respiratory pathophysiology, COPD, ARDS, PE
   and other respiratory diseases as well as the diagnosis, treatment
   options and medications to manage each.

12:00-12:30 p.m. Networking Lunch
12:30-1:45 p.m. Diabetes
   Shelly Joyce, RN, CCRN, TNS, TNCC
   This session will describe Type 1 & 2 Diabetes, Metabolic Syndrome
   and the difference between DKA & HHNK. The pathophysiology as
   well as latest treatment modalities will be discussed.

1:45-2:30 p.m. Sepsis
   Shelly Joyce, RN, CCRN, TNS, TNCC
   This session will describe sepsis and the latest treatment options as
   well as the latest nationwide initiative.

2:30-3:00 p.m. Rapid Response Team - What is it? When do we use it?
   Shelly Joyce, RN, CCRN, TNS, TNCC

3:00-3:15 p.m. Networking Break
3:15-4:45 p.m. HIV: Life cycle, Labs & Medications
   Kim Gray, APRN, ANP-BC
   This session will describe the natural course of HIV disease, how
   medications reduce replication of the virus in the Viral Life Cycle and
   identify routine lab tests necessary for monitoring HIV/AIDS.

4:45 p.m. Question & Answer, Evaluation
5:00 p.m. Adjourn

Purpose:
This activity is designed to provide nurses and other health care professionals with a basic overview of medical/surgical conditions frequently seen in practice.

Date:
Friday, June 12, 2009

Audience:
This activity is appropriate for, but not limited to staff nurses, nurse educators, managers & new nursing graduates who desire updated information on medical/surgical nursing conditions.

Location:
St. John’s Regional Medical Center
Mercy Conference Center 1 & 2
2727 McClelland Blvd.
Joplin, MO 64762

Accreditation:
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“From Advocacy to Policy”
February 25, 2009 • Jefferson City, MO

Missouri Representative
Rebecca McClanahan
speaking to the students
attending Nurse Advocacy Day.

Maryann Coletti, BS, RN,
speaking to Nurse Advocacy Day
attendees.

Jill Kliethermes, MONA CEO; Representative Tom Loehner; Mary Berhorst,
MONA President, and Lucy Brenner, MEd, BSN, RN

Students and faculty attending Nurse Advocacy Day.