ORTHODOX JEWISH NURSES ASSOCIATION

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Healthy Summers: Guidelines for Nurses

7 Years In: Growing in Nursing

The Zika Threat

Nalaxone in the News

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Editorial

Blima Marcus, DNP, AGPCNP-BC, OCN

The weather during the spring of 2018 has been dismal—cold, windy, rainy, and decidedly unpleasant. However, we have gotten through the last of the chill and finally embraced warm days. For many in the tristate area, this means a temporary relocation to grassier destinations—either to stiflingly small shacks in bungalow colonies or camps, or large, luxurious summer homes throughout northern New York or suburban New Jersey. The exodus of urban Jewish families to airier locations along the "Borscht Belt" goes back to the early 20th century when the Catskill Mountains became a refuge for Jewish farmers and Jewish cityfolk who needed a respite from the oppressive summer heat of their New York tenement apartments.

The summer also brings with it an increase in illnesses from vector and foodborne sources, hospitalizations and length of stay, motor vehicle accidents, trauma related to drowning or funpark mishaps, and more. Although nurses may settle into vacation-mode during these months, we are on unconscious duty even more. This is when our side jobs begin, when we receive text messages with photos of mysterious rashes, misshapen fingers, and odd bug bites. And you thought you were on vacation!

A survey of nursing volunteer activities showed that 74% of the respondents (n=315) reported volunteering in the following ways: education of patients or coworkers, family and community related medical assistance, and more [1]. Nurses reported dispensing information related to hand-washing, breastfeeding, and vaccines. Nurses frequently provide advice to friends and family and promote the health of their communities through informal volunteer work. All nurses should check the state laws where they reside, practice, and volunteer, and they should be familiar with their malpractice insurance coverage. Disseminating evidence-based health information and materials to community members is a great way for nurses to safely use their voices and advocate for healthier and safer communities.

As the summer begins and our nursing antennae go up (mine certainly do!), let's become educated resources for our respective Orthodox Jewish communities. In this issue you will find articles on frequent summer safety concerns such a drownings, vector-borne illnesses, drug use and abuse in the Orthodox Jewish community, and more.

The Orthodox Jewish Nurses Association is beginning to strive towards one of our overarching nursing goals: advocacy. Our nursing organization wants to assist Orthodox Jewish nurses in their careers and advocate on their behalf, but we also want to help our nurses discover their voices and become advocates in their own right. This begins with knowledge and support. Be familiar with the issues relevant to your community and become a reliable source of information and support for them.

Best,

Blima Marcus, DNP, AGPCNP-BC, OCN

President, OJNA

Editor-in-Chief, The OJNA Journal

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THIS ISSUE AT A GLANCE:

Now, when I visit my patients I look around their home for clues about their culture and their background.

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36,429 the number of reported cases of Lyme disease in the United States in 2016.

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38 the percentage of camps surveyed which did not have a disaster preparedness plan in place for children with special needs.

page 6

NURSES ARE AT THE FOREFRONT OF EDUCATING THE COMMUNITY ON HOW TO PREVENT SUMMER'S BIGGEST DANGERS: DROWNING AND BURNS.

page 9

What if I give the wrong drug or dose using the wrong route at the wrong time for the wrong reason?

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7,301 the number of pregnant women infected with Zika in the United States as of March 2018.

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1875 the year of the first documented case of newborn opioid withdrawal which was termed morphinism.

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Disseminating evidence-based health information and materials to community members is a great way for nurses to safely use their voices and advocate for healthier and safer communities.

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Nurses can educate adolescents and young adults about high energy beverages and safe use.

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SINCE THE RECENT PASSAGE OF NALOXONE ACCESS LAWS, THERE HAS BEEN A **14%** REDUCTION IN OPIOID-OVERDOSE MORTALITY AS COMPARED TO STATES WITHOUT THESE LAWS.

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In our Orthodox institutions, alcohol and drug use are increasing.

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The Zika Threat: What You Should Know

Tobi Ash, MBA, BSN, RN

Emergence and Reemergence

In the past few years, seemingly out of nowhere, the Zika virus dominated the headlines. Zika was first isolated in Africa in 1947 and human cases were reported for the past 60 years in both Africa and Asia[1]. In 2015, Zika was found in the Western Hemisphere, the Caribbean, and Brazil [2]. In 2016, Miami was the first in the United States to report cases of Zika. As of March 20, 2018, the Centers for Disease Control and Prevention (CDC) reported that there were 7,301 pregnant women and 42,866 non-pregnant individuals infected with Zika in the United States and its territories [3].

Epidemiology

Zika is a virus spread to humans by a mosquito infected with Aedes Aegypti or Aedes Albopictus. These mosquitoes also transmit dengue and chikungunya viruses [3]. Symptoms begin between two days to one week post exposure and are generally mild. Symptoms include: rash, joint pain, headache, conjunctivitis, and a low grade fever. Not everyone who is infected feels very sick and many may not seek medical care. The Zika virus remains in the blood of the infected person for about seven days [4]. Once a person is infected, there are multiple modes of transmission: sexual contact, mother to unborn baby, and via blood transfusions [4]. The biggest risk is a transmission from mother to unborn child, as it causes birth defects [5].

Clinical Presentation

Although the clinical manifestations of Zika are not as severe as compared to dengue and chikungunya, the Zika virus is associated with neurological complications including Guillain-Barre syndrome (GBS) [6]. Guillain-Barre syndrome is when an individual's own immune system damages nerve cells resulting in muscle weakness and, in some cases, paralysis [7]. Research suggests that Zika is linked to GBS, even though only a very small percentage of those infected with the Zika virus acquire GBS [6].

The most devastating effect of Zika is on pregnancy outcomes. A pregnant woman can pass the Zika virus to her unborn child either during the pregnancy or at the time of the infant's birth. Microcephaly and other fetal brain defects occur from this transmission [8].

Congenital Zika virus syndrome is a pattern of birth defects found in infants exposed to the Zika virus in utero or born to Zika infected mothers [9]. These infants have malformations of the head including microcephaly where the skull is partially collapsed. They also have a decreased amount of brain tissue causing brain damage, restricted body movements due to increased muscle tone (limited range of motion of joints), epilepsy, hearing and vision disturbances, and learning disabilities. There is no treatment, but immediate assessment and early intervention can have a positive impact on the child's development [9].

Although Zika has been found in breast milk, there have been no reports of health issues in breastfed babies of infected mothers [8]. Because of the many benefits of breastfeeding, both the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine recommend breastfeeding even in areas where Zika is found [10].

Future Pregnancies

Current evidence shows that Zika virus poses a threat only to women who are pregnant at the time of or close to the time of virus exposure [8]. If a woman is infected with Zika prior to pregnancy and the virus is eradicated, there does not seem to be a risk for Zika virus sequela in future pregnancies. The notion is that once a person is infected with Zika they are protected from future Zika infections [8].

Diagnosis

Zika virus is generally mild, and because only 20% of affected individuals show any symptoms, it may go unnoticed [2]. The current recommendation of ACOG is that all pregnant women in the United States and U.S. territories should be assessed for possible Zika virus exposure at each prenatal visit. Assessment questions focus on travel or residence in an area of mosquito-borne transmission of Zika or unprotected sex with a person who meets the relevant criteria.

If a pregnant woman has a suspected or confirmed Zika virus infection, regular monthly ultrasounds can identify developing anomalies. Once the infant is born, infant serum should be collected within two days of birth. The newborn's head circumference should be measured within the first 24 hours of birth and compared to growth standards related to its gestational age, weight, and length [10].

Management

Treatment for the Zika virus itself is management of its associated symptoms. Acetaminophen is used to relieve joint pain and fever, and fluids are used to prevent dehydration. Rest is encouraged to allow the body to recover [11].

Management for Guillain-Barre, the most common neurological sequelae of Zika, includes supportive care and monitoring of vital signs. Complications include hypertension and hypotension, blood clots, irregular heartbeat, and impaired breathing. Treatments used

(continued on following page)

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THE ZIKA THREAT

(continued from previous page)

include plasmapheresis (plasma exchange) and immunoglobulin therapy (IVIG), along with pain relief and anticoagulant therapy [7].

Treatment of microcephaly and congenital Zika syndrome, the most devastating sequelae of Zika acquired during pregnancy, include initial evaluation, comprehensive ophthalmologic and otic exams, and a head ultrasound within a few days after birth [12]. Infants with microcephaly and congenital Zika syndrome are at risk of developmental delays and disabilities and should be referred to early intervention services. Other referrals include neurology for a comprehensive neurological exam, infectious disease for other possible congenital infections, and genetics for confirmation and evaluation of the initial diagnosis. In addition, families will require ongoing emotional support. A multidisciplinary team will be required to coordinate care for these infants [12].

Conclusion

Zika is a nationally reportable condition. Any suspected Zika virus disease must be reported to the local, state, or territorial health department to mitigate risk of local transmission and to facilitate diagnosis. Nurses provide accurate information and can help guide their patients effectively. If there is a Zika outbreak, healthcare providers and nurses should discuss reproductive plans with women of reproductive age.

Nurses can also support mosquito control in their districts. Nurses that reside in rural areas can campaign for governmental support for mosquito nets and spraying. Nurses should collaborate with health care agencies to prepare protocols of clinical care and follow up for patients diagnosed with Zika.

References

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Zika Nursing Implications

Nurses have a primary role in educating all members of their community with information they need to protect themselves. Zika currently has no cure and no vaccine, although work is currently underway [1]. Therefore, the strategies to prevent transmission of Zika are all preventative. Below are recommendations from the Centers for Disease Control and Prevention (CDC):

Mosquito Safety:

Individuals should be dressed with long sleeved shirts, pants, socks (no bare legs), and shoes. Use an Environmental Protection Agency (EPA) approved insect repellent spray or lotion. If it contains DEET, it should have at least 20% DEET. Do not use repellent under the clothes. Use the repellent night and day, as these mosquitoes are constantly active (unlike others who are active only at dawn and dusk). Protect interior spaces with tightly fitted, intact screens and ensure doors are closed. If possible, use air conditioners. Most importantly, remove all standing water from outside areas. Even a small bottle cap contains enough water for the Aedes Aegypti mosquito to reproduce.

Sexual Safety:

To prevent sexually acquired Zika, individuals should use a barrier method of birth control.

Blood Donation Safety:

If your patient has been exposed to Zika, recommend a minimum of one month's waiting period prior to donating blood.

Caregiver Safety:

Protect yourself from exposure to the patient's blood and body fluids.

Pregnant Caregiver Safety:

Do not expose skin to blood or body fluids or surfaces with these fluids on them. Wash hands thoroughly using soap and water immediately after providing care. If clothing gets blood or body fluids on it, remove and wash immediately following garment label directions. Bleach is not necessary.

Preconception Safety:

If a woman was diagnosed with Zika, she should wait at least two months from initial symptom onset to attempt pregnancy. Men diagnosed with Zika should wait a minimum of six months before attempting pregnancy.

References:

[1] Centers for Disease Control and Prevention. (2018). Treatment. Accessed 4/15/18. https://www.cdc.gov/zika/symptoms/treatment.html

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Resources for Nurses:

American College of Nurse Midwives
http://www.midwife.org/Resources-for-Zika-virus

American College of Obstetricians and Gynecologists
https://www.acog.org/zika?p=1

Association of Women's Health, Obstetric, and Neonatal Nurses
http://www.awhonn.org/?ZikaVirus

Centers for Disease Control and Prevention
https://www.cdc.gov/zika/index.html

Pan American Health Organization
http://paho.org
http://www.paho.org/zika

World Health Organization
http://who.it
http://www.who.int/mediacentre/factsheets/zika/en/

Tobi Ash, MBA, BSN, RN & Tziporah Newman, BSN, RN

Disaster Preparedness in Summer Camps

Parents and children benefit from the Summer camp experience. Parents get respite or a "vacation from the kids". Children gain social skills, have more time for unstructured play, are more physically active than during the school year, unplug from technology, and grow more independent. But how safe are camps during a crisis or an emergency? An article in the Southern Medical Journal surveyed all camps registered with the American Camp Association about their disaster preparedness. They received 169 complete responses. More than 60% were overnight camps and 14% were special needs camps [1].

Disasters are defined as natural, manmade, or medical. Natural ones include all weather related events such as storms, floods, tornadoes, and severe weather. Man-made disasters include a prolonged period of time without electricity or, more frightening, an act of terrorism or a violent crisis that requires a lockdown. Medical emergencies include a spread of illness and the need for quarantine. 53% percent of the camps surveyed did not have emergency plans listed on their website. 40% did not have a plan in place to identify children for evacuation or reunification with parents in case of a disaster. 25% did not have a method to rapidly communicate information with parents in case of a disaster. Worse, 38% did not have a plan in place for children with special needs [1]. Finally, more than 75% percent, the majority of camps did not coordinate with local and national disaster organizations. The camps also had insufficient generators, food, water, and other supplies in case of a disaster [1].

Most camps are located in bucolic, pastoral settings far from emergency medical services, fire stations, police headquarters, and hospitals. More than a third of the camps in the survey were more than five miles away from fire or police stations. About 18% were more than 20 miles away from a major medical center [1]. Additional challenges that these areas face are poor cellular service, minimal security, and counselors that may be young and untrained with little to no knowledge of the area. In addition, the numerous recent bomb threats to Jewish Community Centers across the United States and other countries has revealed vulnerability to Jewish communities leaving Jewish day and overnight camps as a target.

During a disaster, vulnerable children look to the adults in charge to assist them. The Jewish community showcases camps for kids with special needs with various medical, emotional, psychosocial, and physical needs. It is imperative that these camps be prepared for all contingencies.

Camp leadership must identify plans for potential emergencies and create protocols to deal with such crises. They must also train all staff, including counselors and junior counselors, what to do in case of an emergency. Camps should partner with local and national disaster relief agencies to be educated and well prepared for a disaster. Survival during a disaster should not depend solely on individual initiative, but rather collective commitment and planning by and for everyone [2].

Resources:

The American Camp Association offers worksheets and tools for camps. https://www.acacamps.org/resource-library/campline/emergency-preparedness

Are you ready? An In-Depth Guide to Citizen Preparedness from the Federal Emergency Management Agency.

https://www.fema.gov/pdf/areyouready/areyouready_full.pdf

References:

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[2] Roth, M. (2017). Everyone must be prepared for emergencies. Retrieved from https://www.fema.gov/blog/2015-04-29/everyone-must-be-prepared-emergencies

Novel Vaccine Technologies

The Journal of the American Medical Association recently reported that scientists at the National Institute of Allergy and Infectious Diseases (NAID), a division of the National Institutes of Health, stated that synthetic vaccinology and other innovative vaccine technologies are critical to responding to newly emergent and re-emerging infectious diseases. Most vaccines that target viruses are made from weakened (live attenuated) or inactivated whole viruses. This process requires virus culturation, product formulation, testing (via animal studies and immunogenicity), and years of clinical trials over a 15 to 20 year span. Platform manufacturing and synthetic vaccinology shorten the process significantly and allow clinical trials to begin much faster. Additionally, synthetic manufacturing doesn't replicate live pathogenic viruses and therefore doesn't need a high-level containment facility. Synthetic vaccinology platforms use viral gene sequencing to create DNA and mRNA molecules that have encoded viral proteins. Once these platforms are created, the potential is there to create vaccines for multiple pathogens that are in similar virus families or classes. The NAID Vaccine Research Center was able to develop a candidate DNA Zika virus vaccine using synthetic technology using the same platform that was used for the West Nile virus. This technology allows scientists to create a standardized manufacturing process for multiple vaccines, and more importantly, a collective database on efficacy and safety. These processes streamline and shorten the previously lengthy preclinical process from years to several months. These modern technologies can help better prepare for emerging and re-emerging health threats in a quicker fashion [1].

References:

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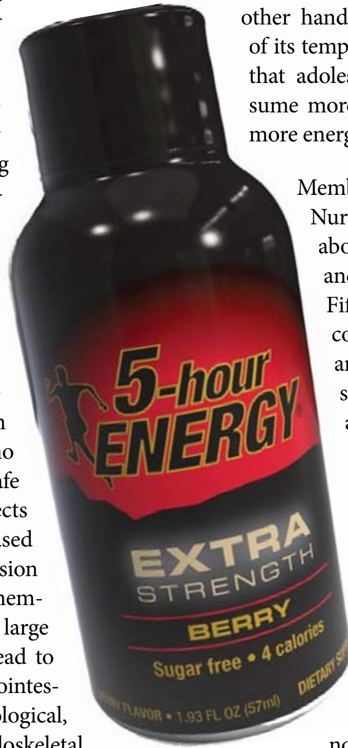
The Buzz on Nurses and Energy Shots

A recent study highlighted nursing knowledge of high energy drinks (HED), coffee consumption, and energy shots. A literature review shows that energy shots have more caffeine per fluid ounce than coffee and high energy drinks [1]. The amount of caffeine varies between 95 mg per 8-oz cup of coffee, 74 mg per 8-oz HED, and an astonishing 200 mg per 2-oz energy shot [2,3,4].



The United States Food and Drug Administration states that the safest amount of caffeine intake per day should be less than 400 mg. However, there is no sufficient evidence of a safe amount. The positive effects of caffeine include increased alertness, improved decision making, and enhanced memory capability. Ingesting large amounts of caffeine can lead to addiction as well as gastrointestinal, cardiovascular, neurological, psychological, and musculoskeletal disorders. The ingestion of energy shots causes a faster metabolization of caffeine because they are kept at room temperatures and are therefore consumed quicker. Hot coffee, on the other hand, is consumed slower because of its temperature. It is interesting to note that adolescents and young adults consume more HEDs while adults consume more energy shots [1].

Members of the New Jersey State Nurses Association were surveyed about their practice, knowledge, and attitudes toward energy shots. Fifteen percent of the respondents consumed at least one HED daily, and 10% consumed daily energy shots. Nurses expressed concern about the use of HEDs and energy shots in conjunction with medication usage. More than half of the respondents stated that while there is no sufficient evidence for safe caffeine intake, they drank an average of one to three cups of coffee per day. Nearly all respondents agreed that energy shots have no nutritional value and were not safe to consume. Nurses who consume energy shots stated that they drank them to enhance their focus and attention and to stave off exhaustion. More nurses are turning toward the consumption of energy shots to stay awake during 12- to 18-hour shifts [1].

Nurses can educate adolescents and young adults, in a variety of healthcare settings, about safe use of high energy beverages. Nurses can educate their patients and coworkers on the side effects of caffeine and safe caffeine levels. Future studies should be aimed towards a larger nursing population and focus on nurses' use of caffeinated beverages, nurses' knowledge of side effects, and the risks of excessive caffeine consumption.

References:

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Vector-Borne Illnesses on the Rise

The Centers for Disease Control and Prevention reported on May 1, 2018, that nine new illnesses spread by mosquitoes and ticks have been discovered or introduced into the United States since 2004 [1]. Incidence of disease related to mosquitoes, ticks, and flea bites tripled in the United States from 2004 to 2016, with more than 640,000 cases reported. Nurses can educate the community to prevent insect bites by using an Environmental Protection Agency (EPA) insect repellent, and treating boots, pants, and socks with permethrin or encouraging the purchase of permethrin-treated gear. Nurses need to educate on the need to wear long-sleeved shirts, pants, and socks, and inspection and removal of ticks on a daily basis on family members and pets. Education should include the importance of managing mosquitoes, ticks, and fleas inside and outside the home.

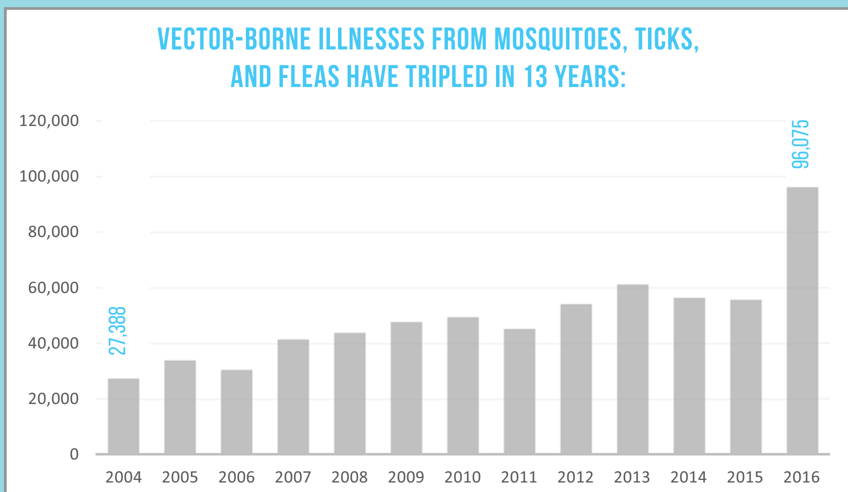

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Chart References:

Centers for Disease Control and Prevention. (2018, May 01). Vital signs: Illnesses on the rise infographic. Retrieved May 15, 2018, from https://www.cdc.gov/vitalsigns/vector-borne/infographic.html

The Woodhull Study: Why Aren't Nurses Present in the Media?

Tobi Ash, MBA, BSN, RN

Nursing is regarded as one of the most trusted professions [1], as well as the largest healthcare occupation in the United States [2]. There are three times as many nurses than doctors [3]. Although nursing may be regarded as providing direct patient care, the work and influence of the nursing profession extends far beyond that. Nurses are focal actors in the entire health care system, supporting and sustaining the delivery of health to the community. Despite nursing's vital role, nurses remain "largely invisible" [4] in the media.

In 1998, the Center for Health Policy and Media Engagement at Georgetown University School of Nursing conducted the Woodhull Study (named for its principal investigator) to look at nurse representation in the media [4]. These articles and stories featured all aspects of healthcare: policy, research, business related to and healthcare practices. Researchers found that nurses were only mentioned in 4% of health-related news articles. Twenty years later, this study was replicated to see if nursing representation in the media had improved [4]. The authors were shocked to discover that nurses appearing as sources in the media had actually fallen to 2%. Nurses were rarely mentioned in articles or stories about research, health policy and health care business. Further, only 44% of articles *about nursing* used nurses as sources [4].

There are several barriers that contribute to nursing invisibility in the media. First, institutional and public perception of nurses may not consider nurses to be important health care decision makers. When health care quotes are needed, physicians are contacted to provide them rather than nurses. The general public does not realize the rich diversity of nursing roles in leadership, education, and health policy. It is challenging to communicate *all* the work that nurses do. Nurses are discouraged from using their credentials in publications, and health institutions rarely grant nurses permission to speak to the media in an official capacity [4].

Second, media depictions of nurses often portray a stereotypical nurse that does not reflect modern, educated nurses. The media also lacks the knowledge of the vast range of nursing roles and positions, as well as nursing educational backgrounds. Additionally, most nursing activities deal with the body, disease and death, subjects most people don't like to talk or even think about.

Approximately 90% of nurses are female [5]. There may be the assumption that women have an innate talent for caregiving and therefore, are merely contributing care from their own natural inclinations, rather than from a well educated perspective. As with any female dominant profession, "women are statistically half as likely as men to be quoted in the media" [4]. The study highlighted that men were quoted 65 percent of the time (almost twice) than women at 34 percent in health articles. If there were any photographs, female images appeared 28 percent of the time and men *72 percent* [5].

Nurses themselves are not reaching out to journalists and reporters which make them less available and less accessible to the media. Medical journals regularly reach out to popular media sources, but nursing journals do not. The researchers also reviewed Twitter hashtags of 47 top nursing schools. Very few of these Twitter accounts used hashtags to capture outside attention; instead, they used hashtags to communicate exclusively with nurses. In fact, less than 2% of these nursing schools' social media followers are from the media at large [4].

There are strategies to make nurses more present in the media. Nurses should seek training in social media and use social media responsibly by writing and sharing their stories with the media [4]. Additionally, overt sexism and society's preconception of what women are must be challenged. Women have been socialized to defer judgments and speak less than men. Women may also be complicit in this very sexism by further restricting nurses from creating and enforcing policy and management decisions and attaining far greater influence.

The health care hierarchies may perpetuate the myth that nurses are only useful as lackeys—with doctors firmly at the top and nurses in their historical subordinate position. Patients are admitted under a single physician, while a rotation of nurses provide virtually all of their care. Do nurses' selfless and subservient diligence further entrench their invisibility?

While nurses grapple with their invisibility, they must analyze all angles to include the possibility that they are not doing all they can to increase their presence and visibility in the media and to the general public. Nurses are a cohort of four million educated health care professionals [6] and are highly regarded by the public as trustworthy individuals. Nurses must use their collective knowledge and resources to educate the public about their important role in the health care community.

Resources for Social Media Savvy Nurses (adapted from Charting Nursing's Futures) [3]:

RN = Real News: Media Relations & You

An online independent study module aimed at helping prepare nurses to use media to communicate and advance their nursing organization's objectives.

http://ana.nursingworld.org/mods/archive/mod230/cerntoc.htm

Media Tools for NPs

This website features "how-to" advice on writing a press release, preparing for an interview, and more. (Available to American Association of Nurse Practitioners members only.)

https://www.aanp.org/press-room/media-tools-for-nps

The OpEd Project

An organization offering programs, resources, and online suggestions to help improve written and spoken media communication skills.

https://www.theopedproject.org/

Nurse Messenger Media Training

Customized workshops in strategic messaging for your workplace or association.

http://healthmediapolicy.com/about/nurse-messenger-media-training/

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Summer Dangers: Drowning and Burns

Tobi Ash, MBA, BSN, RN

The word summer may conjure up visions of picnics, swimming pools, bright sunny days, and fun. Nurses also know that summer is a time of increased dangers and disasters. Summertime usually means a prolonged time outdoors for both adults and children. People are more relaxed and may not be as careful as they ought to be. The most common dangers are drowning and burns.

Drowning

According to the World Health Organization, "Drowning is the process of experiencing respiratory impairment from submersion or immersion in liquid" [1]. Drowning can be fatal. Survival is highly dependent on two variable factors: how swiftly the individual is removed from the water and how quickly resuscitation is performed [1]. In the United States, drowning is the second leading cause of unintentional death in children ages one to 14. The Global Report on Drowning states that drowning is the number one cause of death in children zero to four years old [2]. The Consumer Products Safety Commission (CPSC) tracks pool and spa safety statistics and reports that the majority of deaths related to drowning in the United States happen in June, July, and August [3]. In 2017, 163 children drowned in swimming pools or spas between Memorial Day and Labor Day, with the warm weather states of Florida, California, Texas, and Arizona having the most fatalities [3]. Sadly, of the 163 fatalities, 112 of them were children under the age of five [3]. Children can be very attracted to water and not recognize the inherent danger. Children can drown in as little as 2 in. (6 cm) of water [2]. Males have a higher drowning risk than females, as male drowning victims die from drowning 50% more frequently than females [1]. There is a significant difference in freshwater drowning (most commonly swimming pools, bathtubs, and lakes) and saltwater drowning [4]. Fences, barriers, life jackets or vests, swimming lessons, and constant attention while in the bath or pool are all needed to ensure water safety [1]. Prehospital care is vital if someone has drowned as effective and early CPR gives the patient the best chance of survival [4]. The classic scene of a drowning victim splashing and shouting in the water happens only in the movies. Most individuals who drown do so quietly and calmly [2]. The most effective way to "treat" drowning is by prevention.

The CPSC provides the following recommendations to prevent drownings [3]:

- There must always be a conscientious adult present to supervise children at all time around water.
- Learn how to swim and teach children how to swim.
- Learn CPR for both children and adults.
- All pools and spas should have a four sided fence with a self closing and self latching gate.
- All pools and spas should have a drain cover that complies with federal safety standards.

Burns

Though burns can happen at any time, summertime is synonymous with barbeques, campfires, bonfires, and fireworks. A sunburn is not often thought of as a major injury, but children spend more time outdoors than adults do during the summer. Children may be taking medications that make them photosensitive or even phototoxic. The Centers for Disease Control and Prevention (CDC) states that major sunburns are a risk factor for skin cancers later in life [5]. As with drowning, prevention is key.

Some tips from the CDC to prevent sunburns include [6]:

- Stay in the shade from 10 a.m. to 4 p.m. to avoid the midday sun.
- Wear sun protective clothing and accessories: shirts, hats, and sunglasses.
- Wear sunscreen that blocks both UVA and UVB rays and apply to all exposed skin.
- Apply sunscreen at least 20 minutes before going out in the sun.
- Use SPF 15 or higher.
- Reapply every two hours when outdoors and every time you get out of the water.
- If using a bug spray, apply the sunscreen first and then the bug spray.

Sunburns should be treated with aspirin, acetaminophen, or ibuprofen to relieve pain, headache, and fever. Soothe burns with cool baths or by gently applying cool, wet cloths. Use a topical moisturizing cream or aloe to provide additional relief. Do not go back into the sun until the burn has healed. If skin blisters, lightly bandage or cover the area with gauze to prevent infection. Do not break blisters as this slows healing and increases the risk of infection. Apply antiseptic ointment if blisters break. Go to the emergency room for a severe sunburn that is accompanied by high fever (greater than 101°), pain lasting more than 48 hours, and/or dehydration [6].

The American Burn Association (ABA) reviews data of burns from all fires. In the summer, most burn injuries occur from grilling, campfires, and fireworks [7]. There must be a minimum 3 ft (1 meter) radius around the fire or grill as a safety zone for burn prevention [7]. More than 70% of barbeque and campfire burns are caused by embers rather than flames, so no one should handle hot coals. Campfires must be extinguished with water rather than sand as the remaining embers can cause full thickness burns up to eight hours later [7]. Independence Day celebrations usually feature professional fireworks but many individuals purchase fireworks from stores and kiosks. The National Fire Protection Association reports that non-professional fireworks cause structure, vehicle, and outdoor fires with direct property damage, permanent and debilitating injuries, and even death [8]. The Annual Fireworks Report compiles statistics on firework damage to humans [9]. In 2016, close to 12,000 people were treated for firework injuries in emergency rooms in the United States [9]. More than half of those injuries were to the extremities and 39% of those injured were under the age of 20 [9]. Sparklers and bottle rockets may look harmless, but they accounted for 1,300 injuries alone. 69% of all firework injuries resulted in burns [9].

Summer is a wonderful time to enjoy the family, beach, or pool, to relax outdoors, and reconnect with nature. Nurses are at the forefront to educate the community on how to prevent summer's biggest dangers: drowning and burns.

Resources:

Pool Safety Pledge

https://www.poolsafely.gov/

The Federal Emergency Management Agency and the American Burn Association have excellent fact sheets in English and Spanish with vital lifesaving information on campfire, grilling, and firework safety.

https://www.usfa.fema.gov/prevention/outreach/summer.html

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Lyme Disease Prevention and Education

Tobi Ash, MBA, BSN, RN

Lyme Prevalence, Symptoms, and Treatment

According to the Centers for Disease Control and Prevention (CDC), Lyme disease is a disease caused by the Borrelia burgdorferi bacteria which is transmitted to humans through the bite of an infected blacklegged tick [1]. Although these ticks can be found year-round, they are most active in the summer months [2]. Lyme disease is the most commonly reported vector borne illness in the United States [3]. In 2016, there were 36,429 reported cases of Lyme disease in the United States and its territories [4]. Since not every diagnosis is reported, the CDC adjusts the amount of individuals affected to account for unreported data. The CDC conducted two studies in 2015 to survey laboratories for positive Lyme tests and reviewed medical insurance claims for Lyme disease [3]. These studies revealed that approximately 300,000 individuals are infected with Lyme annually in the United States and its territories [5]. Ninety six percent of these cases occur in 14 states in the Northeast and upper Midwest regions [3].

Lyme disease is diagnosed based on physical findings and history of exposure to infected ticks [1]. Initial symptoms occur three to 30 days after the tick bite and include: fever, headache, fatigue, joint and muscle aches, and the characteristic "bullseye" rash known as erythema migrans. This rash usually begins at the site of the tick bite although it can appear anywhere on the body. The rash can expand to about 12 in. (30 cm) gradually over a few days. It is rarely itchy or painful, but may feel warm to touch. Although the bullseye rash is well known as an indicator of Lyme disease, it is important to note that approximately 25% of infected patients do not develop it. If left undiagnosed, within days to months after the infection, Lyme disease can affect the heart, joints, and nervous system. Lyme carditis includes cardiac symptoms such as heart palpitations or an irregular heart beat. Nervous system involvement would include symptoms such as facial palsy, dizziness, inflammation of the brain and spinal cord, nerve pain, shooting pains, numbness or tingling in the hands and feet, and affected short term memory. Musculoskeletal symptoms include neck stiffness, severe headaches, joint swelling, and severe pain in large joints, especially the knees, and intermittent pain in muscles, joints, tendons, and bones [2].

Treatment of Lyme disease should begin as soon as the diagnosis is made. Oral doxycycline, amoxicillin, or cefuroxime axetil is prescribed to children and adults during the initial stage of Lyme disease. It is typically given for 10 to 21 days. Patients who have delayed treatment or have a more severe form of Lyme disease, will receive IV ceftriaxone or penicillin treatment for one to three months. According to the CDC, even with a timely and appropriate course of antibiotics, about 28% of patients experience residual symptoms after treatment [10].

Nursing Measures for Lyme Disease

Prevention is always the best medicine. Nurses have the opportunity to educate about the prevention of Lyme disease, how to identify and remove ticks, and what the early symptoms of Lyme disease are.

The easiest and best method of preventing Lyme disease is reduce exposure to ticks. In the summer months, it is difficult for families and children at camp to avoid grassy lawns and wooded areas where ticks are found. Nurses can educate the community to avoid playing with leaves, sitting on rock walls, rolling down grassy hills, or leaning against tree trunks. Nurses can encourage the use of products that contain 20% or more of DEET, picardin, or IR3535 which are safe to use on exposed skin. Parents should be instructed to apply repellent to their children, avoiding the eyes, hands, and mouth. Clothing pretreated with permethrin (tick killer) is available on Amazon, L.L.Bean, and other sites. Pretreated clothing retain insect repellent for up to 70 washes which makes it useful for wear at summer camp. Permethrin spray is also available for purchase but should not be applied directly to skin.

Similar to prevention of mosquito bites, nurses should emphasize the importance of wearing socks and shoes in addition to long sleeved shirts tucked into long pants, as this makes it difficult for ticks to attach to skin. Light colored clothing makes it easier to spot dark colored ticks. Hair should be pulled back to avoid ticks climbing on hair. After spending time outdoors, patients should be instructed to do a full body check and inspect household pets and outdoor equipment. A bath or shower is encouraged within two hours of being outdoors to find or wash off ticks that may be crawling on the body. Parents of children should scan their children's outer and inner ears, underarms, around their waist, umbilicus, between their legs and knees, and their hair. Ticks cannot tolerate heat, so after washing clothes worn outdoors, clothing should be dried thoroughly with high heat [6].

Adult ticks are the size of a sesame seed. Young ticks, known as nymph ticks, are the ones that infect most humans and are the size of a poppy seed [7]. To transmit the bacteria which causes Lyme disease, the tick has to be attached to skin for longer than 36 to 48 hours [8]. Nurses should instruct patients to remove the tick as soon as it is found. If the patient is too frightened to do it themselves, they can contact their healthcare provider to assist in removal. The proper way to remove a tick is to use a fine tipped tweezer (needle style) and grasp the tick as close to the skin as possible. Pull the tick straight up and out in a smooth motion using steady pressure.

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LYME DISEASE

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Under no circumstances should one grasp, twist, or squeeze the body of the tick. A hot match should never be used to "burn" the tick. Further, nothing should be applied to the skin while the tick in embedded. If the health care provider wants verification, the patient removing the tick should place the tick into a ziploc bag. If not, the patient can flush the tick down the toilet or they can place the tick from the tweezers onto a cotton pad soaked in isopropyl alcohol. The cotton pad can then be placed into a plastic bag and thrown away. After the tick has been removed, antiseptic ointment should be applied to the skin. Wash hands thoroughly after tick removal, and monitor the affected skin for 30 days. If any symptoms such as rash, fatigue, headache, or fever occur, a healthcare provider should be notified [8].

For the past 15 years, nurses have been consistently ranked as one of the most trusted professions [9]. Prevention is the best protection against Lyme disease. Nurses need to increase awareness about Lyme disease prevention and education within the community. In any setting, nurses always have an opportunity to share knowledge and education to patients and families.

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Naloxone in the News

Sarah Bracha Cohen, MS, RN

The Opioid Epidemic

In the late 1990s, there was an increase in opioid prescriptions based on reassurance by pharmaceutical companies that patients were not at risk of becoming addicted [1]. By the time it became clear that these medications could, in fact, cause addiction, there was already widespread misuse of prescription and non-prescription opioids [1]. According to the Centers for Disease Control and Prevention (CDC), opioid-related overdose deaths quadrupled between 1999 and 2015 [2]. More than 115 people die of opioid overdose every day in the United States [3], and it is now the leading cause of death among Americans aged 50 and under [2]. The CDC estimates that prescription opioid misuse costs the United States a total "economic burden" of $78.5 billion each year, which includes costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement [4]. In 2017, the United States Department of Health and Human Services (HHS) declared opioid misuse a public health emergency [1].

What Are Opioids?

Opioids are medications that act on opioid receptors found in the spinal cord, brain, gastrointestinal tract, and other organs in the body to inhibit the transmission of pain signals [4]. The most commonly prescribed opioid medications include hydrocodone (Vicodin), oxycodone (OxyContin, Percocet), oxymorphone (Opana), morphine (Kasian, Avinza), codeine, and fentanyl [4]. These medications are chemically very similar to heroin, which was originally synthesized from morphine in the late 19th century [4]. Misuse of prescription opioids can lead to eventual transitioning to heroin use [4]. The most common use of opioids is for treatment of acute pain; but despite weak evidence on the effectiveness in long term use, they have been increasingly prescribed to treat chronic pain [4].

In addition to pain relief, some opioids, such as codeine and diphenoxylate (Lomotil), relieve coughs and severe diarrhea [4]. Opioids also activate the reward centers in the brain causing euphoria—or a high—that contributes to the potential for misuse, addiction, and overdose. This is especially true when they are taken in ways other than intended, such as by snorting or injecting them, or at doses higher than prescribed [4]. Opioids, even when taken as prescribed, can produce drowsiness, mental confusion, nausea, constipation, and respiratory depression, which can be fatal [4].

When taken regularly or for long-term use, opioids can lead to dependence (physical discomfort when not taking the drug), tolerance (diminished effect from the original dose which leads to an increased amount needed to attain the desired effect), and addiction (compulsive drug seeking and use) [4]. Withdrawal symptoms may occur if drug use is suddenly reduced or stopped [4]. These symptoms may include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goosebumps, and involuntary leg movements [4].

A consequence of chronic opioid use among pregnant women is newborn drug withdrawal, known as neonatal abstinence syndrome (NAS). This is due to opioid use and misuse during pregnancy [3,5]. More than 50 babies are born each day suffering from opioid withdrawal [5].

The Opioid Reversal Drug, Naloxone

Naloxone, first manufactured in 1960 [6], is an opioid-antagonist which binds to opioid receptors to block the effects of opioids to rapidly reverse overdose [7]. It can quickly restore normal respiration to a person whose breathing has slowed or ceased as a result of an opioid overdose [7]. Having immediate access to naloxone is crucial in preventing irreversible opioid overdose-related harm that increases with the amount of time a person suffers from respiratory depression [2].

There are currently three Food and Drug Administration (FDA)-approved naloxone formulations: professional use injectable vials, prefilled auto EVZIO devices for quick and easy injection into the outer thigh with guided verbal instructions by the device (similar to automated defibrillators), and prepackaged needle-less NARCAN Nasal Spray [7]. Both EVZIO and NARCAN Nasal Spray are easy to use and appropriate for home use in emergency situations and are supplied in a carton containing two doses to allow for repeat dosing if needed [7]. There have been other medications combining the injectable form of naloxone with an aerosol form to deliver naloxone intranasally. However, these were found to deliver ineffective doses of naloxone according to FDA-approved guidelines. In

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2016, one manufacturer issued a voluntary recall when the medication was found to be ineffective [7].

The legality of prescribing and administering naloxone varies by state. While some states allow anyone to administer the auto-injector and nasal spray naloxone to one who has overdosed, other states require a prescription from a physician [7]. Some states even allow pharmacies to distribute naloxone in an outpatient setting without a prescription [7]. Since the recent passage of naloxone access laws, there has been a 79% increase in the dispensing of naloxone in retail pharmacies [2] and a 14% reduction in opioid-overdose mortality as compared to states without these laws [8].

Naloxone, A Complex Resolution

Naloxone use in opioid-dependent individuals can lead to induction of an acute withdrawal syndrome with agitation and irritability, wild mood swings, insomnia, muscle cramping, nausea, diarrhea, or potentially life-threatening vomiting and aspiration [6,9]. Additionally, the effect of naloxone may wear off quickly when used for treatment of opioid-induced respiratory depression, and high-dose naloxone and/or rapidly infused naloxone may cause catecholamine release, which can lead to pulmonary edema and cardiac arrhythmias [6]. Naloxone can cause fatal seizures and respiratory failure in patients who have been chronically addicted to certain opioids, such as heroin [9]. These risks require cautious use of naloxone and close cardiorespiratory monitoring after administration [6], which can be a challenge when faced with administration outside of a healthcare setting.

Naloxone administration comes with many challenges. Before administering naloxone, especially to a close friend or loved one, many feel a sense of panic and anxiety related to a lack of preparation, inexperience with overdose, the need to respond quickly, the terrifying state of the victim, and the fear of being blamed for the outcome [10]. These feelings, in turn, often cause people to act on instinct rather than protocol [10].

In contrast to the daunting feelings pre-administration, many feel a sense of relief and pride after successful naloxone administration, providing the administrator with a sense of empowerment [10]. Many relationships are strengthened after a successful naloxone administration [10]. Some reevaluate their own lives and make changes after witnessing an overdose [10].

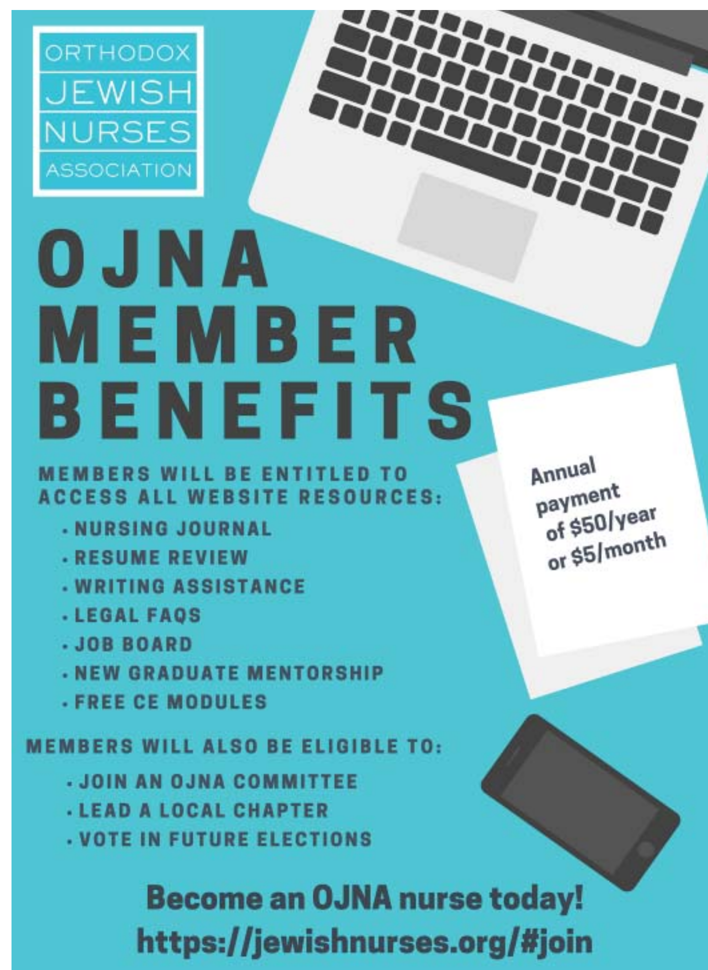
Others feel a sense of disappointment and heartbreak when the drug does not work as expected and their loved one dies [10]. Often times people are faced with verbal and physical abuse from those they are trying to save as a result of the onset of acute withdrawal [10]. In addition, naloxone recipients are often resentful about being robbed of their "hit" or the interruption of a suicide attempt, and may accuse others of drug theft [10]. These negative reactions can be very detrimental to relationships when one administers naloxone to a loved one. People often return to their drug-seeking behaviors following a naloxone revival which can be very disheartening to those trying to save them [10].

Other Treatment Solutions

There are various pharmacotherapies that can be used in the treatment of opioid and substance use disorders (OUD and SUD). Methadone has been legal in the United States since 1947 and is used to suppress opioid withdrawal symptoms up to 36 hours after administration [11]. Patients receive methadone (Dolophine), an opioid analgesic, as an opioid replacement therapy in either pill or liquid form at both public and private methadone clinics [11]. Methadone is prescribed by a doctor, and although it is not a cure for addiction, it is considered effective when used as part of a more comprehensive treatment program [11]. People who visit methadone clinics often see a decrease or complete avoidance of withdrawal symptoms, opioid cravings, illicit opioid effects, and opioid dependence [11]. In addition to administering methadone, these clinics can provide patients with counseling and ensure treatment compliance by requiring random blood and/or urinalysis tests [11]. Counselors often use Cognitive Behavioral Therapy (CBT) to help change patients' behaviors and expectations and develop various coping skills during opioid treatment [11].

Common side effects of methadone use include light-headedness, labored or shallow breathing, chest pain, rapid heartbeat, confusion, hallucinations, muscle tremors, nausea, vomiting, diarrhea, and abdominal cramps [11]. If not administered appropriately, methadone can become addictive and can even cause overdose, and therefore must be closely managed by trained medical personnel [11]. Potentially fatal signs of methadone overdose include constipation, nausea, vomiting, stomach/intestinal spasms, low blood pressure, weak pulse, breathing disturbances, dizziness, fatigue, disorientation, weakness, blue fingernails and lips, cold and clammy skin, and coma [11].

More than 115 people die of opioid overdose every day in the United States, and it is now the leading cause of death among Americans aged 50 and under.



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NALOXONE IN THE NEWS

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A recent medication listed on the World Health Organization's essential medications list is sublingual buprenorphine hydrochloride [12]. This medication is a partial μ-opioid receptor agonist and is used to relieve drug cravings with fewer side effects [11]. Despite its efficacy, daily sublingual and buccal buprenorphine with combined naloxone (Suboxone) [9] have limitations including poor medication adherence, diversion, intravenous misuse, and unintended pediatric exposures [12]. Weekly and monthly subcutaneous buprenorphine depot injections and six-month buprenorphine implants are new buprenorphine formulations that are dose-proportional and long-acting with improved efficacy and higher rates of no illicit opioid use in a six month period [12].

Other treatment options of OUDs include naltrexone, a non-addictive daily medication that blocks opioid effects without causing physical dependence, and Vivitrol which is monthly injectable form of naltrexone [11]. Some patients choose to experience intentional medical detox with close monitoring until withdrawal symptoms subside [11]. Physical symptoms, such as runny nose, teary eyes, hot and cold sweats, pains, nausea, vomiting, diarrhea, and abdominal cramps, can take anywhere from one week to a month to subside, and emotional symptoms, such as anxiety, insomnia, and low energy, can last for several months [11].

Many European countries have decided to take a very different approach to addressing its opioid epidemic. In Denmark, a comprehensive harm reduction initiative has been established that includes needle and syringe distribution, take-home naloxone programs, drug consumption rooms, and heroin-assisted treatment [13]. Prevention and treatment is also provided, including counseling, screening, vaccination against hepatitis A and B viruses, and access to general health services [13]. Needles and syringes are provided at pharmacies, treatment institutions, drop-in centers, public dispensing machines, and shelters and hostels [13]. Supervised drug consumption facilities provide services to those injecting and inhaling drugs. Between 2012-16, drug consumption rooms supervised more than 920,000 drug administrations to more than 9,400 drug users, without any fatal outcomes [13]. Heroin-assisted treatment provides hard-to-treat opioid users with clean heroin for self-injection or oral use [13]. Other countries implementing such programs include France, Germany, Luxembourg, Netherlands, Norway, Spain, and the United Kingdom [13].

What is the United States Doing?

In 2017, under President Trump, HHS released a new five-point opioid strategy. The five priorities include: improving access to prevention, treatment, and recovery support services; promoting the availability and distribution of overdose-reversing drugs; strengthening public health data reporting and collection; supporting cutting-edge research on addiction and pain; and advancing the practice of pain management [14]. In 2017, HHS invested nearly $900 million in opioid funding including the support of treatment and recovery services, availability of overdose-reversing drugs, and training first responders in support of state and local governments and civil society groups [14].

At the National Rx Drug Abuse and Heroin Summit in April 2018, the National Institute of Health (NIH) announced the launch of the Helping to End Addiction Long-term (HEAL) Initiative, an aggressive, multi-agency effort to speed scientific solutions to stop the national opioid public health crisis [15]. The NIH stated it is nearly doubling funding for research on opioid misuse/addiction and pain to $1.1 billion in 2018 [15]. Prior successes from NIH opioid research include the development of the nasal spray form of naloxone, development of buprenorphine for OUD treatment,

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Opioid Statistics [4]:

- More than 115 people die of an opioid overdose in the United States each day.
- About 21-29% of patients prescribed opioids for chronic pain misuse them
- 8-12% develop an opioid use disorder
- About 80% of those who use heroin first misused prescription opioids

Signs and Symptoms of Opioid Overdose [21]:

- During an overdose, reduced or ceased breathing can cause brain damage or death. It is important to recognize the signs of overdose immediately and act quickly.
- Small, constricted "pinpoint pupils"
- Falling asleep or loss of consciousness
- Slow, shallow breathing
- Choking or gurgling sounds
- Limp body
- Pale, blue, or cold skin

Sudden Opioid Withdrawal Symptoms, Including From Naloxone [22]:

- Body aches
- Nausea, vomiting, or diarrhea
- Increased heart rate
- Fever, sweating; shivering or trembling
- Runny nose
- Sneezing
- Goosebumps
- Yawning
- Nervousness
- Restlessness or irritability
- Stomach cramping
- Weakness
- Increased blood pressure
- In infants: seizures, crying more than usual, and increased reflexes

What to Do If You Think Someone Is Overdosing [21,22]:

- If you are not sure if it is an overdose or not, it is better to treat it like it is.
- Call 911 immediately
- Administer naloxone, if available
- Try to keep the person awake and breathing
- Lay the person on their side to prevent choking
- Stay with the person, and perform CPR if necessary, until emergency response personnel arrive

Resources:

- Call SAMHSA's National Helpline at 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/ to find local counseling and therapy.
- Visit www.narcan.com to find out where to get and how to use Narcan Nasal Spray.
- Go to the Prescription Drug Abuse Policy System (PDAPS) website at http://www.pdaps.org for up to date drug-related legal information for researchers and the general public.

(continued from previous page)

and evidence to support nonpharmacologic and mind/body techniques to help control and manage pain, such as yoga, tai chi, acupuncture, and meditation [15].

Physician Guidance and Practice

Physicians are advised to follow the CDC Guideline for Prescribing Opioids for Chronic Pain which addresses opioid initiation, selection, dosage, duration, discontinuation, and follow-up, as well as the risks and harms of opioid use [16]. When prescribing opioids for chronic pain, physicians should assess the patient's pain and functioning, consider non-opioid treatment options, discuss a detailed treatment plan with the patient, evaluate the patient's risk of harm or potential for misuse, and prescribe emergent naloxone [4]. Physicians should prescribe the lowest effective opioid dose for the shortest therapeutic duration and only continue treatment if sig nificant improvement in pain and functioning are seen without harm, and the patient should be monitored at regular intervals [4].

In August 2013, New York announced the Internet System for Tracking Over-Prescribing—Prescription Monitoring Program (I-STOP/PMP) which requires most prescribers to consult the PMP Registry when writing prescriptions for Schedule II, III, and IV controlled substances [17]. The PMP Registry is available 24 hours a day, seven days a week and reports on all controlled substances dispensed in New York State over the last year [17]. This makes it easier for providers evaluate the effectiveness of their patients' treatments with controlled substances and determine whether or not there may be an issue of abuse [17].

Nurses Pave the Way

Under the guidance of President Obama in October 2015, the American Association of Colleges of Nursing (AACN) and the American Nurses Association (ANA) joined with more than 40 other healthcare provider groups to address the opioid epidemic in the United States [17,18]. The various groups committed to providing extensive education and training to more than 540,000 opioid prescribers over the following two years [20]. Together with the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), AACN supports student research at AACN accredited schools through their joint Blending Initiative, providing grants to support projects that promote knowledge of SUDs and advance research and integration of evidence-based SUD treatment [18].

In September 2017, the Addiction Treatment Access Improvement Act of 2018 was introduced to expand the Controlled Substances Act to allow all advanced practice nurses (APRNs) to provide care to those suffering from opioid addictions [18]. The CARA 2.0 Act of 2018 was announced in January 2018, a Senate companion legislation amending the Comprehensive Addiction and Recovery Act (CARA) of 2016, and making Section 303 of CARA permanent, allowing nurse practitioners and physician assistants to prescribe buprenorphine as part of Medication Assisted Treatment (MAT) [18]. Additionally, it extends the definition of "provider" to include all APRNs, so that certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists can prescribe MATs [18]. This bill was finally passed by the House of Representatives on June 22, 2018, as Section 303 of H.R. 6: the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act [19].

Conclusion

Nurses are in an optimal position to educate patients and caretakers on the signs and symptoms of addiction, withdrawal, and overdose. They can also advocate for their patients to try non-opioid pain medications and nonpharmacologic alternatives. When their patients are prescribed opioids, nurses need to make sure they fully understand how to take their medications and that they adhere to proper opioid administration and prescription usage. Nurses can be at the forefront of informing the public about access to naloxone and distributing kits. Nurses should provide adequate education and training on naloxone administration—including the possible dangers to recipients and administrators—to patients, caretakers, and the general public. Nurses should check their local laws and policies for opioid and naloxone administration, especially APRNs such as nurse practitioners who can prescribe.

Because there is a high potential for opioid overdose, even when taking prescribed opioids as directed, it is important for caretakers of patients taking opioids, such as family members and aides, to learn the signs of overdose and have immediate access to naloxone for quick and efficient usage. Even children and pets are susceptible to opioid overdose, as they can accidentally access it from their loved ones. It is important to remove the stigma that opioid overdose only happens to those with negative intent.

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Waging War on the Deadly Diseases of Addiction and Abuse

Rabbi Zvi Gluck

Cancer. Stroke. Alzheimer's disease. Diabetes.

We hear a lot about these life-altering, and sometimes deadly, diseases and how major investments are being made to find cures that will save lives.

But drugs? In our circles, we don't really talk much about drug addiction, even though it is a disease that kills.

Hard drug use is on the decline in mainstream high schools throughout the country because so many schools have implemented drug and alcohol awareness programs [1]. However, in our Orthodox institutions, alcohol and drug use are increasing. Denial, stigma, and shame continue to be the biggest obstacles towards getting the ball rolling in a positive direction. We don't discuss drugs in the Jewish community because it might create problems when we want to get our son into yeshiva or when our daughter is in shidduchim. We are failing our children and teens because we aren't willing to face or address the problems.

And that is why we have lost more than 400 of our own to this terrible plague in just the past four years. The number of grieving parents, orphans, and shattered loved ones who have been left behind is just too large to count. And the death toll will continue to rise unless we take action.

We have seen community awareness and educational programming become more widespread and have an impact, but it isn't enough. The cases that we see at Amudim have us trying to jam our collective thumbs into the dam to stop the flood, but truthfully, what we need is more prevention, education, and awareness. It's not just about taking the message to more communities, but also about reaching inward to our own demographics, which includes our children.

As a community, we must approach this problem from several directions.

Parents need to acquire the tools to have these discussions with their children. Parents who, from an early age, express active interest in their children's lives, encourage positive decision making, set clear boundaries, and maintain open and judgement free communication are best suited to have those difficult conversations surrounding drug and alcohol use. Their children will be more likely to feel comfortable approaching their parents should substances of abuse become relevant in their lives, and will be better equipped to stand strong in the face of peer pressure. It is unfortunate that we live in a world where we need to talk to children as young as 11 and 12 years old about the threats of alcohol and drug use that surround them, but we must. We can either hide our heads in the sand and hope for the best, or we can empower our children so that they make the right choices.

Schools need to realize that there is virtually no yeshiva anywhere that is completely drug-free. Instituting prevention and education programs and normalizing conversation about these issues are necessary to continue the dialogue. Community leaders and organizations need to step up and continue to address these issues publicly and regularly, thereby erasing the associated stigmas, if we want to stop burying people who didn't need to die.

It is also time for us to tackle this problem on another front, by educating the medical community on signs of abuse and addiction. Nurses, who have considerable interaction with patients in hospitals, clinics, and schools, have opportunities to pick up on these problems and catch them in the early stages before they become something much larger and complex. Nurses should be able to recognize the warning signs of drug and alcohol abuse. Early interventions may help the crisis that we now face, and can create a positive change which may ultimately save lives.

We spend endless hours at Amudim trying our best to prevent disaster, and it is clear that none of us can win this battle alone. By joining together on all fronts, increasing education and awareness, and implementing age-appropriate and culturally sensitive programming, we can make a difference and turn the tide that has taken too many lives already. Each and every one of us has the ability to fight back in our own way, and by working together, we can and will eliminate these catastrophic and deadly threats to our community.

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Zvi Gluck is the director of Amudim Community Resources, an organization dedicated to helping abuse victims and those suffering with addiction within the Jewish community and has been heavily involved in crisis intervention and management for the past 18 years. For more information go to www.amudim.org.

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Substance Abuse Information for Nurses

Chaya Milikowsky, MSN, AG-ACNP-C

Substance of abuse	Signs and symptoms	Associated clinical features
Alcohol, acute intoxication	Altered mental status, slurred speech, nystagmus, incoordination, memory impairment, stupor, coma	Hypovolemia Hypotension Malnutrition
Alcohol, withdrawal	Anxiety, tremors, headache, sweating, palpi-tations, hallucinations	Fluid and electrolyte abnormalities (magnesium, potassium, phosphorus) When severe, delirium tremens (DTs), hallucinations, tachycardia, hypertension, hyperthermia, agitation
Opioids, overdose	Decreased mentation, decreased respiratory rate and volume, constricted pupils	Hypoxia Hypothermia Mild hypotension
Benzodiazepines, overdose	Slurred speech, ataxia, altered mentation (symptoms often do not present unless there is a coingestion)	If significant ingestion: central nervous system (CNS) depression and respiratory compromise "Coma with normal vitals"
Marijuana, overdose	Euphoria, altered perception, impaired atten-tion and executive functioning, tachycardia, tachypnea, increased appetite, nystagmus	Life threatening complications are rare in adults In children: hyperkinesis, severe CNS de-pression, respiratory depression
Psychotropics (antipsychotics, antidepres-sants), overdose	Varies widely depending on the drug May have features of an anticholinergic toxidrome, sedation, or extrapyramidal symptoms	EKG abnormalities (prolonged QTc) Seratonin syndrome Neuroleptic malignant syndrome (with profound hyperthermia) Hypotension
Hallucinogenics	Neuropsychiatric alterations: feelings of euphoria, heightened sensory awareness, synesthesia, sense of fear or dread, time distortions	Seratonin syndrome
Amphetamines, methamphet-amines, bath salts	Hypertension, tachycardia, agitation, psychosis, sweating	Hyperthermia Metabolic acidosis Tachydysrhythmias In a severe overdose: seizures
Cocaine	Hypertension, tachycardia, increased alertness, feelings of euphoria, pupil dilation	Cardiac ischemia, Aortic dissection, Hyperthermia, Seizures, Agitation, Bronchospasms, Pneumothorax, Cracked lung

Note: this is not a comprehensive review of all drugs subject to abuse, nor are signs, symptoms, management, and treatments limited to those noted above

Rescue treatment/ antidote	Additional nursing interventions	Long term use complications	Appropriate usage of the substance
Supportive care	Monitor respiratory status Provide IV fluids After acute treatment, screen patients for alcohol dependence	Malnutrition Liver disease	Possible cardiovascular benefits if consumed in moderation
Benzodiazepines are the mainstay of treatment Phenobarbital may be given for refractory DTs Supportive care	Clinical Institute Withdrawal Assessment (CIWA) Monitoring and administration of benzodiazepines Provide IV fluids and nutritional support	Same as above	Same as above
Narcan	Monitor respiratory status Administer Narcan to the level of adequate respirations	Opioid tolerance Constipation Increased risk of falls	Pain relief (especially cancer pain) Procedural sedation
Supportive care Flumazenil (do not give if the patient takes benzodiazepines chronically)	Monitor respiratory status	Tolerance and dependence Increased risk of accidents	Treatment of anxiety, seizures, overdoses, and insomnia Used in procedural sedation
Supportive care Benzodiazepines for seizures (children) or agitation (adults)	Monitor Airway, Breathing and Circulation (pediatric population) Keep room dim, decrease stimulation, provide reassurance	Cannabis hyperemesis syndrome (nausea, vomiting, and abdominal pain relieved with hot showers)	Appetite stimulant Chronic pain relief
Supportive care Benzodiazepines if seizures are present Benadryl and benztropine for extrapyramidal symptoms	If hyperthermic: cool the patient Monitor with serial EKGs	Tardive dyskinesia	Treatment of depression, other psychiatric illnesses, and some medical disorders
Supportive care Benzodiazepines if agitation occurs (rare)	Provide a calm, quiet environment	Rare - persisting psychosis, flashbacks	
Heavy sedation with benzodiazepines Paralysis for extreme hyperthermia	Cool the patient Administer benzodiazepines Monitor for violent behavior, but avoid physical restraints	Malnourishment, tooth decay, sensation of bugs crawling on the skin, impaired memory and behavior	Amphetamines: treatment of ADHD, obesity, narcolepsy
Symptom specific treatment For chest pain/myocardial infarction (MI): give ASA, nitro, but do NOT give beta blockers For agitation: provide benzodiazepines	Get an EKG Other interventions will depend on organs affected	Accelerated atherosclerosis Left ventricular hypertrophy Increased risk of MI Increased risk of pulmonary infection	

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The Opioid Crisis Affects the Youngest of Patients

Shevi (Elisheva) Rosner, MSN, RN-C

Ask a Neonatal Intensive Care Unit (NICU) nurse, "Who is the most challenging patient to care for?" Many NICU nurses will agree that newborns with Neonatal Abstinence Syndrome (NAS) can be the most difficult ones to care for, as they require tremendous patience and emotional energy.

NAS develops from opioid exposure in utero. Prescription pain relievers, such as Vicodin, Oxycodone, and Percocet, illicit substances such as heroin, and synthetic opioids such as Fentanyl are responsible for the development of NAS in the newborn population. Polysubstance abuse, nicotine use, and use of serotonin reuptake inhibitors (SSRIs) during pregnancy also contribute to NAS. With the national increase of opioid usage on the rise, the number of newborns affected with NAS has risen dramatically [1]. Infants with NAS require increased length of hospital stays, require NICU care and management, have an increased rate of hospital readmission, and increased cost for their care as compared to healthy newborns [2,3].

The first documented case of newborn opioid withdrawal was recorded in 1875 and was termed morphinism. At that time, affected newborns died due to lack of treatment. In 1903, morphine was used to treat withdrawal symptoms and it took several years to develop a scoring system and treatment plan for this syndrome [3].

Full term newborns typically show signs and symptoms as early as two to three days of life. Signs and symptoms include high pitched or continuous crying, decreased sleep, tremors, yawning, increased muscle tone, seizures, feeding difficulty, vomiting, loose or watery stools, sweating, fever, nasal stuffiness and nasal flaring, sneezing, and low birth weight [1]. Opioid use in pregnancy increases the chance of preterm delivery. Preterm infants show fewer symptoms of NAS due to an underdeveloped neurological system and decreased exposure time to opioids as compared to full term infants [3]. In the long term, prematurity and exposure to in utero opioids makes these infants at a higher risk for poor neurodevelopmental outcomes [4].

The Finnegan scoring system, published in 1975, is the most widely used tool to assess the severity of NAS. It assesses 21 findings and is measured every three to four hours according to the infant's feeding schedule. Clinicians decide on a treatment plan based on the Finnegan score [5]. Three consecutive scores greater than or equal to eight or two scores greater than or equal to 12 would indicate the need for pharmacologic treatment. Scores of less than eight shows signs of readiness to wean pharmacologics. The Finnegan tool is subjective to a nurse's judgement and therefore the total score can vary slightly from nurse to nurse [6]. Because many of the symptoms assessed on the Finnegan tool are seen in regular premature infants, this tool is not used in the premature population [5].

A newer tool used in the treatment of NAS is the Eat, Sleep, Console (ESC) approach, which assigns a numeric value to these three categories and also allows for clinical decisions to be made based on this score. This tool requires further study and validation to indicate correlation with long term outcomes [5].

Pharmacologic treatment varies from one NICU to another. Morphine, methadone, and buprenorphine are all used as first line pharmacologics. Phenobarbital and clonidine are used as second line therapies in addition to other drugs [5].

Non-pharmacologic treatment includes rooming-in, encouragement of breastfeeding (unless contraindicated for other reasons), and acupuncture. The presence of parents at the bedside throughout the infant's hospitalization has shown to decrease the infant's length of stay [5]. Swaddling, providing a quiet and dark environment, minimal stimulation, and use of vibration and infant swings are very important methods to soothe and care for these irritable newborns.

Compassion fatigue and burnout are common in the nursing field and care of infants with NAS exacerbates these conditions. Inconsolable and irritable infants are emotionally demanding and require frequent care, attention, and feeding. Moral distress, exhaustion, and frustration are commonly experienced by nurses who care for these infants. In addition, caring for the parents and families who could be verbally abusive or aggressive compound the stress on nurses [7]. Mothers of NAS babies tend to come from abusive and challenging backgrounds and NICU nurses have minimal training and education on substance abuse disorder and care of these mothers [8]. Nurses need to be assertive when seeking assistance from coworkers and make use of available volunteers to hold and cuddle infants with NAS. As with other high acuity and stressful nursing specialties, nurses need to practice self-care and mindfulness and insist on strong teamwork to prevent compassion fatigue and burnout [7].

Prevention and management of maternal opioid dependence is key in minimizing the incidence of NAS. Drug use among women of reproductive age must be decreased. Healthcare providers should prescribe non-opioid pain medications whenever possible, promote individual counseling and group therapy, and provide education on the maternal and fetal effects of opioid use. The World Health Organization has released guidelines for identification and management of substance abuse in pregnancy [3]. In addition, the American College of Obstetricians and Gynecologists recommends the initiation of drug screening of all pregnant women. However, due to ethical and social considerations, the guidelines and screening are not uniformly implemented across health care facilities [5,9].

The incidence of NAS has increased with the drastic rise in use of opioids in the general population over time. Health care provider prenatal screening, minimization of opioid use for pain control, and prenatal education are instrumental in reducing NAS. Health care providers rely on nurses to provide scoring and hands-on care for newborns with NAS. It is important that nurses ensure strong teamwork, education, and support in addition to utilizing self care and relaxation techniques to prevent burnout from care of these difficult, irritable, and vulnerable patients.

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NURSES TO KNOW

Profiling Chaya Milikowsky, MSN, AG-ACNP-C

Nursing role: Adult/Gerontology Acute Care Nurse Practitioner

Where do you currently work?

I am the night shift provider for the Intensive Care Unit (ICU) at MedStar Montgomery Medical Center in Olney, MD. Though the hospital is a small community hospital, it is part of a larger network of hospitals and health-related organizations in the region. The ICU is a 12 bed medical surgical unit of moderate acuity. Though I am the official provider for the ICU, I also assist with coverage in the Intermediate Care Unit and do surgical admissions.

Can you share what your responsibilities are at work?

As the sole in-house overnight ICU provider, I am responsible for managing the care of all the patients in our ICU, as well as admitting critically ill patients from the ED or transferring deteriorating floor patients to our ICU. On occasion, I am also responsible for transferring patients out to a higher level of care if we cannot provide for their escalating needs. For example, we do not have an interventional cath lab in my hospital, so if one of my patients appears to be having a ST-elevation myocardial infarction (STEMI), I am responsible for getting that patient transferred to another hospital as quickly as possible. Though I function independently, there is always an intensivist on call who is available to provide backup support if needed. If at any point I feel that I am dealing with something beyond my scope or abilities, it is comforting to know that I can call that provider for assistance.

As far as managing my patients, I order medications, diagnostics, and interventions as needed. When necessary, I do basic procedures such as intubations or insertion of central lines. When admitting or transferring a patient I write a history and physical, progress note, and/or transfer note. I know how much we all groan about documentation, but I really appreciate when providers fully and clearly convey the patient's hospital course and plan of care, so I try to do the same for those who will be managing the patient after me.

A huge part of my job is speaking with patients and their families. In the face of critical illness, sometimes just understanding what is going on or being able to express concerns or fears can make a huge difference to the patients and their family members.

Did you work as a nurse while going for your masters? If so, do you think that was necessary?

I worked part time while doing my advanced practice nurse degree (APRN). While this decision was primarily financial, it was also very important to me since I didn't have many years of critical care nurse experience prior to going for my APRN degree. I have always made a point to learn something new each shift, so for me every shift as a nurse (RN) was an additional experience and education to add to my developing knowledge base. There is no doubt that working in the field strengthened me as a student APRN. I would write practice progress notes on my patients or mentally try to create a differential diagnosis and plan of care, and then I would read the doctors' notes and orders and see how my assessment of the situation measured up.

The majority of students in my APRN classes worked, mostly part-time, during school. As a frum (Orthodox) woman married with children, I probably had more responsibilities than most, so I don't know how many would recommend working in my situation. There is no doubt that the few students who were able to focus exclusively on school were less stressed!

What made you decide to go for your APRN?

I pretty much knew from the time I graduated nursing school that I would want to become an APRN someday. Towards the end of my initial degree, I thought I would work in labor and delivery and then eventually become a nurse midwife (CNM), but I did not end up going the obstetrician (OB) route. After two years of working in critical care, I strongly considered becoming a nurse anesthetist (CRNA), but for the sake of work/life balance, I decided to pursue the acute care nurse practitioner role, and I couldn't be happier with that decision. There was one acute care NP who I worked with while I was a bedside RN who was so incredibly competent, smart, and compassionate, and she was probably the one who influenced me the most to take this career path.

I'm one of those people who can't stay in the same place for long (and I love being in school too), so there never really was a question about my going back to school. The question now is what I am going to do next! I promised my husband that I will spend a few years actually earning money instead of spending it on my education, so my decision is still a few years away.

Do you have work/life balance tips to share?

One thing we have going for us in our career as RNs or APRNs is that this is a job we typically don't take home with us. When I am home, I do my best to completely shed what went on during the prior shift. As far as practical tips, I keep my housekeeping role to a minimum. I'm lucky that my husband and kids would rather have a present wife/mommy than gourmet meals or perfectly folded laundry. Having lots of shabbos guests is important to us as a family, so I make heavy use of paper goods, foil pans, the dishwasher, and easy recipes. One thing I used to do when I was in school and incredibly short on time was utilize necessary household activities as dedicated time with my husband and kids. A trip to Costco could become a special outing with my child, or I would sit next to the kids doing homework and do my homework alongside them. Even now, my husband and I go on "dates" to the supermarket. When possible, I make moments and activities count twice!

When you are not at work, what do you enjoy doing?

Sleep, sleep, and more sleep! I have a four-month-old, so I have somewhat of a sleep fixation at this time. But in all seriousness, I do find that engaging in hobbies and activities that I love actually makes me a better mother, wife, and healthcare provider. I'm fairly artistic and specifically enjoy making jewelry and multimedia painting. I love color, and my jewelry and paintings reflect that. I also enjoy dancing, but unfortunately I have not had much opportunity to dance recently.

If you had not gone into the nursing profession, what career might you have pursued?

This question is actually more practical than theoretical! I did not plan on becoming a nurse and I worked in a few jobs prior to going to nursing school. I had a brief stint as a seventh grade science teacher, and later wrote patents for a technology company while I lived in Israel. It was only after I had three children and moved back to the United States that I decided to become a nurse. By the way, that was one of the best decisions of my life. In a theoretical sense, I would love to be an architect or a meteorologist.

How long have you been involved with the Orthodox Jewish Nurses Association (OJNA)?

I've been involved for quite a few years, thanks to my friend and former neighbor Rivka Pomerantz, founder of OJNA. I feel lucky to have attended every one of the OJNA annual conferences since 2013. I have gained so much from this organization, and I look forward to giving back.

If you would like to be profiled in future issues of The OJNA Journal, send a short paragraph detailing your background and role to OJNAjournal@gmail.com.

CAREERS TO CONSIDER

Nurse Manager

Chaya Milikowsky, MSN, AG-ACNP-C

Job title	**Nursing management**
Job description/ basic responsibilities	**Evaluate staff performance** **Mentor and provide feedback to staff** **Develop education programs** **New staff orientation and training** **Encourage staff professional development** **Recruit, interview, and participate in the hiring of nurses and other staff** **Budget development** **Supply and equipment inventory** **Communicate to upper management on behalf of staff** **Monitor and evaluate patient and staff data** **Responsible for patient satisfaction, quality and safety assurance** **Develop and implement unit based programs** **Involvement in scheduling and patient assignments**
Educational requirements	**RN license** **Typically needs a BSN degree, MSN preferred**
Recommended experience	**Charge nurse** **Assistant nurse manager**
Salary	**Median US salary $82,633** (payscale.com) **Pay varies widely depending on location, ranging from $61K to $110K**
Work environment	**Hospital, 1 or more units**
Typical work schedule	**Generally 8-10 hour days** **Usually greater than 40 hours per week**
Job outlook	**Expected to grow much faster than average (U.S. Gov Bureau of Labor Statistics)**
Suggested skills	**Leadership ability** **Business acumen** **Nursing expertise**

MUSINGS

Token Judaism

Laura Silverstein, BSN, RN, WCC

I have always known I am different.

I grew up in a small Jewish out-of-town community. My father is a convert. My parents became frum (Orthodox) when I was a pre-teen. I had an unusual maiden name. I was the only Jew on my block. I played little league baseball. My father was deployed to Saudi Arabia during the first Gulf War. I was the only girl in my high school class with an English name.

I spent my whole life apologizing for being different and making excuses for myself. I pronounced my maiden name so it wasn't obviously Italian. I didn't tell people that I knew what bacon or bologna and cheese sandwiches tasted like. I stopped playing sports. I never talked about the Gulf War or how terrible it was not to have my father around.

When I went to nursing school I found myself being different again, and I continued to downplay my differences. Even though I went to school in Queens, NY, I was the only Orthodox Jewish student. I tried to be part of the gang at school. We hung out during lunch even though I couldn't eat the cafeteria food. When my friends talked about their social life, I weakly tried to participate. I didn't ask for special consideration at school. I quietly sat out during the operating room rotation because I wouldn't wear scrub pants.

When I started seeing patients, I wasn't prepared for their questions. The most common question my patients asked was, "Where are you from?" I quickly learned that the correct answer was neither, "I live in Far Rockaway," nor was it, "I grew up in Scranton, Pennsylvania." My patients were all so disappointed with my responses because they wanted to hear about my religion and culture. I apologized for that as well, saying, "Sorry, I'm just plain old American."

My patients were thrilled to tell me about what made them unique.

They told me beautiful stories of how they came to this country and the life they left behind. I took care of a sweet lady who told me that she left Europe on the Kindertransport. She shared the heartbreaking story of how she didn't see her parents for many years and that her parents had never had more children. Another patient told me the incredible story of her mother-in-law who hid Jews during the Holocaust and how her family was so angry at her for putting her life and their lives in danger. A gentleman told me about his childhood in Austria and his British school teachers. He explained that his father was a translator and they eventually moved to Turkey before emigrating to America. I had a patient who proudly told me she was 11th generation American and that she could trace her family back to the Mayflower, and she had a family tree to prove it.

My patients were always eager to talk about their backgrounds. They were happy to teach me phrases in their various languages. They wanted to help me pronounce their names. My patients loved to feed me special foods and send me home with leftovers. Their stories made me question my lifelong desire to downplay my differences.

I heard what my patients were trying to tell me, so I changed my responses.

When they ask me about my background, I now tell them

(continued on following page)

OJNA RECOMMENDS: BOOK REVIEW

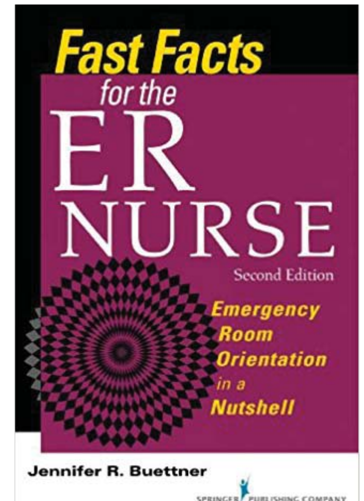
Fast Facts for the ER Nurse: Emergency Room Orientation in a Nutshell, Second Edition

Author: Jennifer Buettner, RN, CEN
Review by Yehudis Appel, BSN, RN

"Fast Facts for the ER Nurse: Emergency Room Orientation in a Nutshell, Second Edition" is a book specifically written for new nurses working in the emergency room (ER), and for their preceptors. At the time the book was published, the author Jennifer Buettner was a member of the Emergency Nurses Association, a nurse educator, and held certifications in trauma nursing core course (TNCC), emergency nursing pediatric course (ENPC), certified emergency nurse (CEN), advanced cardiac life support (ACLS), and pediatric advanced life support (PALS). This book is organized, informative, and incredibly handy for any ER nurse, seasoned or otherwise.

The book speaks about many different topics ranging from simple tips on how to survive being a nurse in the ER to more complicated patient scenarios such as those seen in triage. Some of the major topics include acid-base imbalances, fluid and electrolyte imbalances, disaster response, and environmental emergencies. Cardiovascular, neurological, respiratory, gastrointestinal, genitourinary, and endocrine emergencies are detailed in this book. Other topics include obstetrics and gynecology, ocular, shock and multisystem trauma, toxicological and substance abuse, orthopedic and wound care, and dental and ear nose and throat (ENT) emergencies. Mental health emergencies are also written about, as well as a range of emergencies associated with patients' ages, such as pediatric and geriatric emergencies.

The book is divided by the above topics. Each chapter of the book includes a quick introduction, definitions of disorders and diagnoses, disease etiology, common signs and symptoms, and interventions, including drugs and equipment that are commonly used. At the end of the book, the reader will discover a very handy list of everyday ER medications and intravenous drips, and common lab values and electrocardiogram (EKG) rhythms that are vital for the ER nurse to know.



What makes this book extra special is that it is written in an organized, easy-to-read and understand format. Bullet points are used throughout the book. Other features include brief summaries of important points, and questions and answers at regular intervals throughout the book.

The ER nurse needs to think quickly and act fast and this book teaches the reader just that. This book provides basic ER knowledge and is a good reading source for any ER nurse. This book is certainly worth the price and I highly recommend it for anyone who is interested in becoming an ER nurse.This book can be purchased as a paperback or kindle download.

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TOKEN JUDAISM

(continued from previous page)

confidently that my mother is Jewish and my father is Italian. I correctly pronounce my maiden name and assure them that my grandmother's gnocchi recipe is unbeatable. I tell them the story of my great grandmother who climbed out of her window to elope with her boyfriend as her parents didn't approve of him because he was an immigrant. I talk about my relatives who had to lie to get out of Europe—one changed his last name to Miller while the other kept the family name Javitz.

I pride myself with my ability to notice my patients' surroundings and help them talk about their past. Now, when I visit my patients, I look around their homes for clues about their culture and background. I ask them about their old pictures and knick knacks. We talk about their paintings and sculptures. I notice their mezuzahs and crosses. I invite them to talk about their history and I happily share mine.

I am grateful that I have had the opportunity to learn this incredible lesson from my patients. I am different, but I am no longer ashamed. I will not apologize. I am different, but not embarrassed. We all have parts of ourselves that make us unique, and these differences make me a better person and a better nurse. I have more empathy and understanding because of my background. My differences are my pride; they are my happiness and they are my own special story.

Laura J. Silverstein, BSN, RN, WCC, graduated from Queensborough Community College in 2008 with an ADN and received her BSN from Drexel University in 2014. She is a wound care specialist and has worked in various areas of home care for the past 10 years. She enjoys reading Stephen King novels and writing about her experiences as a nurse. She lives in Elizabeth, NJ with her very patient husband and their seven precocious children.

MUSINGS

Seven Years In...

Julie Rubenstein, BScN, RN

I started nursing school in September 2010. I'm amazed by how much has changed since those initial days. Starting off, my classes were general. Then they advanced to nursing-specific courses, to educating patients, and finally my becoming independent during clinical rotations. It is eye-opening to review who I was, and not just from a professional perspective. Since I began writing, I moved out of my parents' home, developed a fashion sense, and learned how to snowshoe.

The things that excited me in the past have changed. When I first started nursing school, the most exciting thing was knowledge. Books written entirely about hand eczema! Types of tissues and cells! How to say "malaria" in French (it's le paludisme)! And, of course, I enjoyed showing off my knowledge to friends and family.

After I started learning health assessment and working with patients, it became all about the skills and the stethoscope and sphygmomanometer I was just beginning to learn how to use. S1 and S2! Crackles! Borborygmi! Korotkoff sounds! This was also the year that we started to learn about pathophysiology, so of course I ended up diagnosing myself with all sorts of diseases.

Then my focus switched to patient safety. I was terrified when I started working with patients. What if I miss something and they get sicker or even die? Will it be my fault? What if I give the wrong drug or dose using the wrong route at the wrong time for the wrong reason? And, how do I get these patients out of my head once I am no longer looking after them? I cared for them, I worry about their welfare, and I remember their names!

My fear of harming patients, while indicative of a good nurse, was crippling for quite some time. I failed a clinical rotation partly because of this. I was so afraid to make any decisions without running it by my preceptor that I failed to develop any sense of independence. While upsetting, I was able to use the time to re-evaluate what I wanted to do as a nurse and how to best use my strengths. I repeated the course in home health nursing, maturing and spreading my wings under the caring, all-seeing guidance of a wonderful mentor. After 360 practice hours with her, I finally felt ready to have my own patients.

This is also when I began to think like a nurse. My attitude towards death changed from something to be feared and fought to something that is natural and eventual. My fascination with medicine changed from the purely intrinsic pleasure of collecting facts to figuring out how I could use them to make patients better. I learned how important research is for nursing practice, how to interpret the articles I read, and I even had a summer job researching congenital bowel disease at the local children's hospital.

My first nursing job was as a home visit nurse, and the steepest learning curve was working with clients. Not the skills as had been my learning goal before. Many nursing skills can be taught to lay people including peritoneal dialysis and administration of IV antibiotics via central lines. But what lay people lack is sound nursing sense, knowing what to say and how to say it, how to explain something in the least scary way possible, which details are necessary to divulge and which are extraneous. In short, nursing judgement.

The most important thing I learned, however, was how to not panic. In a hospital setting there is always someone around to assist with whatever you see: colleagues to double-check your assessment, charge nurses to advise, physicians who can order antibiotics, oxygen nozzles poking out of the wall for moments that take the patient's breath away . In the home care setting, I would be alone in a patient's home at 9pm, confronted with a new situation, and I would have to assess how soon follow-up was needed or if it could be put off until the next working day. For someone who likes to accomplish tasks as soon as they become relevant, it was very difficult for me to learn to relax and let something go until the next visit or until a nurse had the time to email me back with a suggestion. Currently, this appears to be the most important cognitive pattern that I have developed with time. I now "think like a nurse," as I was told I would have to do once I left nursing school.

Today, I am working in an inpatient geriatric unit. There are days I enjoy it and other days where I think about quitting. My current learning goals are developing time management skills, managing sleep hygiene while working long shifts, and coping with difficult patient medical or social situations where there is very little I can do to make it better. I'm amazed when I realize how much I have changed since I started at my current position one year ago, how much I have developed since I passed the NCLEX-RN in May 2015, and how I am no longer the eager, geeky teenager who started nursing school at the University of Ottawa in September 2010.

It makes me wonder how I will grow as a nurse in the next seven years.

JOB POSTINGS:

Are you looking for an RN/NP job? Do you know others looking for one?

We have over 100 jobs posted on our job board. Visit https://jewishnurses.org/job-dashboard/ to search our job posts or to share a job posting with others.

1. Mount Sinai (New York City) looking for an NP or PA in a busy outpatient neurovascular practice.

2. Pediatric Home Care RN (New York City) needed for summer months. New grads welcome!

3. MDS nurse, 30 hour week. Offering an excellent salary and benefits. LTC experience required. MDS experience preferred. Located in East Orange, NJ.

4. LPN needed in Ezras Choilim Health Center (Monroe, NY). Excellent salary and benefits.

5. RN Case Manager needed for Chemed (Lakewood, NJ). Excellent salary and benefits. State of the art facility.

6. School Nurse needed for the School for Children with Hidden Intelligence (SCHI). Certified School Nurse with be responsible for coordinating school health services for private school servicing children 3-21 years old with multiple disabilities and chronic health care needs according to the NJ Administrative code. NJ School Nurse Certification required.

7. Camp Nurses needed in various camps in NY and PA. Visit the job board for details!

8. Home Care RN needed in Passaic, NJ, for 20 year old male with multiple disabilities, G/J tube, medication administration, nebulizer treatments, non-mobile, non-verbal. Need to be able to manage a PICU environment at home. Looking for daily coverage.

CONFERENCE RECAP

Our annual nursing conference was held on Thursday, May 10, in Lander College for Women in New York. We had a crowd of 190 nurses, and the energy in the room was incredible! Participants heard lectures on various topics, enjoyed cholov yisroel breakfast, lunch, and snacks, and obtained 6.8 contact hours. Participants were able to network and socialize with nurses from New York, New Jersey, Maryland, Michigan, Florida, Massachusetts, Indiana, Illinois, and Pennsylvania.

Special thank you to our sponsors JScreen, Ezras Choilim, and Madison Programs and to our vendors Bayada, Preferred Home Health, Jacob Gerlitz NP, Evolve Physical Therapy, Accureference, and Sharsheret.

For those of you who were unable to attend the conference, please visit jewishnurses.org for videos, pictures, conference recording, and contact hours.

Attention all APRNs, student APRNs, and those considering a future as an APRN:

Based on the responses to the APRN survey, we are excited to begin working on a mini-APRN conference that will take place in December. The event will further provide opportunities for networking, skill practice, and continuing education.

For more information please check out Advanced Practice RN under the events tab on our website jewishnurses.org or email us at ojnaaprn@gmail.com.

OJNA Board Members and Conference Committee present an award to OJNA Founder, Rivka Pomerantz, BSN, RN, IBCLC.

Esther Lebovic, DNP, FNP-BC, CSC, lecturing on Sexual Health Assessments.

Attorneys lecturing on malpractice law.

Male nurses get to meet and greet.

Nurses enjoying lunch, socializing, and networking.

Nurses from as far as Florida, Illinois, Indiana, and Michigan attended the conference.

Feedback from Our Sponsors:

"Thank you for having me at your conference last week. I really enjoyed meeting so many nurses and the feedback was very helpful. As a reminder, JScreen is a national non-profit Jewish genetic screening program dedicated to educating the community about their genetics and helping them plan ahead for a healthy future. The program makes it easy for anyone planning to start or expand their family to get screened by providing 24/7 access to at-home, highly subsidized, saliva testing access to comprehensive carrier screening for over 200 diseases, including those most common in people with Ashkenazi, Sephardi, and Mizrahi ancestry. To register for a kit, visit www.jscreen.org."

Esther Rose, JScreen Presenter:
esther.rose@emory.edu

"Just wanted to thank you so much for the opportunity to join you this morning. What a great group. *Kol hakavod* (great job) for all your efforts for this wonderful organization. It is very impressive."

Rabbi Dr. Edward Reichman, Presenter

"Thank you so much for today's opportunity; I had a great time! All of the participants were very nice and iy"h business should come out of this conference."

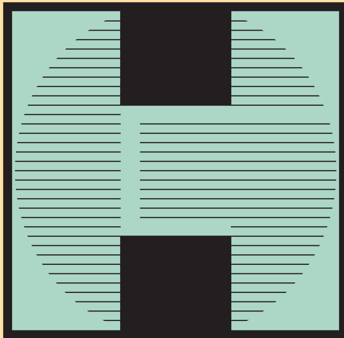
Robby Lederman, Madison Programs
madisonprograms@aol.com

"The event was very informative and provided me with the opportunity to meet some great prospects for some positions we are looking to hire. I learned a great deal from all the presentations and also met with many nurses who were very professional and pleasant to speak with. They seemed to show an interest in the opportunities I was offering as an employer. Overall, it was a great experience and I am looking forward to attending again."

Neisha Alvarado, Recruitment Coordinator at Ezras Choilim Health Center

A view of some of the crowd at the conference.

Some of our participants.



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School Nursing in the health office

One to One Cases caring for special needs students

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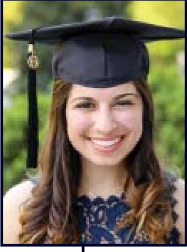
Contact Kerry McNeill 516-326-2020 x302 kerry@hhstaff.com

Member Milestones



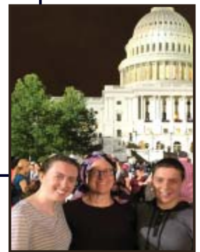
JESSICA NOORIEL, BSN, recently graduated from Emory School of Nursing with her baccalaureate degree. She received recognition for being amongst the Top 100 in her class of 1,400 students. She is currently waiting to take her boards. She would like to find employment in critical care.

CHAYA EIDENSOHN, BSN, and FAIGIE GOODWIN, BSN, recently graduated from the University of Maryland School of Nursing. Chaya will begin working at Newark Beth Israel Medical Center in Newark, NJ, on the step down telemetry unit in August.

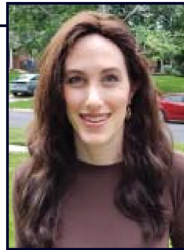
Congratulations to the 10 recent graduates from SUNY Downstate's Accelerated BSN Program. Together, they represented 15% of their graduating class.

ARIELLA DAVIDMAN
GABBY POPOVSKY
CHANA BEYLIN
LEETAL FREINER
SHALOM LICHTENSTEIN
MOISH WARSAWSKY
LAUREN ABADY
GLORIA TERZI
RIVKY JACUBOV
ERITA YEVDAYEVA

RIVKA LOWY, BSN, RN, recently graduated from University of Texas Arlington with her baccalaureate degree. She has been a nurse for nearly 30 years. She received her ADN from Essex Community College (now Baltimore County Community College). She has mostly worked med/surg, but also did 16 years in acute rehab, and two years in the ER at Shaarei Tzedek in Israel. She currently works as a med/surg/tele float at Englewood Hospital and Medical Center in Englewood, NJ.



CHAYA MILIKOWSKY, MSN, AG-ACNP-C, received her post-masters certificate as an Acute Care Nurse Practitioner from University of Maryland in 2015, and completed her initial nursing degree there as well. She has worked exclusively in the critical care setting since becoming a nurse in 2010. She currently works as the ICU nocturnist at MedStar Montgomery Medical Center in Olney, Maryland. She has been a part of the OJNA since 2013, and is now eager to take a more involved role as secretary of the board.



TO HAVE YOUR MILESTONE FEATURED IN OUR NEXT JOURNAL EMAIL OJNAJOURNAL@GMAIL.COM

OUR NEXT ISSUE

The Fall issue of The OJNA Journal will be focusing on the following topics:

Intensive care
Geriatrics
Palliative and end-of-life care
Oncology
End-stage renal disease
Heart failure
Best practice updates
Halachic issues

Recurring columns include:

Nurses to Know:
profile a nurse you find inspirational

Careers to Consider:
write up an analysis of a nursing career you find interesting (request a template from the editors)

Musings: thoughts on being a nurse, being a patient, or anything in between

Book Review: any book you feel OJNA nurses would enjoy and learn from

Please review author guidelines at www.JewishNurses.org under the Journal tab or email us at www.OJNAjournal@gmail.com

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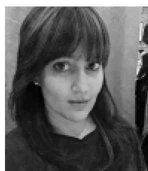
Orthodox Jewish Nurses Association Inc.
5712 15th Ave
Brooklyn, NY 11219-4729

MEET THE TEAM:



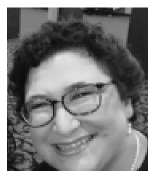
Blima Marcus, DNP, AGPCNP-BC, OCN, received her Bachelor of Science in Nursing from the New York University Rory Meyers College of Nursing and received her Doctorate in Nursing Practice in adult primary care from the Hunter-Bellevue School of Nursing in January 2018. She is a nurse at the NYU Perlmutter Cancer Center and has been published in the American Journal of Nursing and in the Forward. She is a member of Sigma Theta Tau International Honor Society of Nursing, Oncology Nursing Society, American Cannabis Nurses Association, and Eastern Nurses Research Society. She lives in Brooklyn, New York, with her husband and two children.

Tobi Ash, MBA, BSN, RN, received her Bachelor of Science in Nursing from Barry University in 1998, her Masters in Business Administration from Nova Southeastern University in 2001, and is currently completing her Ph.D. at Walden University. Tobi is the Director of Women's Health Care at Nano Health Associates in Miami Beach, Florida. Tobi has more than 20 years of experience working with families, with an emphasis on women's health. She is a member of Sigma Theta Tau International Honor Society of Nursing and served on the Health Care Advisory Committee for the City of Miami Beach for two consecutive terms. She lives in Miami.

Batsheva L. Bane, BSN, RN, received her Bachelor of Arts from Adelphi University, her Bachelor of Science in Nursing from New Jersey City University, and is currently pursuing her Master of Science in Nursing at Frontier Nursing University. She is a Certified Breastfeeding Counselor and is a member of Tau Sigma National Honor Society, the New York State Association of Licensed Midwives, and the American College of Nurse Midwives. Batsheva worked at Monmouth Medical Center in both the neonatal ICU and postpartum units, and at CHEMED health center in the Women's Health Department. In addition to her role at OJNA, she volunteers for the New York State Association of Licensed Midwives for the IMPACT committee. She lives in Riverdale, New York, with her husband and children.

Sarah Bracha Cohen, MS, RN, received her Bachelor of Arts in Health Sciences from Hebrew Theological College and her Master of Science in Nursing and Clinical Nurse Leader (CNL) from the University of Maryland School of Nursing in December 2017. She is a member of Sigma Theta Tau International Honor Society of Nursing, The Honor Society of Phi Kappa Phi, and the American Nurses Association. In addition to her work for the OJNA Journal, she works as a doula, is an editor and contributing writer for a local Jewish newspaper, and is a post anesthesia care unit (PACU) nurse at NYU Langone in Manhattan.

Shaindy (Shari) Lapides BN, RN, received her Bachelor of Nursing from McGill University and her RN from Dawson College in Montreal, Canada. She has worked with children with visual, motor, and hearing impairments. She has also worked in Managed Long Term Care as a Field Assessor, completing Uniform Assessment System for New York. She lives in Manhattan with her husband and baby.



Tziporah Newman, BSN, RN, received her Associate Degree in Nursing from Middlesex County College and Bachelor of Science in Nursing from Thomas Edison State College. She currently works with medically fragile children as a private duty home care nurse. She previously worked as a Director of Nursing for a home health care agency, supervising and teaching nurses and home health aides. She is a member of the American Nurses Association, the New Jersey State Nurses Association, and the Society of Pediatric Nurses. She actively volunteers for Chai Lifeline and her local Bikur Cholim.