



UNIVERSITY *of* ALASKA ANCHORAGE

School of Nursing

College of Health



STUDENT HANDBOOK AAS NURSING PROGRAM

2011-2012

Revised August 2011

The Nursing Programs of the School of Nursing (SON) are approved by the Alaska State Board of Nursing (BON) and are accredited by the National League for Nursing Accrediting Commission (NLNAC).

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Note: *Updates to the 2011-2012 Student Handbook may periodically be made and will take precedence.*

All updates will be posted on: <http://www.uaa.alaska.edu/schoolofnursing/studenthandbooks.cfm>

Welcome...

to the

University of Alaska Anchorage School of Nursing

The faculty and staff of the University of Alaska Anchorage (UAA) School of Nursing (SON) take this opportunity to welcome all new students. We are pleased you have chosen to attend our school and we hope your educational experience with us will be rewarding.

This handbook has been divided into two parts. Part I applies to all students in all programs and Part II is specific to your program. The handbook is designed to assist you in becoming familiar with various aspects of your chosen degree program. Please take the time to familiarize yourself with the contents so that you will know where to locate specific information as it is needed. Use this handbook in conjunction with the UAA Course Catalog. In addition, please take advantage of interacting with the SON faculty.

Throughout this handbook, we will use the term 'semester,' which applies to most students. However, in the Baccalaureate program, many courses follow a trimester (14 week) schedule. The rest of the UAA courses and deadlines are based on a semester system.

The UAA School of Nursing programs offer both challenges and rewards. We wish you success in pursuit of your nursing career.

The School of Nursing Faculty

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PART 1: School of Nursing Information

SECTION I – INTRODUCTION

MISSION

The mission of the School of Nursing is to educate students for productive citizenship, personal growth and professional nursing practice. The programs are designed to reflect Alaska's needs and health care delivery systems, although graduates are prepared for practice positions in other geographic areas as well.

MISSION STATEMENT

The mission of the UAA School of Nursing is to educate undergraduate and graduate students to provide high quality, culturally sensitive, ethical and compassionate nursing care.

CURRENT STRUCTURE

The School of Nursing (SON) is a department within the newly formed College of Health (COH). The College was formed in July 2011 when the College of Health and Social Welfare was restructured. In addition to the COH, other major units at UAA include the College of Arts and Sciences (CAS), the College of Business and Public Policy (CBPP), the College of Education (COE), the Community and Technical College (CTC) and the School of Engineering (SOE).

The School of Nursing is one of many units in the COH. The units are listed below:

- Department of Health Sciences
- Department of Human Services
- Justice Center
- Occupational Therapy Program (*through an affiliation agreement with Creighton University*)
- Pharmacy Program (*through an affiliation agreement with Creighton University*)
- School of Allied Health
- School of Nursing
- School of Social Work
- WWAMI School of Medical Education

The College of Health also houses a number of research centers and institutes that exist to serve a variety of research, service and occasionally instructional needs. They are listed below:

- Center for Community Engagement and Learning
- Center for Human Development
- Institute for Circumpolar Health Studies
- National Resource Center for Native Elders

The College of Health is administered by a Dean, Dr. Cheryl Easley, who reports directly to the Provost. The Interim Director of the School of Nursing (Barbara Berner, EdD, RN, FNP, ANP, FAANP) reports to the Dean and is responsible for the day-to-day operations of the School, as well as for planning with the faculty to meet future nursing education needs throughout the State. Assisting the School of Nursing Director in administration of the nursing programs are the Interim Associate Director (Maureen O'Malley, PhD, RN), the Chair of the Graduate Nursing Program (Jill Janke, PhD, RN), the Chair of the Baccalaureate Program (Gail Holtzman, MSN, CCRN, CNE) and the Chair of the Associate of Applied Sciences (AAS) Nursing Program (Kathleen Stephenson, MS, RN).

PURPOSE

The purpose of the School of Nursing is to optimize quality of life through excellence in health care education, service and research.

VISION

The vision of the School of Nursing is to become a magnet for highly qualified students, educators and researchers. By 2015:

- We will become the standard of excellence in healthcare education.
- We will be recognized as an innovative leader in the use of technology for learner centered education.
- We will become fully integrated and visible throughout the communities of Alaska.
- We will provide students with opportunities to explore the unique health care needs of frontier populations.

CORE VALUES

The core values held by the School of Nursing include:

- Excellence – The quality of our graduates reflects the competence, professionalism, compassion and collaboration of faculty and staff.
- Integrity – We demonstrate unwavering ethical, moral, intellectual and emotional honesty.
- Creativity – We exemplify vision, passion, innovation, flexibility and ingenuity.

CULTURE STATEMENT

Organizational culture is defined as the integration of patterns of human behavior that include language, thoughts, communications, actions, customs, beliefs and values within an organization. Culture encompasses the customary way of thinking and behaving that is shared by members.

- A collaborative culture is sustained and student success is fostered. Individual and collective behaviors incorporate positive communication, collegiality, support, trust, respect and celebration of diversity.
- Organizational goals are accomplished through a participative leadership/management style that fosters safety, openness to ideas and input from members. All ideas and opinions are valued.
- Individual and collective behaviors reflect organizational core values of excellence, integrity and creativity.
- Leadership sets agendas with input of members and functions as coach and team builder. Leadership expects results and holds members accountable. Membership expects results and holds leaders accountable.

UNIVERSITY ADVISING AND COUNSELING SERVICES

Academic advising and testing services are available to students from UAA Enrollment Services (and from the UAA Advising and Testing Center, located in the University Center). Counseling services are available at the Student Health Center located in Rasmuson Hall. For students enrolled in Outreach sections of the program, there are designated advisors at each site in addition to these Anchorage-based services. Students seeking information about academic programs should refer to Part 2 of this document.

SECTION II - GENERAL POLICIES

INFANTS AND CHILDREN

Infants and children are not permitted in classes, audioconferences, laboratories or clinical settings, even when a parent is present and involved in a scheduled learning experience. Children should not be left unsupervised in university or clinical facility hallways or lobby areas. Students who bring children to class will be asked to leave with the absence being treated as unexcused. When this policy creates a special hardship, the student should discuss the problem with his/her advisor or with the relevant program chair.

PETS

According to the 2011-2012 UAA Catalog, "Anyone wishing to bring pets onto campus must first contact the University Police Department. Pets are not permitted in any of the campus buildings without prior permission". To be consistent with UAA policy, pets will not be permitted in SON classroom or laboratory settings. Students who bring pets to class will be asked to leave, with the absence being treated as unexcused.

ELECTRONIC COMMUNICATION DEVICES

Cellular phones and audible electronic devices should be turned off during classes, audioconferences, laboratory and clinical laboratory sessions. If audible communication devices ring during scheduled learning experiences, the student will be required to leave the setting and not return for the remainder of the day; absences resulting from violating the policy are treated as unexcused. When this policy creates a special hardship, the student should discuss the problem with his/her advisor or with the program chair.

TRANSPORTATION

Students are required to provide their own transportation to and from clinical sites, including those clinical experiences scheduled outside the Municipality of Anchorage. Students assigned to clinical learning experiences on military bases are required to carry and provide proof of automobile liability insurance.

DISTANCE CLASSES

On occasion a student may elect to complete a clinical learning experience at a site distant from the primary learning site (e.g., for Anchorage-based students, in another community) and to participate in required classroom sessions by telephone audioconference. When this occurs, the student is responsible for the cost of all additional long distance charges incurred in relation to such participation.

COMPUTER COMPETENCIES

Students are strongly urged to gain basic skills in the use of computerized word processing programs prior to beginning the clinical nursing major as well as use of the UAA e-mail system and Blackboard. Competence in Microsoft Word will enable the student to utilize the word processing software that has been loaded onto the computers located in the Nursing Resources Center. Use of UAA e-mail and Blackboard will be required for all nursing courses.

PERSONAL COMPUTERS

Access to a personal computer with Internet access is strongly encouraged for all students enrolled in the clinical nursing major. **NOTE: THE UAA CAMPUS HAS WIRELESS INTERNET ACCESS.**

SECTION III - CONDUCT POLICIES

UAA STUDENT CODE OF CONDUCT

Students are expected to adhere to the UAA Student Code of Conduct (Code), which outlines standards for students to act honestly and responsibly, showing respect for others. Violations of the Code will result in referral to the UAA Dean of Students for judicial review and disciplinary action.

The Code is available on the UAA website: <http://www.uaa.alaska.edu/deanofstudents/StudentJudicialServices/code.cfm>.

UAA faculty have developed a web page which includes UAA policies and student resources regarding Academic Integrity and Honesty: <http://www.consortiumlibrary.org/blogs/ahi/uaa-apu-policies-and-procedures/>. The site includes material designed to help students understand what plagiarism means and how it can be avoided. Students are encouraged to complete the tutorial which provides more detail.

Students are expected to meet individual course academic expectations for functioning safely, responsibly and professionally in the clinical setting. Failure to meet course professionalism expectations may result in grade penalty, course failure and/or program dismissal.

Cheating and plagiarism are grounds for dismissal from the School of Nursing (SON). It will be the student's responsibility to maintain the moral standards of academic honesty.

SON faculty define cheating and plagiarism as follows:

CHEATING: *"To deceive, mislead or act dishonestly." (Webster, 1980)*

- In the context of your university and nursing education, cheating includes actions, verbalizations and written material which are given or received in a manner that breaks the rules of conduct and nursing standards in the clinical or academic setting.
- Examples include covering an untruth, sharing what is on an exam or quiz with someone else, copying or using someone else's work as your own, using sources during a closed book exam, etc.

PLAGIARISM: *"To take and use as one's own the writings or ideas of another." (Webster, 1980)*

Plagiarism is a form of cheating. Any use of someone else's information or ideas without giving credit to the source is plagiarism.

- Examples include copying or paraphrasing without quotes or citing the source. Students should also familiarize themselves with the *University Policy on Academic Dishonesty* in the UAA Catalog.

PROFESSIONAL/ACADEMIC ETHICS

SON faculty and students will perform in an ethical and legal manner as set forth by the American Nurses' Association (ANA) and the Alaska State Board of Nursing Statutes governing nursing practice. SON supports the moral value of caring as a foundation for nursing practice. This ethos of care guides the nurse and nursing student in protecting and enhancing the dignity and well being of all clients or patients (Holmes and Purdy, 1992; Noddings, 1984). The UAA SON expects all faculty and students to follow the ANA Code of Ethics. The Code can be viewed online: <http://nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/2110Provisions.aspx>.

Course work will be provided to help students make ethical decisions. Students will be expected to make a commitment to these ethical standards and sign the necessary ethical documents as required by each clinical facility.

GIFTS TO AND FROM STUDENTS

Students are strongly discouraged from accepting gifts from clients and families. Health care agencies do have ethical guidelines for their employees prohibiting the acceptance of gifts and students should follow these same guidelines. Although not strictly forbidden in the ANA Code of Ethics, the issues of boundaries, relationship to clients and provision of care support the non-acceptance of gifts from clients. A *thank you* card is acceptable, but any monetary gift or gift of value should not be accepted by students.

Gifts to instructors are highly discouraged using the same ethical principles used for the student-patient relationship. Appreciation can be expressed to instructors through the use of *thank you* cards and letters of appreciation for faculty files which are used for promotion and tenure review for faculty.

References: Standards for Professional Nursing (ANA, 11/86)
 Ethics in Nursing: Position Statements and Guidelines (ANA, 6/88)
 Ethical Dilemmas Confronting Nurses (ANA Committee on Ethics, 2/90)
 Code for Nurses with Interpretive Statements (ANA, 6/91)
 Ethical Principles in the Conduct of Research With Human Subjects (APA)
 Caring: A Feminine Approach to Ethics and Moral Education (Noddings, 1984).
 Feminist Perspectives in Medical Ethics (Homes and Purdy, 1992)

HONOR PLEDGE

I have read the University of Alaska Anchorage (UAA) School of Nursing (SON) Honor Code. I understand all the provisions of the Honor Code and accept my responsibility as a member of the UAA community to uphold the Honor Code at all times.

HONOR CODE

Statement of Purpose

The University of Alaska Anchorage School of Nursing supports and abides by the American Nurses Association's (ANA) Code of Ethics and believes that trust is an integral part of the learning process and that self-discipline is necessary in this pursuit. The purpose of the Honor Code is to provide a mechanism for students to affirm their commitment to following the ANA Code of Ethics and as a mechanism to report those who violate the code.

Objectives

- The UAA Student Code of Conduct [University Regulation 09.02.090(A)] forms the foundation for the SON Honor Code. The Honor Code fosters a community based on trust, academic integrity and honor and mandates the following:
 - Secures a centralized system of education and awareness of the Honor Code through the nursing program Student Honor Advisory Council.
 - Clarifies what constitutes academic misconduct among nursing students at the UAA SON and what is expected of them by the School, the faculty and their peers.
 - Cultivates an environment in the UAA SON nursing program where academic dishonesty is not tolerated among the students.
 - Ensures that students, faculty and administrators understand that the responsibility for upholding academic honesty lies with them.
 - Prevents any students from gaining an unfair advantage over other students through academic misconduct.
 - Ensures that students understand that academic dishonesty is a violation of the profound trust of the entire academic community.

Student Responsibilities

All students must sign the Honor Agreement affirming their commitment to uphold the Honor Code before becoming a part of the UAA School of Nursing community. The Honor Agreement may reappear on exams and other assignments to remind students of their responsibilities under the UAA School of Nursing Honor Code.

Students are expected to act according to the highest ethical standards. The immediate objective of an Honor Code is to prevent any students from gaining an unfair advantage over other students through academic misconduct. Academic misconduct is any act that does or could distort student grades or other academic records. Some of these acts are specified in the UAA Student Code of Conduct and include cheating, plagiarism or other forms of academic dishonesty but need not be limited to the following:

1. Using material sources not authorized by the faculty member during an examination or assignment.
2. Using devices not authorized by the faculty member during an examination or assignment.
3. Providing assistance to another student or receiving assistance from another student during an examination or assignment in a manner not authorized by the faculty member.
4. Presenting as their own the ideas or works of another person without proper acknowledgment of sources.
5. Knowingly permitting their works to be submitted by another person without the faculty member's permission.
6. Acting as a substitute or utilizing a substitute in any examination or assignment.
7. Fabricating data in support of laboratory or clinical work.
8. Possessing, buying, selling, obtaining or using a copy of any material intended to be used as an instrument of examination or in an assignment in advance of its administration.
9. Altering grade records of their own or another student's work.
10. Offering a monetary payment or other remuneration in exchange for a grade.
11. Falsifying patient records in the clinical setting.
12. Misrepresenting self to patients, staff and facilities in the clinical setting.
13. Accepting monetary payment from patients or families in the clinical setting.

While these acts constitute assured instances of academic misconduct, other acts of academic misconduct may be defined by the professor.

STUDENT HONOR ADVISORY COUNCIL

The Student Honor Advisory Council has been formed to provide a forum for students to uphold academic ethical behavior during nursing program activities. All SON nursing students sign the SON Code of Ethics. A violation of this code is serious and may result in a review by the SON Honor Advisory Council.

The SON Honor Advisory Council is composed of three nursing students in good academic and disciplinary standing and two faculty members. The SON Honor Advisory Council and the SON Administration appoint members of the Board jointly. All members sign a pledge of confidentiality.

Upon allegation of a code violation by a SON nursing student, the SON Honor Advisory Council must petition the President of the Union of Students (Student Union) and the Dean of Students to have one of its student members serve during the judicial process at the SON, if the matter involves a major sanction and the accused student has opted for such proceedings.

The student in question will be given proper notice in writing five days prior to the meeting of the SON Honor Advisory Council and will be given the opportunity to speak or give a defense of his or her conduct at the meeting.

The SON Honor Advisory Council decision includes, but is not limited to, consideration of past record, the seriousness of the offense, remorse of the student and degree of cooperation during the review process and any extenuating circumstances.

Sanctions given by the SON Honor Advisory Council may include probation, suspension or dismissal from the Program at the SON.

Students may appeal the decision of the SON Honor Advisory Council to a joint meeting of the SON Honor Advisory Council and the SON Administration.

Membership

1. The SON Honor Advisory Council is composed of three currently enrolled nursing students and two faculty members.
2. Student members of the SON Honor Advisory Council must be in good academic standing in the SON.
3. Student members of the SON Honor Advisory Council must be in good disciplinary standing at the UAA.
4. Membership on the SON Honor Advisory Council will require signing a pledge of confidentiality for any proceedings and deliberations of the Ethics Board, Judicial Review Board and any Administrative Review in which the members participate.
5. All members of the SON Honor Advisory Council will be jointly appointed by the SON Honor Advisory Council and the SON Administration.
6. Student members of the SON Honor Advisory Council must register with the President of the Student Union each year to be in the pool of students available for Judicial Board hearings.
7. SON Honor Advisory Council students under review by the SON Honor Advisory Council may request that a member of the Board recuse himself or herself because of possible bias or conflict of interest; SON Honor Advisory Council students under review by the University Ethics Board may request his or her SON Faculty Advisor to attend the SON Honor Advisory Council review.

Duties and Powers

1. The SON Honor Advisory Council may report allegations of misconduct to the Office of Student Affairs.
2. Upon receipt of an allegation of a code violation by a SON student, the SON Honor Advisory Council must petition the President of the Student Union and the Dean of Students to have one of its student members serve on the Judicial Board, if the matter involves a major sanction and the accused student has opted for such proceedings.
3. If a SON student has given permission to forward the results of any judicial or administrative review to the SON Honor Advisory Council, then the Council may call a meeting for the purpose of determining whether or not to impose sanctions pertaining to the SON student in question.
 - a. The student in question will be given proper notice in writing five days prior to the meeting of the SON Honor Advisory Council.
 - b. The student in question will be given the opportunity to be present at the meeting and will be given the opportunity to speak or give a defense of his or her conduct.
 - c. SON Honor Advisory Council must make its determination on the basis of criteria that includes, but is not limited to, consideration of:
 - i. Past record.
 - ii. The seriousness of the offense.
 - iii. The severity and extent of harm or damage resulting from the prohibitive behavior.
 - iv. Remorse of the student and degree of cooperation during the review process.
 - v. Any extenuating circumstances.
 - d. Based on the severity of the misconduct, the findings of a Judicial Board hearing or the findings of an Administrative Review for the alleged misconduct and the result of the SON Honor Advisory Council meeting, the SON Honor Advisory Council may determine that those findings warrant one of the following sanctions:
 - i. Probation, with the time of probation and conditions specified. Probation serves as a warning to the student that further misconduct may result in suspension or dismissal from the nursing program.
 - ii. Suspension from the nursing program, with the time of suspension and conditions specified. Suspension temporarily removes the student from the nursing program and serves as a warning to a student that further misconduct may result in dismissal from the SON.
 - iii. Dismissal from the SON. If the Judicial or Administrative Review process has resulted in a sanction of suspension, expulsion or revocation of a degree, then these are automatic grounds for dismissal from the SON.
 - e. Students may appeal the decision of the SON Honor Advisory Council to a joint meeting of the SON Honor Advisory Council and the SON Administration.

SUBSTANCE ABUSE

On April 21, 1989, the University of Alaska Board of Regents adopted Policy 04.10.09 concerning a drug-free workplace. The following points will further explain the position of the School of Nursing on this important issue.

- Students are expected and required to report to class in appropriate mental and physical condition. It is our intent and obligation to provide a drug-free, healthy, safe and secure learning environment.
- The manufacture, distribution, dispensation, possession or use of illegal, controlled substances on University premises or clinical sites is absolutely prohibited. Violations of this policy will result in disciplinary action.

- The University recognizes drug dependency as a major health problem. The University also recognizes drug abuse as a potential safety and security problem.

Additionally, students must, if they are also employed by UAA, abide by the terms of the above policy and report any conviction under a criminal drug statute for violations occurring on or off University premises while conducting University business. (A report of a conviction is mandated by the Drug-Free Workplace Act of 1988). The SON policy for dealing with substance abuse by students begins below.

Policy and Procedure for Suspected Substance Abuse by Students

Abuse of chemical substances, including alcohol and illegal drugs, is incompatible with success as a nursing professional. This may include drugs that have been obtained with a prescription.

Engaging in clinical nursing practice activities or coming to class, the auto-tutorial and computer laboratory and the simulation laboratory while under the influence of alcohol or controlled substances constitute unprofessional nursing practice and will not be tolerated. Possessing and/or using alcohol or controlled substances on campus violates UAA policy (described in the UAA Catalog, Student Life Section) and may subject the student to University discipline.

Procedure When Substance Abuse is Suspected

The following behaviors may indicate substance abuse by a student:

- Change in behavior.
- Chronic lateness.
- Missed assignments.
- Erratic or uneven performance in clinical or classroom settings.
- Chronic alibiing (excuse-making).
- Possible odor of alcohol on breath.

A faculty member who suspects substance abuse by a student is advised to discuss the behavior that led to the suspicion with the Program Chair.

When indicated, consultation with faculty members with special expertise in substance abuse may be sought.

When indicated, the faculty member will initiate a conference with the student. At the conference:

- The suspicion of substance abuse and supporting evidence will be conveyed to the student.
- The potential and professional consequences of substance abuse will be conveyed to the student.
- The student is given the opportunity to respond verbally and in writing.
- Options for substance abuse treatment or, if indicated, other forms of counseling will be discussed with the student.

A summary of each conference with a student regarding the possible substance abuse will be written. The faculty member and the student shall sign the original. The student's signature shall be construed to mean that the conference occurred and that the summary accurately describes the conference content and outcomes (original placed in the student's file, a copy to the student). Conference Summaries regarding possible substance abuse shall be retained in the student's file until graduation and at that time removed and destroyed.

Procedure When Student Appears Under Influence

Procedure when a student appears to be under the influence of a chemical substance in the clinical setting:

The instructor will confront the student with the suspicion that s/he is under the influence of a chemical substance (drugs or alcohol). The instructor will share the specific observations that led to the suspicion with the student.

If the student admits that s/he is under the influence of a chemical substance, s/he will be required to leave the clinical setting immediately.

If the student denies being under the influence of a chemical substance and the evidence is strong (e.g., odor of alcohol on breath or use of a drug observed by an instructor, a staff member or another student), the student will be immediately requested to have a urinalysis and blood drawn for a toxicology screening. Refusal to undergo a toxicology screening will result in the student being required to leave the clinical setting immediately.

If the student denies being under the influence of a drug and the evidence is unclear, the student will be allowed to remain in the clinical setting unless, in the instructor's judgment, safety would be compromised.

When arriving at a decision regarding the safety of allowing the student to remain in the clinical setting, the instructor may consult with the nurse manager of the unit to which the student is assigned (if this occurs in a clinical agency) or with the SON Administration. Prior to the next class/clinical day, the student will be required to meet with the instructor to discuss the behavior that led to the suspicion and to develop a plan for preventing similar behavior in the future.

If a student has been under the influence of a controlled substance in a clinical setting, the student will not be permitted to return until a satisfactory plan for preventing future occurrences has been achieved.

Student Ride Home When Under Influence

Students required to leave the clinical setting for being under the influence of a chemical will not be allowed to drive themselves home. The process for ensuring that the student arrives home safely will be as follows:

- The student will call someone to come to drive him/her home. If there is no one to call:
- The student will contact a taxi cab to drive him/her home. If the student cannot pay for a cab:
- The instructor will call a taxi cab and pay the cab fare in advance. The receipt for the "in-advance" cab fare should be turned in to the School of Nursing Office Manager for a petty cash reimbursement.
- If the first three options are not feasible, the instructor shall contact the Course Coordinator, Program Chair or Director of Nursing for assistance.

Plan for Preventing Future Occurrences

The plan for preventing future occurrences will include the following elements:

- Requirement that the student undergo a substance abuse evaluation by a qualified counselor approved by the Director of Nursing or designee.
- Requirement that the student comply with counseling recommendations resulting from the evaluation with documentation of compliance to be provided by the counselor to the School of Nursing at least every six weeks until, in the judgment of the counselor, treatment is no longer required.

- Requirement that the student agree to undergo an immediate toxicology screening when requested to do so "for cause" in the clinical setting. "For cause" is defined as exhibiting behaviors suggestive of being under the influence of a chemical substance.

The cost of the substance abuse evaluation, recommended counseling and required toxicology screening shall be the responsibility of the student.

Refusal to agree to a plan including the elements described above will result in the student being dismissed from the nursing major. Readmission shall be on a space-available basis and shall be contingent upon agreement to cooperate with a treatment plan that contains the elements described above.

Student's Continued Presence in Clinical Setting

A judgment that the student's continued presence in the clinical setting constitutes a threat to safety or the clinical environment is justified if:

- The clients to whom the student is providing care may be harmed by that care.
- The student is disrupting the clinical environment for others. Or
- The student requires such close supervision by the instructor that other students cannot be adequately supervised if the student remains in the setting.

Conference Summary

In all cases involving admitted or suspected substance abuse in the clinical setting, a Conference Summary will be written. The Conference Summary will include the following:

- A description of the behavior that resulted in the need for a conference.
- A description of the conference and its outcomes, including any plan that is developed to prevent similar situations in the future or a refusal by the student to participate in the development of such a plan.

The original Conference Summary will be signed by the faculty member, the student and, if appropriate, the Program Chair. The student's signature shall be construed to mean that the conference occurred and that the summary accurately describes the conference content and outcomes (original to be placed in the student's file with a copy going to the student). Conference Summaries regarding possible substance abuse shall be retained in the student's file until graduation and at that time shall be removed and destroyed.

Classroom, NRC or Nursing Laboratory Procedure When Student Appears Under Influence of Chemical Substance

Procedure for dealing with suspicion that a student is under the influence of chemical substances on the UAA campus shall be the same as the procedure for dealing with such suspicions in the clinical setting. In the event a faculty member becomes suspicious of use of a chemical substance or influence in the classroom or laboratory setting, the faculty member shall implement the procedure described for clinical setting situations. In the NRC, if chemical use or influence is suspected by a graduate assistant or work study student, the suspicion shall be reported immediately to the NRC Coordinator, who will implement the procedure. If the NRC Coordinator is unavailable, the Director of Nursing or designee shall be informed and will implement the procedure.

The same procedures apply to equivalent settings located at Outreach sites.

Students who admit to being under the influence of a chemical substance or who demonstrate behavior described as strong evidence (*under item 3 in the Clinical Setting section*) will not be allowed to participate in clinical practice activities until a satisfactory plan (*as described in item 2 of the Clinical Setting section*) is developed.

Drug Testing

Students may be required by the assigned clinical agency to undergo a substance abuse test on or before the first day of their clinical experience. If a substance abuse test result is positive, the student will be denied access to the clinical setting in accordance with the policies of the clinical agency and the SON Substance Abuse Policy in this Handbook.

SECTION IV - CLINICAL POLICIES

DOCUMENTATION OF HEALTH STATUS

Students wishing to be enrolled in clinical nursing courses are required to provide documentation of having met the following health requirements before the first clinical experience:

1. Immunity to rubella and rubeola, demonstrated by titer (having had immunizations to these diseases is not sufficient).
2. Either immunity to hepatitis A by titer OR beginning the two-shot hepatitis A immunization series with documentation of completion of the series within six months of the first immunization.
3. Immunity to hepatitis B by titer OR beginning the three-shot immunization series with documentation of series completion and a post-series titer that demonstrates immunity.
 - i. Students whose post-immunization titer fails to demonstrate immunity are required to repeat the 3-shot series followed by a second post-immunization titer.
 - ii. If the second post-immunization titer fails to indicate immunity, the student is declared to be a non-responder and no further action is required.
4. Immunity to chicken pox, documented by titer or immunization.
5. Immunity to Tdap (Tetanus, Diphtheria, Pertussis). This immunization must remain current throughout the student's time in the nursing program.
 - i. If a student has had Td (Tetanus, Diphtheria) within the past five years, the student will not need to obtain a Tdap immunization.
6. Freedom from active tuberculosis, demonstrated annually by negative PPD or by health examination from an approved health provider (MD, NP or PA).
7. Documentation of having obtained an annual HIV test (*results are not required and should not be turned in*).

SUBMISSION DEADLINES

1. The deadline for submission of health requirements documentation is:
 - August 1 for enrollment in Fall semester courses.
 - December 1 for enrollment in Spring semester courses.
 - April 1 for enrollment in Summer semester courses.

2. To be considered valid, health requirements must extend through the entire semester; health requirements that expire midway through the semester are considered as non-current.
3. Students for whom the submission deadline imposes undue hardship may file a "Request for Extension of Deadline" to the Program Chair. A form for this purpose is located in the SON Forms section of the Handbook. Such requests must be filed at least one month prior to the April 1, August 1 or December 1 deadlines. If approved, a temporary extension of the submission deadline is granted. However, all health status documentation requirements must be met prior to the student actually beginning clinical learning experiences (including clinical orientation).
4. Students who do not meet the specified deadline and who do not have an approved deadline extension will be administratively dropped from clinical nursing courses and will be required to provide the necessary documentation before re-enrolling. Seats in particular clinical courses/sections will not be held for students who are administratively dropped because of failure to meet documentation submission deadlines.
5. Students may obtain the necessary immunizations or tests to meet health requirements through the UAA Student Health Center during the summer months even if they are not enrolled in summer course work. An additional fee may apply.

Documentation Requirements

Documentation should be in the form of a photocopy rather than the original. Acceptable documents may include:

- The School of Nursing Health Requirements Checklist signed or stamped by the health provider (SON Forms).
- Official Alaska Immunization Record Card.
- Copies of blood test results. OR
- Copies of actual health records signed by provider

Documentation is maintained in a separate and secure health documentation file in the School of Nursing offices. Upon request, documentation may be returned to the graduating student at the end of the final semester of enrollment.

BASIC LIFE SUPPORT

- Students must provide documentation of current certification in infant, pediatric and adult basic life support (BLS), one- and two-man rescue and automatic external defibrillator (AED). Certification as a BLS instructor is acceptable. Heart Saver courses are not acceptable. Courses approved by the American Heart Association are preferred.
- Certification must remain current throughout the entire semester.
- Submission deadlines are:
 - August 1 for the Fall semester.
 - December 1 for the Spring semester.
 - April 1 for the Summer semester.

If needed, a "Request for Extension of Deadline" may be submitted. However, even if approved, such extensions are only temporary and may not extend into the time that the student is actually participating in course-related clinical learning experiences. Go to SON Forms section for the Extension form.

- Upon request, documentation will be returned to graduating students at the end of the final semester of course work.

CRIMINAL BACKGROUND CHECKS

General Information and Purpose

Students enrolled in the School of Nursing (SON) programs either have or are seeking a professional license as a registered nurse or as an advanced-practice nurse. In the interest of patient safety, State Boards of Nursing are guided by statutes and regulations that govern the licensure requirements for nurses.

The State of Alaska has a list of barrier crimes that may impact a student's ability to obtain a nursing license or prevent a student from pursuing a nursing degree.

Nursing students provide care to vulnerable individuals in clinical agencies that must ensure the safety of patients. Therefore, the criminal background check is required for two reasons:

- To identify students who have committed crimes that could preclude their eligibility for a nursing license or the pursuit of a nursing degree. And
- To meet the requirement of clinical agencies that provide clinical learning experiences for students.

A student who is denied access to clinical agencies because of their criminal background will be dismissed from the nursing program.

The background checks must be obtained and reported to the School of Nursing prior to beginning clinical courses. Students should note the following policy:

POLICY: Students are not eligible to participate in clinical courses until the SON receives the provisional approval of the criminal background check from the State of Alaska.

Failure to Obtain a Criminal Background Check

It is the student's responsibility to obtain the criminal background check as directed by the School of Nursing. If the provisional approval is not available prior to clinical orientation and/or clinical activities, the student will be administratively dropped from the course and may be dismissed from the nursing program. If there are extenuating circumstances as to the reason the background check was not completed on time, a student may appeal to re-enroll in a future semester, being placed on a waiting list to take the course when space is available.

Results of Initial Background Check

If a student has a history of a barrier crime, the student will be denied access to clinical agencies and will be dismissed from the nursing program.

Students with concerns about infractions/crimes that may impact their ability to attend SON clinicals should contact their Program Chair. Students with concerns about their eligibility to obtain licensure as a registered nurse should contact the Alaska Board of Nursing via <http://www.dced.state.ak.us/occ/pnur.htm>.

Results of Ongoing Criminal Background Checks

Criminal background check information will be reported to the SON on an ongoing basis by the State of Alaska.

- If a student commits a crime while in the nursing program, that crime will be reported.
- If a student has committed a felony or other serious crime, the student will be dropped from clinical courses and may be dismissed from the nursing program.

- If a student commits a crime while enrolled in the nursing program and as a result is denied access to clinical agencies, the student will be dismissed from the program.

Depending on the seriousness of the crime, students may or may not be considered for re-admission to the nursing program at a later date.

HEALTH INSURANCE AND STUDENT ILLNESS OR INJURY

It is strongly recommended that students maintain personal health insurance throughout their enrollment in the nursing programs. Health insurance at relatively low cost can be purchased through the University.

Students are also encouraged to take advantage of the low cost health services available through the UAA Student Health Center.

Some clinical agencies require that students present documentation of health insurance in effect for the duration of the clinical experience. Students will be notified of this requirement with sufficient time to provide documentation of existing health insurance or to purchase health insurance.

The cost of health care for injuries or illnesses sustained or contracted during clinical learning experiences is not covered by either the University or the health facility. Such costs are the responsibility of the student.

PROFESSIONAL LIABILITY INSURANCE

All students enrolled in clinical courses are covered by student professional liability insurance through University of Alaska Statewide Risk Management. The cost of this insurance is covered by fees for the clinical courses.

ATTIRE GUIDELINES

Student appearance is a reflection of the individual and of the School of Nursing. A professional, neat and well-groomed appearance must be maintained.

Each student is required to have a picture UAA School of Nursing name badge, worn at all times in the clinical area. Name badges will be issued with the first clinical course. Stickers will be provided to indicate the date of the current semester.

Students must adhere to both the UAA and the clinical agency policies regarding attire and appearance, including:

- Appropriate footwear should also be worn. Tennis shoes and open sandals are not considered appropriate footwear.
- A white laboratory coat, fingertip length, with UAA patch is to be worn over street clothes (not jeans) when visiting the clinical facility. UAA School of Nursing name badges are to be worn in a visible location with the lab coat.
- Hair should be clean and arranged neatly. Long hair should be pulled back and secured.
- Beards/mustaches must be short and neatly trimmed.
- Nails should be kept clean and short. Nail polish, if worn, should be light-colored or neutral. Artificial nails are not allowed.

- Extreme styles of dress, hairdos and makeup are not permitted.
- Tattoos should be unobtrusive in the clinical setting. Tattoos of a nature that could be found offensive to others must be covered while in clinical.
- Jewelry should be limited to post-type non-dangling earrings and rings that do not pose a safety risk to the student or patient. Students should keep in mind that rings with stones may be difficult to keep sufficiently clean as bacteria may be harbored in the settings.
- Wearing jewelry on other exposed pierced body sites may pose a safety risk to the student and/or patient and, therefore, should be removed. The wearing of such jewelry may also negatively impact the ability of the student to establish a therapeutic relationship with a patient based on their perception of suitability of such jewelry or body piercing and should be considered when deciding whether or not to wear such jewelry to clinical.

Students should not wear strong scents (e.g. perfume) while in clinical. Many patients and staff are allergic.

BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN

Exposure Determination

Persons with potential for exposure to Blood Borne Pathogens include:

- Nursing students
- Nursing faculty
- Persons emptying waste containers or handling contaminate waste

Tasks and activities with risk for exposure to Blood Borne Pathogens include:

- Finger-stick, blood glucose monitoring practice
- Practice with injections
- Breaking of ampules
- Suturing
- Handling any sharp items

Gloves are the required PPE for these activities.

Methods of Compliance

- Universal precautions will be taught to students early in the first semester of nursing lab, prior to any practice or handling of blood or body fluids, and will be practiced at all times in the lab or clinical setting.
- Puncture resistant, leak proof containers for all sharp objects will be provided by the UAA SON and used for disposal of all sharp items, including needles and glass.
- Needles used for practice will have protective sheaths or guards. Needles will be used only when required for practice of key nursing skills and will be disposed of in designated sharps containers.
- Gloves will be provided by the UAA SON and will be worn at all times by students or faculty when there is any risk of exposure to blood or body fluids.
- If blood or body fluid is spilled on any surface, it will be cleaned as soon as possible with disinfectant soap and water by an individual wearing the appropriate protective garb and equipment.
- Hands are to be washed immediately after removing gloves that have had contact with blood or body fluids.

- Non-sharp contaminated waste (used gloves, alcohol swabs, cotton, gauze, etc.) will be disposed of in regular trash cans which will be emptied using Universal Precautions.
- Full sharps containers will be disposed of through local agencies that are in compliance with OSHA regulations. Sharps containers will be placed in large red container and ENTECH notified when full.

Protective Equipment

Students must follow clinical agency policies regarding the use of personal protective equipment (including protective eyewear) when in clinical settings where exposure to body fluids is possible.

Vaccination

All UAA nursing students and faculty are required to show evidence of meeting health requirements, to include displaying the required immunity as discussed in the “Documentation of Health Status” section of this handbook. Vaccination records for each person are on file at the UAA School of Nursing.

Post-Exposure Follow-Up

Immediate steps to take in the event of a suspected exposure to body fluids:

- Apply first aid or arrange for emergency assistance (911) if needed. Allow affected person to self-administer first aid to him/herself if possible to reduce the potential for causing secondary infections. Always follow universal precautions when administering first aid.
- Allow a small amount of controlled bleeding, if wounded, being careful to capture fluids in a safe manner.
- All potentially contaminated material must be stored in red biohazard bags with the words “Biohazard” labeled on the bag or container. Refer to disposal guidelines for biohazards.
- Thoroughly wash the wound with disinfectant soap and running warm water.
- After immediate medical needs are attended, assume that you have incurred a true exposure and seek immediate post-exposure care from a qualified provider. Students may go to the Student Health Center.
- The cost of health care for injuries or illnesses sustained or contracted during clinical learning experiences is not covered by either the University or the health facility; such costs are the responsibility of the student. Health insurance at relatively low cost can be purchased through the University. UAA employees should contact Environmental Health and Safety at 786-1335 for further advice and action.

Communication of Hazard

- For students: UAA faculty will clearly inform students in the first semester of the nursing skills lab of the hazards of exposure to blood and body fluids, including the potential for contaminated injury with sharps whether in the lab or the clinical setting.
- UAA nursing faculty involved in an exposure should complete the UAA Needlestick Mandatory Report Form within two working days. The form can be located at <http://ehsrms.uaa.alaska.edu/UAA%20Needlestick%20Report%20Form.pdf>.

Information and Training

- The UAA School of Nursing has in place a mandatory training for all students and faculty, to be completed annually, which includes prevention of exposure to blood borne pathogens, body fluids and other biohazards and hazardous materials.
- Documentation of completion of this training by each student and faculty person is maintained in the School of Nursing at UAA.

Extended Sites

- UAA students and faculty in extended nursing school sites outside of Anchorage will complete the UAA Needlestick Mandatory Report Form and will be referred to the emergency room or physician of their choice for appropriate follow-up of the exposure.

LATEX ALLERGY

The SON has a latex allergy policy that provides guidelines for the prevention, identification and management of allergic reactions to latex among nursing students and faculty.

Natural latex products are manufactured from fluid derived from the rubber tree, *Hevea brasiliensis*. Latex proteins and chemicals used in processing of the rubber product have been determined to cause allergic reactions. A wide variety of products contain latex, including medical supplies, protective gloves and many household items (balloons, elastic on clothing, diapers, rubber bands, plastic storage bags, etc). Latex proteins fastened to the powder in powdered gloves can become airborne when the gloves are changed, resulting in inhalation as well as contact exposure to the latex proteins. Most individuals who have contact with latex household products have no health problems related to their use. However, reports of work-related allergic reactions to latex or chemicals used in the manufacture of latex have increased in recent years, especially among health care workers who frequently use latex gloves to prevent exposure to infectious organisms.

Individuals with allergies to certain foods (particularly avocado, potato, banana, tomato, chestnuts, kiwi and papaya) are believed to be at increased risk for developing a latex allergy. Several types of synthetic rubber gloves are available which do not release the proteins that cause true latex allergies.

The SON will attempt to minimize the exposure of students and faculty to latex by purchasing non-latex gloves for use in the nursing lab. Students and faculty, however, may experience exposure in clinical facilities that still utilize latex gloves.

Purpose of this Policy

- Educate nursing students and faculty about the sources, types and signs and symptoms of reactions to latex.
- Provide recommendations for prevention and management of latex reactions and allergy.
- Provide references for further information about latex allergy.

Types of Reactions to Latex and Associated Signs and Symptoms

Irritant Contact Dermatitis:

This reaction is caused by skin irritation and is the most common reaction to latex products. It is not a true allergy.

Signs and symptoms:

- cracking of skin, which typically stops at the wrist
- redness
- burning
- itching
- scaling
- drying

Potential causes:

- hand soaps
- glove chemicals or powders
- frequent hand washing
- incomplete hand drying

Management:

- identify and avoid contact with causative agent (change soaps, use powder-free gloves)
- allow hands to heal
- use water-based hand lotions
- consider use of cotton glove liners

Allergic Contact Dermatitis (Type IV delayed hypersensitivity or allergic contact sensitivity):

This allergic reaction is similar to skin reactions caused by exposure to poison ivy. This type of allergy will not become systemic or progress to anaphylaxis.

Signs and symptoms:

- blistering, itching, crusting, oozing lesions which usually begin 24 to 48 hours after contact
- rash may spread up the arm beyond the border of the glove

Potential causes:

- usually from exposure to chemicals used in processing latex or other glove materials
- soaps, chronic eczema or other allergies may also be factors

Management:

- identify and avoid contact with causative agent
- allow skin to heal
- obtain an evaluation by a dermatologist or an allergist
- consider use of cotton glove liners
- use gloves specifically formulated for chemical allergies ("hypoallergenic")

Latex protein allergy (Type I immediate hypersensitivity):

This is the most serious type of reaction to latex. This type of reaction can involve local or systemic symptoms that can occur within seconds or minutes after exposure. With many allergic persons, however, there is a progression from skin to more serious respiratory symptoms over a period of months to years when they have continued exposure to latex.

Signs and symptoms:

- local: skin redness, hives, itching
- systemic: runny nose, sneezing, itching or swollen eyelids, swelling lips, shortness of breath, asthma, anaphylaxis

Potential causes:

- skin contact with or breathing latex protein allergens
- possible cross-sensitivity to certain food allergies (avocado, potato, banana, tomato, chestnuts, kiwi and papaya)
- persons with a history of atopic reactions (an increased immune response to common allergens resulting in asthma, contact dermatitis or eczema)

Management:

- avoid contact with latex or food allergen
- seek immediate medical attention for systemic respiratory symptoms
- obtain an evaluation by a dermatologist or an allergist
- use only non-latex (vinyl) exam or synthetic surgical gloves
- be aware that most gloves on the market today labeled "hypoallergenic" do contain natural rubber latex and are formulated for chemical allergies, not for latex allergies

Hand Care Protocol

Utilizing a proper hand care protocol will decrease the risk of skin irritation and the development of contact dermatitis.

Handwashing:

- wash hands thoroughly with an appropriate hand soap
- rinse thoroughly to remove residual soap
- dry hands appropriately by gently patting

Lotions:

- use appropriate hand lotions, preferably those provided in the lab/clinical facility
- products containing mineral oil, petroleum or lanolin should not be used when wearing latex gloves

Procedures for Students

- Utilize the proper hand care protocol in both lab and clinical settings
- Monitor self for the signs and symptoms of irritant contact dermatitis, allergic contact dermatitis or latex protein allergy
- Inform your clinical instructor should you experience any of these signs or symptoms.
- Follow the management recommendations should you develop the signs and symptoms of chemical or latex reactions
- Read latex allergy policies in your assigned clinical facilities and follow agency guidelines

Selected References for Further information

Alert Inc.
Allergy to Latex Education and Resource Team
PO Box 23722
Milwaukee, WI 53223
(888) 972-5378 <http://www.execpc.com/~alert/>

National Institute for Occupational Safety and Health, (800) 356-4674
"NIOSH Alert: Preventing Allergic Reactions to Natural Rubber Latex in the Workplace". June 1997 (request publication number 97-135).

"Latex Allergy: A Prevention Guide" (request publication number 98-113).
<http://www.cdc.gov/niosh/latexalt.html>

American Nurses Association, (800) 637-0323
"Latex Allergy: Protect Yourself and Your Patients" (request item number WP-7).

Latex Allergy Web Links
http://www.netcom.com/~nam1/latex_allergy.html

Allegiance Healthcare Information Center
 Latex Allergy Information
<http://www.allegiance.net/hic/latex/latex.htm>

Latex Allergy News
 176 Roosevelt Ave
 Torrington, CT 06790
 (860) 482-6869 <http://www.latexallergyhelp.com>
 Gritter, M. "The Latex Threat." AJN.98:27-32, September 1998.

UNUSUAL OCCURRENCES

The SON has an unusual occurrence policy that provides a mechanism for the reporting of unusual occurrences involving students while in the clinical setting. Examples of unusual occurrences include medication errors, patient falls and student injuries. Unusual occurrences are reported on a "UAA School of Nursing Unusual Occurrence Form" within 24 hours of the occurrence; the form is located at the end of this section. These reports are used to document the event and safety hazards and as a basis for student counseling. See the SON Forms section for Unusual Occurrence Form.

Purpose

The purposes of this policy are to:

- Provide a mechanism for unusual occurrences to be reported according to the policies and procedures of the institution/agency in which UAA nursing students gain clinical experiences.
- Document a safety or environmental hazard that may result in injury, damage or loss to a client or an institution/agency.
- Preserve evidence in the event of legal action against the student and/or University.
- Provide a basis for counseling the student involved in the unusual occurrence.
- Allow for the recognition of a pattern of involvement in unusual occurrences by individual students for the purposes of counseling and decision-making regarding progression within the nursing program.

Definition

An unusual occurrence is:

- Any situation that actually or potentially results in injury to persons or damage to property in the clinical settings.
- Any situation involving a student that is not congruent with operational or safety standards of the clinical agency.

Examples of Unusual Occurrences *(the following list of occurrences is not exhaustive)*

- medication errors (including errors involving lateness, omission or commission)
- treatment errors
- patient falls or injuries
- student injuries - or potentially injurious events
- instructor injuries
- equipment damage
- administrative errors
- errors that may be "remedied" within the institution by obtaining a "covering" physician's order

Applies to:

- students engaged in clinical practice within the context of their studies in clinical nursing courses
- faculty members performing within the context of their UAA employment

Philosophy

Unusual occurrences are regarded by the faculty as providing opportunities to students, faculty and institution/agency staff to identify and prevent potentially dangerous situations in the clinical setting. They also present a learning opportunity to individuals involved in the occurrence.

The role of the faculty member is to promote and facilitate student learning. Additionally, the faculty member bears a responsibility for protecting clients from harm. When a conflict between the two responsibilities exists, the protection of the client takes precedence over the responsibility of teaching the student.

It is the responsibility of the faculty member to create an environment that encourages students involved in unusual occurrences to report those occurrences and participate in analysis and planning to prevent future occurrences of a similar nature. It is the joint responsibility of the student and faculty member to demonstrate professional accountability in reporting unusual occurrences and in implementing the policies and procedures of the clinical institution/agency and the UAA SON regarding unusual occurrences.

Procedure for Unusual Occurrences Involving Students

When an unusual occurrence involving a student of the UAA SON is identified by the student or the faculty member, the following steps should be carried out.

1. The student and faculty member shall immediately implement the policy of the institution/agency regarding unusual occurrences.
2. Within 24 hours following the incident, the student and instructor shall jointly complete the "UAA School of Nursing Unusual Occurrence Form."
 - a. A copy of the form shall be placed in the student's file in the School of Nursing. Forms reporting injuries to the student shall be retained in the file indefinitely; all other unusual occurrence forms shall be retained in the student's file until the student's graduation and at that time removed and destroyed.
 - b. The original form shall be forwarded through the Program Chair to the Director of Nursing and retained by the Director of Nursing indefinitely.
3. Prior to the next clinical day the supervising faculty member shall review the student's file to determine whether a pattern of unusual occurrences is developing.
 - a. If it is apparent that such a pattern is developing, the supervising faculty member, the student and the Program Chair shall meet to:
 - 1) Develop a plan for interrupting the pattern and for preventing future unusual occurrences; plans will be in writing and retained in the student's file.
 - 2) Discuss the potential consequences of repeated unusual occurrences with the student.
 - b. If no developing pattern is apparent, the supervising faculty member and the student shall meet to discuss plans for preventing future unusual occurrences.

When the unusual occurrence involving a student is noted by a staff member while the student and the faculty member are present in the institution/agency, the staff member shall notify the instructor immediately. The faculty member and the student shall implement steps 1 through 3 above.

When the unusual occurrence involving a student is noted by a staff member after the student and faculty member have left the facility:

1. The staff nurse shall:
 - a. Implement the policy of the institution/agency regarding unusual occurrences.
 - b. Notify the unit Nurse Manager, who will notify the faculty member of the incident by telephone as soon as possible.
2. The student and faculty member shall implement Steps 1-3 within one working day following notification.

When the unusual occurrence involves a student being precepted by a member of the staff of the institution/agency:

1. The student and preceptor shall:
 - a. Implement the policy of the institution/agency regarding unusual occurrences.
 - b. Complete the "UAA School of Nursing Unusual Occurrence Form."
 - c. Notify the faculty liaison of the occurrence as soon as possible (within 24 hours of its occurrence).
2. The faculty liaison shall carry out Step 3 (review of student file to determine developing pattern and appropriate counseling).

Potential Consequences of Repeated Occurrences Involving a Student

The faculty of the SON and the staff of clinical facilities recognize that unusual occurrences may occur as a result of circumstances that may or may not be within the control of the involved student. In general, the response of faculty and institutional/agency staff will be to study unusual occurrences to develop preventative action. However, when a pattern of unusual occurrences within the control of the student is apparent and when remedial action is not effective in reversing that pattern, protection of clients requires action on the part of the SON. Depending upon the severity and frequency of unusual occurrences, the potential consequences may include any one or more of the following:

- Remedial study assignments related to the circumstances of the unusual occurrence.
- Remedial assignments in the Nursing Resource Center, through an online tutorial or simulation laboratory.
- Remedial course work.
- Dismissal from the course and award of a failing grade with an option for re-enrollment in a future offering of the course, contingent upon satisfactory completion of remedial assignments and on a space-available basis.
- Dismissal from the course and award of a failing grade with no option for re-enrollment in a future offering of the course. This consequence includes dismissal from the nursing program. (This penalty is automatically applied if it is apparent that the student has deliberately concealed an error or occurrence or has made dishonest statements about the event.)

Note: Dismissal from a course with or without the option of re-enrollment in a future offering of the course shall occur only in situations in which the student's behavior leads the faculty member and the staff to believe that the student is not likely to seek appropriate assistance or follow direct instructions from faculty or staff. Such actions shall be subject to the Grade Appeals Policy outlined in the UAA Catalog.

SECTION V - CONFLICT POLICIES

PROCEDURES FOR RESOLVING CONFLICTS

To view the UAA Fact Finder Student Handbook, go to <http://www.uaa.alaska.edu/studentaffairs/fact-finder.cfm>. Academic rights of students and academic dispute resolution procedures begin on page 73.

On rare occasions a substantial conflict between a student and faculty member may prompt the student to seek resolution of the issue. What steps you should take in attempting to resolve such a conflict follow.

Students must realize that conflict and how to deal with conflict, are important aspects of professional nursing practice. Thus, learning to cope with conflict is an important skill to develop. The following informal and formal grievance procedures should be followed for resolving your conflict.

1. REQUEST AN APPOINTMENT WITH FACULTY MEMBER

It is recommended that you make an appointment to thoroughly discuss the problem with the faculty member in question. Discussing is more than merely mentioning the problem or complaining. It is expressing your concerns and offering a solution that is acceptable to you both. It is expected that student/faculty disagreements will be worked out at this step.

2. REQUEST AN APPOINTMENT WITH COURSE COORDINATOR AND/OR DEPARTMENT CHAIR

If the issue cannot be resolved in step 1, you should request an appointment with the Course Coordinator and/or the Department Chair. If the course has a Course Coordinator, it is appropriate to make an appointment with that individual prior to making one with the Department Chair.

It is a professional courtesy to inform the involved faculty member of the steps you are taking. At the meeting with the Course Coordinator and/or the Department Chair, you should be prepared to discuss:

- what the issue or conflict is.
- what previous efforts you have taken to resolve the issue and the outcomes.
- how you expect the Department Chair to assist you in resolving the problem.

- #### **3. If the problem is unable to be resolved on an informal basis in steps 1 and 2, the student has a right to follow the University Dispute Resolution Process.**

POLICY ON RESOLUTION OF DISPUTES INVOLVING ACADEMIC DECISIONS OR ACTIONS

Authority: This policy and procedure represents the operationalization of University of Alaska Board of Regents policy 09.03.02 and the related University Regulation on Resolutions of Disputes Regarding Academic Decisions of Actions.

Definitions Applicable to Academic Disputes: The following terms are defined specifically for this policy and related procedures:

- a. **Academic Decision Review Committee:** This Committee is an ad hoc Committee appointed by the Director of the School of Nursing or designee to review contested academic decisions or actions.

Membership of the Committee will include at least three faculty and a non-voting student representative. Faculty membership shall include at least **three members**.

Faculty Member 1: One nursing faculty member with a primary instructional assignment *in* the program in which the student is actively enrolled.

Faculty Member 2: One nursing faculty member with a primary instructional assignment in a program *other than* the one in which the student is actively enrolled.

Faculty Member 3: One additional nursing or non-nursing faculty member.

One faculty member will be designated as the non-voting Chair of the Committee. Faculty members of the Committee will be appointed by the Director of the School of Nursing.

Student Representative: The student representative shall be a nursing student enrolled in a program/specialty *other than* the one in which the complainant student is enrolled. To the extent feasible, the student representative will be a student at a level of practice comparable to that of the complainant student (i.e., basic [non-RN] nursing students will sit on Academic Decision Review Committees appointed to hear disputes involving basic [non-RN] students).

The student member of the committee will be appointed by the campus student government president from a list of students recommended by the School of Nursing director/designee.

- b. **Arbitrary and Capricious Grading:** Arbitrary and capricious grading means the assignment of a grade on the basis of something other than the student's performance in the course or the use of standards different from those applied to other students enrolled in the same course; or substantial, unreasonable and/or unannounced departure from the previously articulated standards or criteria announced by the instructor.
- c. **Class Day:** A class day is any day during which the University delivers scheduled instruction, including days during the final examination period but excluding Saturdays and Sundays. The term class day does not refer to the specific days that a particular class is normally scheduled to meet.

- d. Comparable Level of Professional Practice: A comparable level of practice refers to the level of licensure sought or held by the complainant student. Associate degree students are at a comparable level of professional practice as basic baccalaureate students and RN→BS students are at a comparable level of clinical practice as graduate nursing students.
- e. Course Completion: Course completion refers to the date when the course is scheduled to end. Course completion for nursing courses does not necessarily coincide with the end of the regular semester.
- f. Days: The term “days” always refers to class days (see definition above).
- g. Final Grade: The final grade is the grade assigned for a course upon its completion.
- h. Grading Error: A grading error is a mathematical miscalculation of the final grade or the inaccurate recording of the final grade.
- i. Next Regular Semester: The next regular semester is the Fall or Spring semester following that in which the disputed academic decision was made. For academic decisions made in Spring or Summer course offerings, the subsequent Fall term constitutes the “next regular semester.” For academic decisions made in Fall course offerings, the subsequent Spring term constitutes the “next regular semester.”
- j. Nursing Program/Specialty in Which the Student is Actively Enrolled:

At the undergraduate level:	At the graduate level:
<ul style="list-style-type: none"> ▪ AAS Nursing Program ▪ LPN→AAS Nursing Program ▪ BS Nursing Program ▪ RN→BS Nursing Program 	<ul style="list-style-type: none"> ▪ Family Nurse Practitioner Specialty ▪ Advanced Psychiatric-Mental Health Nursing Specialty ▪ Nursing Education Specialty ▪ Graduate Study

- k. Timely: Within the timeframes outlined in this policy. With regard to academic decisions involving a final grade, a student who wishes to make uninterrupted progression towards graduation in the event of a resolution of the dispute in the student’s favor should initiate the resolution process **within 15 days of learning of the failing grade**. However, due to the two week break between trimesters, students are encouraged to start the appeal process as soon as possible. Final grades are to be posted on UAOnline within three days of the end of class. Students are advised to learn their final grades through UAOnline or Blackboard and initiate a review, where desired, as soon as possible. A student who wishes to delay initiation of the process to the next regular semester should be aware that s/he may not be able to re-enter required course work for an additional semester, even if the decision is in his/her favor, due to having already missed a significant amount of content or number of clinical hours.

Policy

Students may challenge academic actions or decisions by faculty or the academic administration of the relevant program or the School of Nursing when that decision or action is arbitrary and capricious or erroneous.

When an academic decision or action by a member of the School of Nursing faculty or academic administration is disputed, informal resolution procedures will be carried out, where possible. If the use of the informal procedures leaves the dispute still unresolved, the student may file a request for a formal hearing to the Director of the School of Nursing. Upon receipt of a request for a formal hearing, the Director of the School of Nursing shall establish an ad hoc Academic Decision Review Committee that includes three faculty members (at least two of whom shall be nursing faculty members and at least one of whom is from the program in which the student is enrolled) and one nursing student.

Obligations of the Student with the Dispute

A student who wishes to resolve an academic dispute is required to:

1. Give notice of the desire to implement the dispute resolution policy by discussing disagreement with the final grade with the course instructor or program chair in a timely manner (**within 15 class days of learning of the final grade** or sooner) to facilitate steady progression in the program of study; within a maximum of 15 class days of the next regular semester if steady progression is not a concern).
2. Make a good faith effort to resolve the dispute using the informal dispute resolution procedure prior to requesting the implementation of the formal dispute resolution procedure.

Note: Because of the potential that the receipt of a failing grade in a required nursing course may prevent their enrollment in subsequent required nursing courses, ultimately extending the time to graduation, students are strongly urged to implement dispute resolution procedures as soon as possible after learning of the grade under dispute. When the maximum time limits specified in this policy are strictly adhered to, even if a dispute is resolved in favor of the student, the decision may occur too late to enable the student to enroll in the next required course in the program of study during the next semester.

Obligations of the School of Nursing Faculty and Administration:

Once a faculty member or the School of Nursing academic administration is notified of the existence of an academic dispute, faculty and administrators are obligated to:

1. Activate dispute resolution procedures in a timely manner (**within five class days** of notification of the student's disagreement with the final grade).
2. Make a good faith effort to resolve the dispute using the informal procedure.

Description of Academic Decisions or Actions Leading to Implementation of Dispute Resolution Procedures:

Dispute resolution procedures may be activated for the following reasons:

1. Actions or decisions by faculty alleged to involve arbitrary and capricious grading or grading error.
2. Actions involving the denial of admission to an academic program.
3. Actions involving the dismissal of the student from an academic program.

It should be noted that admission, progression and retention criteria as well as course requirements, policies and grading standards are matters reserved to the faculty. Such matters are inappropriate targets of disputes and will not lead to implementation of the dispute resolution procedures.

Procedures:

General Provisions:

1. Students may challenge a grade or academic decision on the basis of alleged grading error or arbitrary and capricious grading.
2. Because grades may affect such things as a student's ability to progress to the next nursing course, eligibility for financial aid or eligibility to participate in selected University activities (e.g., athletic team participation), students are strongly urged to learn their grades in a timely manner and to initiate dispute resolution procedures (if desired) as soon as possible after learning of the final grade.
3. Maximum time schedules within which the processes must be completed are included within this procedure. Extensions must be requested in writing by the student and, if sufficient justification is provided, may be granted by the Director of the School of Nursing or designee. Determination of sufficient justification

will be at the discretion of the Director of the School of Nursing. The time limits specified in this policy are maximum time limits. They may be shortened at the request of the student and with the agreement of the involved faculty member.

4. When the academic decision under dispute would prevent the student's progression into a subsequent course in the student's program of study, the student may not enroll in the subsequent courses for which the course under dispute is prerequisite until the dispute resolution process is completed.
5. During the review of an action or decision by the University, the action or decision being contested will remain in effect until the dispute is resolved. Should an academic action or decision affect the student's eligibility for financial aid, housing or other university service, the student will be informed of the steps to be taken that may maintain or reinstate the affected service. The student will be responsible for initiating any necessary actions or procedures relative to the maintenance or reinstatement of services.
6. Unless an extension has been granted by the School of Nursing Director or designee, disputes concerning academic actions must be completed by the next regular semester following the term in which the disputed action occurred. Requests for extension must be submitted in writing to the School of Nursing Director.

ACADEMIC DISPUTE RESOLUTION PROCEDURES INVOLVING FINAL GRADE ASSIGNMENT

Informal Procedures

1. Where possible, the student will be expected to first request an informal resolution of the final grade assignment with the course instructor. Requests may be made verbally, by e-mail or by letter.
2. **The process must be initiated by the 15th class day of the next regular semester.** Students wishing to make continued steady progress toward program completion are strongly advised to initiate the process by the 15th class day after learning of the final grade.
3. The course instructor must respond to the request **within five class days of receipt.**
4. If the instructor's decision is to change the final grade, the instructor must promptly initiate the process.
5. If the instructor does not change the grade and the student's concerns remain unresolved, the student may notify the program chair of the dispute. Such notification must occur within **five class days of receipt** of the instructor's decision to not change the grade.
6. Within **five class days of receiving notification**, the program chair must either work with the student and the instructor to affect a resolution of the dispute or provide the student with written notification of the process for formally appealing the final grade assignment.
7. Alternative informal procedures:
 - a. If the course instructor is not reachable within the specified time frame, the informal procedure shall be initiated with the program chair.
 - b. If the course instructor and the program chair are unavailable within the specified time frame, the informal procedure shall be initiated with the School of Nursing Director or designee.
 - c. It should be noted that the only individuals who are able to change a grade are the course instructor who initially awarded the grade or an Academic Decision Review Committee (see formal procedure). If the instructor is no longer employed by the University, the Program Chair or School of Nursing Director must either effect resolution of the issue through contact with the course instructor or inform the student of the process for formally appealing the final grade assignment.

Formal Procedures

1. The request for initiation of the formal procedure for dispute resolution must be submitted to the Director of the School of Nursing in writing **within five class days** of receipt of notification of the outcome of the informal process by the program chair.

2. The request for initiation of formal procedures shall include the following:
 - a. Specific academic decision being reviewed.
 - b. Basis of the dispute (i.e., evidence of arbitrary and capricious behavior by the course instructor or of grading error).
3. The School of Nursing Director shall convene an Academic Decision Review Committee and will forward the student's written request to the Committee Chair **within three class days** of receiving the written request.
4. The Committee Chair will convene the Committee **within 10 class days** of receipt of the student's written request.

Academic Decision Review Committee Activities

Initial Considerations

1. The Committee shall first consider whether the facts submitted by the student warrant a formal hearing. The student and course instructor must be notified in writing at least three class days in advance of the time and place of the meeting at which the student's request will be considered and of the process to be followed.
2. If the Committee determines that the facts, as presented, do not constitute arbitrary and capricious grading or grading error, the Committee will dismiss the case without a formal hearing.
3. The Committee Chair shall submit the Committee's decision in writing by the Chair to the student, the course instructor, the program chair and the School of Nursing Director **within three class days** of the Committee meeting.
4. This decision shall constitute the final decision of the University.

Formal Hearings

1. If the Academic Decision Review Committee determines that the facts, as presented, may constitute arbitrary or capricious grading or a grading error, the committee will proceed to a formal hearing.
2. The Committee Chair shall inform the student and the course instructor in writing **at least three class days** in advance of the date, time and place of the formal hearing.
3. At the hearing, the Committee shall consider information provided by the student, by the instructor and by others as it sees fit.
4. Academic Decision Review Committee hearings will normally be closed to all parties except the committee members, the student and the course instructor.
 - a. Requests for an open proceeding must be made to the Committee Chair in writing prior to the start of the hearing by a party to the dispute (the student or the course instructor).
 - b. Such requests shall be granted to the extent allowed by law unless the Committee Chair determines that all or part of a proceeding should be closed, based on considerations of fairness, justice or other relevant factors.
 - c. Either party to the dispute may choose to have an advisor present at all times during the hearing. However, the advisor may not speak on behalf of the party.
 - d. Either party may suggest potential witnesses to provide information to the Committee. Such suggestions shall include a description of the type and relevance of the information the witness may be expected to provide.
 - e. The Committee may direct that witnesses, but not the parties or their advisors, be excluded from the hearing except during their testimony.
5. The deliberations of the Committee will be closed to the public, the parties and their advisors.

6. Academic Decision Review Committee Decisions
 - a) The Academic Decision Review Committee proceedings will result in the preparation of written findings and conclusions. Conclusions will result in one of the following:
 - 1) The request for the grade change is denied.
 - 2) The request for the grade change is upheld and the Committee requests the course instructor to change the grade and the course instructor does so.
 - 3) The request for the grade change is upheld and the course instructor is either unavailable to change the grade or refuses to do so. The Review Committee will then direct the Program Chair or the School of Nursing Director to change the grade.
 - b) The decision of the Academic Decision Review Committee constitutes the final decision of the University and will be provided in writing to the student, the course instructor, the Program Chair and the School of Nursing Director. The Committee Chair is responsible for the preparation of a record of the hearing.

PROCEDURES FOR RESOLVING DISPUTES REGARDING DENIAL OF ADMISSION TO OR DISMISSAL FROM A PROGRAM OF STUDY FOR ACADEMIC REASONS

A student formally requesting a review of a denial of admission to or dismissal from a program for academic reasons must provide the School of Nursing Director a signed, written request for a formal review, indicating the basis for requesting a review.

The request must be filed by the **20th class day of the next regular semester or within five (5) class days of receipt of notification of the process for filing a formal review** by the Program Chair after completion of any informal review. The only exception will be when written permission for an extension of time is granted by the Director of the School of Nursing.

Formal reviews and hearing of academic decisions involving denial of admission to or dismissal from a program of study for academic reasons will be conducted by an Academic Decision Review Committee according to the same timelines and procedures for academic disputes regarding arbitrary and capricious grading or grading error with the following exceptions:

1. The Academic Decision Review Committee proceedings will result in the preparation of written findings and recommendations to the School of Nursing Director and the student. The Committee Chair will be responsible for the preparation of the record of the hearing.
2. The student will be given the opportunity to comment on the findings and recommendations of the committee. Written comments must be submitted to the School of Nursing Director or designee **within seven (7) class days** of the day that the committee findings and recommendations are sent to the student.
3. The Director or designee will review the written findings and recommendations of the Academic Decision Review Committee, the record of the hearing and any written comments submitted by the student and make a decision. The Director's decision will constitute the final decision of the University on the matter and will be provided in writing to the student, the Program Chair and the Committee.
4. The Dean of the College of Health will make the final decision of the University on the matter if the Director of the School of Nursing is the person who made the academic decision under review.

STEPS IN THE DISPUTE RESOLUTION PROCESS - ASSIGNMENT OF FINAL GRADE

STEP	REQUIRED ACTION	TIME LIMITS
1	Student receives notification of final course grade. Notification may occur in writing from the instructor to the student, in a conference between the student and instructor or via UAOnline following posting of grades, whichever occurs first.	
2	Student notifies instructor of disagreement with final grade by requesting an appointment verbally or in writing (but not by voice mail). If the student is unable to contact the instructor, notice is given to the Program Chair or in the Chair's absence, to the Director of the School of Nursing.	Within 15 class days of next regular semester; to facilitate steady progress to program completion, within 15 class days of final grade notification.
3	Instructor meets with student to discuss the request for change of academic decision.	Within 5 class days of request for grade change.
4	Instructor provides written response to student's request for a change in the academic decision under dispute. If the dispute is resolved in the student's favor, instructor initiates change in academic decision (usually submits a grade change).	Within 5 class days of meeting with student.
5	If the dispute remains unresolved, student requests continuation of informal resolution processes in writing to the Program Chair.	Within 5 class days of notification by instructor.
5a	Program Chair either affects a resolution or provides student with notice of the process for initiating formal dispute resolution processes.	Within 5 class days of notification by student.
6	If the dispute remains unresolved, student notifies School of Nursing Director in writing of desire to initiate formal dispute resolution processes.	Within 5 class days of notification by Program Chair.
7	Director appoints Dispute Resolution Committee and forwards the student's complaint to the Committee Chair.	Within 3 class days of notification by student.
8	Committee Chair notifies student and instructor of date of planned meeting of Committee.	Within 7 class days of appointment of Committee.
9	Committee Chair convenes Committee meeting to consider whether facts submitted by student constitute a basis to convene a formal hearing. At the meeting, the Committee determines whether the evidence provided by the student merits movement to a formal hearing.	No less than 3 class days of notification of student and instructor of meeting date and within 10 class days of appointment of Committee.
10	Committee Chair communicates Committee decision to all parties in writing. If decision is that there is no basis to the student's complaint, the matter is ended. If the decision is to proceed to a formal hearing, the Committee Chair will schedule the hearing and notify all parties to the dispute of the date.	Within 3 class days of Committee meeting and decision.
11	Committee Chair convenes formal hearing; Committee hears information provided by the student, the instructor and others (as it sees fit). The parties to the dispute may be present for the hearing but will be excluded during deliberations of the Committee.	Not less than 3 class days following notification of all parties and no more than 10 class days following original Committee meeting (Step 9).
12	Committee arrives at decision and communicates that decision to all parties and to the School of Nursing Director.	Within 3 class days of conclusion of hearing.
13	School of Nursing Director directs the implementation of the Committee decision.	Within 3 class days of notification.

Individual(s) responsible for taking action within each step indicated by bold face type.

Time frames may be compressed except those relating to notification of parties to dispute of dates of Academic Dispute Resolution Review Committee meetings. In no case will Committee meeting occur less than three (3) days following notification of the parties to the dispute.

SECTION VI - STUDENT RECORDS POLICIES

POLICY REGARDING MAINTENANCE OF STUDENT EDUCATIONAL RECORDS

Student files are kept by the School of Nursing to facilitate pre-major advising, admission to the major and faculty advising within the nursing major. The primary purpose of the files is to contribute to the educational development of students and to comply with various yearly statistical reports required by the School of Nursing, the Alaska State Board of Nursing and the National League for Nursing. Maintenance of these files complies with the UAA Policy on the application of the Family Educational Rights and Privacy Act (FERPA) of 1974, as amended. For additional information on the Federal law, see the UAA General Course Catalog or the UAA Fact Finder Student Handbook, page 68. Download the Fact Finder Handbook at: <http://www.uaa.alaska.edu/studentaffairs/fact-finder.cfm>.

Maintenance of Active Student Records: A file for each student actively pursuing the nursing major is kept in a secure location. The hard copy file is referred to as the advising file. It contains all admission documents: application to UAA, copies of transcripts from high school and previous post secondary institutions attended, transcript evaluations and evaluation worksheets, admissions test scores, a current unofficial UAA transcript, School of Nursing application, letters of recommendation and a plan of study. Additionally, the advising file may contain petitions, progress reports, incident or unusual occurrence reports, letters or statements of disciplinary action, scholarship award letters, financial aid appeal letters and references prepared by SON faculty and/or staff.

A separate confidential computerized database is maintained. It contains the following: name, current address, phone number and e-mail address, assigned advisor and current clinical class enrollment. In addition, this database will contain personal information submitted on the UAA application and SON confidential form, such as birth date, gender, ethnic background, marital status and income (see copy of SON confidential form).

Copies of the Health/CPR Certification/Background Check records are maintained separately from the student's academic advising file. Students are advised to retain the originals of these documents. While copies of health/CPR Certification/ Background Check records must be maintained throughout the student's enrollment in clinical coursework, they are returned to the student upon request at the completion of the final clinical class.

Retention of Student Files: Student advising records are maintained as active files until graduation, at which time they will be transferred to a separate but equally secure location and kept for five years. Copies of faculty letters of reference and program verification forms may be added to the files of graduated students. At the end of five years, letters of reference originally generated by SON faculty will be inserted into a reference letter file to assist faculty in completing future requests for letters of reference. All other documents in the individual files will be shredded, including health requirement documents.

The file of a student who does not continue enrollment in the nursing program after being admitted to the clinical major will be kept in an inactive status for not more than seven years. Though the student may be required to reapply to UAA, to demonstrate currency of curricular information or to meet updated School of Nursing requirements, retaining the file will facilitate advising for re-entry and appropriate placement within the nursing program. Student information will remain in the computer database indefinitely, listed under the status of attrition along with reason for leaving if known.

Records of students who transfer out of nursing to a non-nursing major will be forwarded to the academic department responsible for the new major after all nursing specific documents have been removed (i.e. School of Nursing application, letters of reference, correspondence related to the nursing major and clinical evaluations and summaries of advising conferences). Nursing specific documents will be placed in a separate file with student name and retained in an inactive status for not more than seven years. Student information will also remain in the computer database indefinitely, listed under the status of attrition/career change.

Upon graduation, student information in the computer database will be transferred to a perpetual alumni database. In addition to the transferred information this database will contain graduation date, NCLEX results, employment status and employment site and other graduate follow-up data that may be collected. As with the active student database, this information will be utilized for statistical purposes and for maintaining contact with alumni.

A separate Alumni Directory will be compiled utilizing current name, address, telephone number and personal and professional information of all alumni who give written permission to be included in such a directory. The Alumni Directory will be available for purchase through the SON Alumni Association Chapter.

Exceptions to the Retention Policy: The files of students who have been dismissed from the nursing program for reasons of academic failure, dishonesty or other disciplinary actions may be kept indefinitely in a secure location.

Maintenance of Confidentiality: In keeping with the Family Educational Rights and Privacy Act (FERPA), students have the right to expect that information in their School of Nursing files will be kept confidential. Files may be accessed only by those SON personnel involved in advising, instructing or assisting students in an official capacity or in filing or maintaining the database. Those who have direct access include the Director of the School of Nursing, the Coordinator of Student Affairs, faculty and designated staff.

Random student records may be reviewed for the purpose of assessing the degree to which the School implements its published policies and procedures by individuals officially designated as Program Evaluators by regulatory or accrediting bodies. When such reviews occur, they will be conducted in the presence of an official of the School of Nursing (e.g., Director, Program Chair, Coordinator of Student Affairs or other designated staff member). Outside reviewers will be prohibited from making any notations that include identifying information.

Students have the right to review the contents of *their own* School of Nursing file in the presence of their faculty advisor or other faculty personnel or designated staff (students may not view the file of any other student). Such viewing may occur at a regularly scheduled advising appointment or at a time specifically set for review of the file. The student may not remove any of the contents of the file. No other party may view the contents of a student's file without the student being present unless the student has provided written permission to the School of Nursing. Such third party review will only be provided in the presence of designated School of Nursing personnel and will require valid photo identification.

Tests or other course work being returned to students are also considered confidential. A student must provide written permission if s/he wishes to have such documents picked up by another person.

Information contained in the computerized database will be available to faculty and designated staff on a "need to know" basis. Specific information to document that students have met the conditions established in the School's Memorandum of Understanding/Agreement with that facility/agency may be provided to an authorized representative of the facility on demand of request. Examples of situations when such documentation may be required by a clinical agency include a review of the facility/agency for continuing accreditation (e.g., JACHO

Review). Documentation of students' immunity to rubella and rubeola was also requested by agencies in Fall 1997 when the state experienced a measles outbreak.

Information contained in the computerized database is also utilized to compile statistical reports (i.e., to the National League for Nursing and the Alaska State Board of Nursing) or to prepare grant applications and submit progress reports to granting institutions. No personal data that could enable the identification of the individual student will be disclosed to a third party without the student's written permission.

Documenting Access: If a student's file is reviewed by anyone other than designated School of Nursing personnel, a copy of the student's signed permission form must be placed in the file to document such access has occurred.

Copying of Records: It is strongly recommended that students keep copies of all letters and reports provided to them by faculty. Copies of documents originated within the School of Nursing and placed in the student file may be provided to a student upon written request for a charge of ten cents per page.

School of Nursing personnel may not copy or forward to a third party any information that has not originated within the School of Nursing. This includes but is not limited to transcripts, application materials and letters of recommendation contained within the student's application packet and occurrence reports forwarded directly to the School of Nursing from a clinical site or individual preceptor.

Maintenance of Applicant Records: Advising files for students interested in pursuing a nursing degree and for those accepted to UAA as a nursing pre-major will be kept in a secure location. The hard copy may contain the same documentation as does that of the active nursing major. This file will be utilized for purposes of advising, individual student program planning and for admission to the nursing major.

From the first point of contact, all student information in a pending/applicant file will be governed by the School of Nursing policies regarding confidentiality.

Upon receipt of the "Certificate of Admission" to the pre-major and accompanying documents from the UAA Enrollment Services Office, the School of Nursing will consider the student to be in a pre-major/applicant status and will enter the student information into the confidential computerized database.

Applicant records will be maintained as long as the student is enrolled in prerequisite or co-requisite course work and continues to utilize the advising services of the School of Nursing. After three years of inactivity, an applicant file may be destroyed. In no case will an inactive file be kept more than five years for the Associate degree or seven years for the Baccalaureate and Masters degrees. When a file is destroyed, the applicant's information will be maintained in the database under the status of attrition. Individuals at that point will be required to reapply to UAA if they wish to pursue a degree.

MAINTENANCE OF COURSE RECORDS

The School of Nursing will maintain copies of course records. However, it is strongly recommended that students/graduates maintain a copy of the UAA General Catalog, the School of Nursing Undergraduate Handbook and all course syllabi and handbooks. It may also be advisable to retain copies of graded work that was completed in specific courses (e.g., papers, sample care plans, final project reports, etc.).

Records to be Maintained

Curricular Designs: A copy of both the approved curricular design will be kept indefinitely. The following will be included: program outline, curriculum action requests (CARs) and course content guides. Whenever a specific course is substantially changed or deleted or a new course is developed, the new information will be stored with the original curricular design.

Course Syllabi and Handbooks: Copies of course syllabi and handbooks that are prepared each semester will be maintained in a secure location according to the semester in which they were taught. These will be kept for a period of eight years. When the syllabi and handbooks for a course are not substantially changed from one academic year to the next, it will be acceptable to note this on the course records and maintain only one copy to conserve storage space. When curricular design is changed, copies of the relevant syllabi and handbooks will be archived along with the program curricular design materials.

Undergraduate Handbook: A yearly copy of the Undergraduate Handbook will be maintained each year for at least eight years. During that period, if there is no substantial change in the contents of the handbook this may be so noted and one copy may be kept to represent several academic years. Handbooks that reflect major policy revision may be kept indefinitely and archived along with the curricular design materials.

Long Term Storage

All course records, or representation of such as mentioned above, will be kept for a minimum of eight years in an easily accessible form (e.g., actual paper copy of the item). Materials stored for longer than eight years will be those that reflect major curricular design revision and will be utilized to maintain continuity and historical context for the School of Nursing. These records may be stored by utilizing electronic methods.

Accessing and Copying Course Records

During the eight year period in which actual paper records are maintained, students/graduates may request copies of specific syllabi at the cost of ten cents per page plus postage. Requests should include name of course and semester completed. Response time for preparing copies can be expected to be at least one week from receipt of the request. Course handbooks and the Undergraduate Handbook will not be reproduced. After eight years, a student should not expect the School of Nursing to retrieve and copy course materials.

PART 2: Associate of Applied Science in Nursing Program

SECTION I – AAS PROGRAM INFORMATION

ACADEMIC ADVISING

Academic advising and testing services are available to students from UAA Enrollment Services (and from the UAA Advising & Testing Center, located in the University Center). Counseling services are available at the Student Health Center located in Rasmusson Hall. For students enrolled in Outreach sections of the program, there are designated advisors at each site in addition to these Anchorage-based services. General information and advising for the nursing programs available at UAA may be obtained from the School of Nursing Receptionist located in the Health Sciences Building, Room 101, (907) 786-4550. Also at 1-800-577-1770 and ask for AAS Nursing.

Pre-Nursing Majors: Students interested in pursuing the AAS, Nursing (or the BS, Nursing Science degrees are initially admitted to the University as “nursing pre-majors”). Group sessions for students interested in exploring nursing degree options at UAA or in enrolling as nursing pre-majors in either program (AAS or BS) are provided by the Coordinator of Student Affairs, SON Academic Advisors or with designated advisors at Outreach sites. Dates and times of the group advising sessions are available by calling the School of Nursing prerecorded message at 907-786-4560 or the campus at Outreach sites. During group advising sessions, students can expect to obtain information regarding the following:

- introduction to the academic programs in nursing available at UAA;
- application procedures to the University in general and to the nursing programs specifically;
- instructions regarding how to transfer credits from other colleges and universities to UAA; and
- information regarding application of prior degrees to UAA Nursing Program requirements.

Individual advising sessions with the Coordinator of Student Affairs or with a SON Academic Advisor, are available by appointment and for distance sites may be completed over the phone; students formally applying for admission to any of the undergraduate nursing programs are required to have an individual advising appointment with the Coordinator of Student Affairs or SON Academic Advisor prior to being considered for advancement to the Clinical Nursing Major. During individual advising sessions, the Coordinator of Student Affairs or designee will assist the student to:

- formulate an academic plan of study;
- review previously completed course work to determine applicability to nursing degree requirements;
- submit petitions to ensure applicability of prior course work to degree requirements;
- assist the student to make formal application to the nursing major (either AAS or BS).

In addition, the Coordinator of Student Affairs and the SON Academic Advisors provide the following services on an as-needed basis:

- explain degree requirements;
- refer students with special advising needs to appropriate advisor;
- assist students to make contact with other needed services on campus, including, but not limited to, the Financial Aid Office, Student Housing, and Student Health Center; and
- assist students in obtaining documentation of enrollment to meet demands imposed by outside agencies for the purposes of receiving financial aid, tuition reimbursement, etc.

Clinical Nursing Majors: Students who meet specified prerequisites for admission, have applied for admission, been ranked, and then notified of being accepted for admission to the AAS Clinical Nursing Major, have been promised a seat in clinical nursing courses beginning with a specific semester. At the time of this admission to the Clinical Nursing Major, the student is assigned a **faculty** advisor. Students are encouraged to meet with their faculty advisor on a regular basis, at least once each semester, and whenever needed. Contact the Chair of the AAS Nursing Program for information regarding assigned AAS nursing faculty advisors.

LPN Option (Direct Articulation): Licensed Practical Nurses seeking admission to the clinical associate degree nursing major are strongly urged to seek academic advising through the School of Nursing prior to or during the first semester in which they take courses at UAA. Early academic advising can correct misinterpretations of program requirements published in the UAA Catalog as well as inaccurate assumptions regarding the fit of previously completed course work with UAA Nursing Program requirements.

Academic advising is required for all students prior to enrollment in nursing courses. Advising can be initiated by contacting the Chair or administrative assistant for the associate degree nursing program, or through the Coordinator of Student Affairs at 1-800-577-1770 (outside of Anchorage) or 786-4550 in Anchorage.

SECTION II – PROGRAM OF STUDY OUTLINE

**University of Alaska Anchorage, School of Nursing
ASSOCIATE OF APPLIED SCIENCE (AAS), NURSING**

High School prerequisites: (one semester with grade of C or higher)	or	UAA equivalent:
Algebra	or	MATH 055 or math placement test (showing ability to take MATH 105)
Biology with lab	or	BIOL 102 and BIOL 103 (or BIOL 111)
Chemistry with lab	or	CHEM 055/055L or higher level

Co-requisite courses, other than the nursing courses, may be completed prior to the Nursing Major. Enrollment in NURS 120/120L requires acceptance into the Associate of Applied Science Nursing Program Major.

Possible plan of study with full-time enrollment:

FIRST YEAR

SEMESTER I -- AAS_Nursing Major
(Fall semester Anchorage and spring at distance sites)

NURS 120, 120L Nursing Fundamentals (3 + 4=7)	
ENGL 111 Written Communication (3)	
BIOL 111 Anatomy & Physiology I (4)	
PSY 150 Life Span Development (3)	
Totals	17

SEMESTER II -- AAS_Nursing Major
(Spring semester Anchorage, fall at distance sites)

NURS 125, 125L Adult Nursing I (3 + 4=7)	
NURS 180 Basic Nursing Pharmacology (3)	
BIOL 112 Anatomy & Physiology II (4)	
BIOL 240 Microbiology (4)	
Totals	18

All nursing courses must be completed with a grade of C or above before advancement to the next semester. **Bolded** courses (nursing) must be taken in sequence presented here.

SECOND YEAR

SEMESTER III -- AAS Nursing Major
(Fall semester Anchorage and spring at distance sites)

NURS 220, 220L Perinatal Nursing (3 + 1=4)	
NURS 221 Advanced Parenteral Therapy Lab (1)	
NURS 222, 222L Pediatric Nursing (3 + 1=4)	
DN 203 Nutrition for Health Science (3)	
ENGL 213 (or 211 or 212) Written Communication (3)	
SOCIAL SCIENCE General Education Req. (3)	
Totals	18

SEMESTER IV -- AAS Nursing Major
(Spring sem. Anchorage, fall at distance sites)

NURS 225, 225L Adult Nursing II (3 + 3=6)	
NURS 250, 250L Psychiatric Nursing (3 + 1=4)	
NURS 255 Staff RN: Legal, Ethical, Org. Issues (1)	
Oral Communication GER (3)	
General Education Requirement (3)**	
Totals	17

(Note: All Nursing courses must be completed within eight semesters of starting the program)

Minimum total credit hours: 70 for the AAS Nursing degree

**Graduates of this program must perform successfully on the National Council Licensure Examination (NCLEX-RN) to receive RN licensure.

University of Alaska Anchorage, School of Nursing
ASSOCIATE OF APPLIED SCIENCE, NURSING
LPN to AAS Direct Articulation OPTION

Prerequisite: Current unencumbered Alaska LPN license; Certificate of Admission to UAA; Completed School of Nursing Application to AAS nursing on file including submission of references, completion of nursing entrance exam (see advisors for specifics of exam to be taken).

High School Prerequisites: Algebra, Biology with lab, Chemistry with lab, or UAA equivalents (MATH 055 or math placement test showing ability to take MATH 105; BIOL 102 and BIOL 103 or BIOL 111, CHEM 055/055L or higher level).

GENERAL EDUCATION, NURSING SUPPORT & ELECTIVE COURSES-33 CREDITS
(plus High School Prerequisites if not already completed)

COMM 111, 235, 237 or 141 Oral	3 cr	^BIOL 240/L Microbiology/Lab	4 cr
*BIOL 111/L A&P I/Lab	4 cr	~DN 203 Nutrition for Health Science	3 cr
^BIOL 112/L A&P II/Lab	4 cr	~ENGL 211, 212, 213 Writing	3 cr
*ENGL 111 Composition	3 cr	GER (HUM, SOC. Science, Math)	3 cr
*PSY 150 Life Span Development	<u>3 cr</u>	~Social Science Elective	<u>3 cr</u>
	17cr		16cr

*Applicant must also complete BIOL 111/111L, ENGL 111 and PSY 150 prior to admission to NURS 125 and NURS 125L.

LPN LICENSURE CREDIT—7 CREDITS

An accepted, AAS degree seeking UAA nursing student who has successfully passed National Council Licensing Exam (NCLEX-PN) and has a current, unencumbered LPN license in the State of Alaska may be granted the following UAA course credits upon completion of NURS 125 with a grade of "C" or better and NURS 125L with a "Pass." **To receive credits, student must complete the appropriate form and pay the UAA Administrative fee for each credit granted.**

NURS 120 and NURS 120L Nursing Fundamentals and Lab (3 credits + 4 credits) = total of 7 credits

(NOTE: If LPN does not pass NURS 125 or NURS 125L, credit will not be granted and the **LPN must apply for ranking and entry to NURS 120/120L and thus must successfully complete NURS 120 and NURS 120L to continue toward the AAS nursing degree**)

AAS NURSING MAJOR REQUIREMENTS--30 CREDITS

*Applicant must complete BIOL 111/111L, ENGL 111 and PSY 150 prior to admission to NURS 125/125L.

^First Semester:

(May take NURS 180 prior to entering NURS 125/125L or concurrently with NURS 125/L.)

NURS 125/125L Adult Nursing I (3 + 4 cr) = 7 cr

NURS 180 Pharmacology (concurrent 125/125L) = 3 cr

(^Note: BIOL 112/L and BIOL 240/L are required previously or concurrent in this semester) 10 credits

~Second Semester

NURS 220/220L Perinatal Nursing (3+1) 4 cr

NURS 222/222L Pediatric Nursing (3+1) 4 cr

NURS 221L Adv. Parenteral Lab 1 cr

9cr

(~Note: DN 203, 200 level ENGL and social science elective are required concurrent in this semester if not already done).

Third Semester

NURS 225/225L Adult Nursing II (3+3) 6 cr

NURS 250/250L Psychiatric Nsg. (3+1) 4 cr

NURS 255 The Staff Nurse 1 cr

Total 11 cr

(Note: Oral communication and a GER are required concurrent in this semester if not already done).

A total of 70 credits are required for the AAS degree in nursing.

SECTION III – AAS IN NURSING PROGRAM

UAA School of Nursing Mission Statement

The mission of the School of Nursing is to educate undergraduate and graduate students to provide high quality, culturally sensitive, ethical and compassionate nursing care.

AAS Nursing Philosophy

Person, Society and Environment.

People are bio-psycho-social and spiritual beings who constantly interact with their environment. They are unique and individual; possessing intellect, independent thought, a conscience and the capacity for self-determination. They do not exist alone, but as members of families, communities and society; interacting in interdependent but autonomous relationships. People are also shaped by the environment where developmental differences have a direct impact on the relationship between the individual and the environment. Contextual factors of environment can be crucial determinants of well-being in life.

Health

The faculty believes that health is a dynamic process that moves along the health-illness continuum throughout the individual's lifetime. More than the absence of disease, health reflects the individual's ability to meet basic needs as well as adapt to internal and external environmental changes so as to maintain equilibrium. When the individual is unable to adapt or cope with stressors, unmet needs and deviations in equilibrium result.

Nursing

The faculty believes that nursing is a complex, dynamic, goal-oriented process which results in a unique relationship between the patient and the nurse. In diverse settings, care is given to assist people in all developmental stages to achieve optimal health. Fundamental to nursing is the expression of caring behaviors incorporated with the body of nursing knowledge as well as psychosocial and biophysical sciences. Nursing involves the formulation of nursing diagnoses, planning interventions toward reaching desired outcomes, implementation of nursing interventions, and evaluation and revision of nursing care in the context of cultural awareness and respect for diversity. Inherent to nursing is adherence to ethical and legal parameters and the development of collaborative relationships with other members of the health care team. The process of communication is integral to the delivery of nursing care. During periods of health, the role of the nurse is to assist the individual/family to maintain adaptive behaviors and prevent disease. When an individual or family experiences deviations in equilibrium, nursing intervention is utilized to assist the individual to regain a healthy equilibrium.

Education and Lifelong Learning

The faculty believes that learning is a dynamic, continuous process that is individualistic and goal-directed. Students are encouraged to develop self-understanding, self-evaluation, and self-direction. Willingness by the learner to take initiative and to assume responsibility for learning fosters this process as well as assists the learner to develop a high potential for achievement. We further believe that the faculty's tasks are to clearly present objectives, guide students, and provide appropriate experiences and resources for learning to occur. The teacher creates an atmosphere of inquiry by encouraging expression of thoughts and feelings while respecting the individuality and worth of each person. The teacher assists the student to build new knowledge and skills on what was previously learned and proceeds from simple to complex concepts. Learning is evidenced by changes in the students' behaviors that are predictable and measurable. Each student is evaluated on the basis of having achieved the stated objectives. The teacher reinforces a student's strengths and assists each student to identify and improve any weakness.

Diversity

The faculty recognizes that diversity is a core component of the values of professional nursing. We desire that our students learn to understand, respect, and accept any differences and similarities that characterize the varied members of our society. An awareness of and respect for diversity requires self-assessment and sensitivity to how one's view of interpersonal differences impacts the therapeutic effectiveness of his or her nursing practice. Developing this awareness not only fosters excellence in our graduates, it also assures they will contribute to the well being and enrichment of human life during their nursing careers.

Critical Thinking

Critical thinking describes the purposeful and goal-directed process in which the individual uses cognitive and experiential skills to interpret, analyze, and evaluate information in order to determine a particular course of action for a specific situation. The reflective nature of critical thinking, in contributing to the development of insight, flexibility, and objectivity, enables the individual to weigh multiple options in the present and anticipate future choices of action.

AAS Nursing Conceptual Framework *(see next page for visual model)*

The conceptual framework of the AAS Nursing Program reflects the philosophy and is based upon four major interrelated concepts across the lifespan: 1) health-illness continuum, 2) developmental stages, 3) nursing process, and 4) Maslow's Hierarchy of Needs.

The health-illness continuum reflects a belief that health and illness are dynamic rather than absolute states. Movement along the continuum occurs as the individual adapts to internal and external environmental changes. Each individual's adaptive ability is assessed utilizing several dimensions including physical, emotional, intellectual, cultural, developmental and spiritual components.

As individuals move through developmental stages it is recognized they have special needs and at times are at greater risk for disequilibrium in their health. Knowledge of growth and development provides a framework for understanding the behavior of individuals and families. This is utilized in planning individualized care.

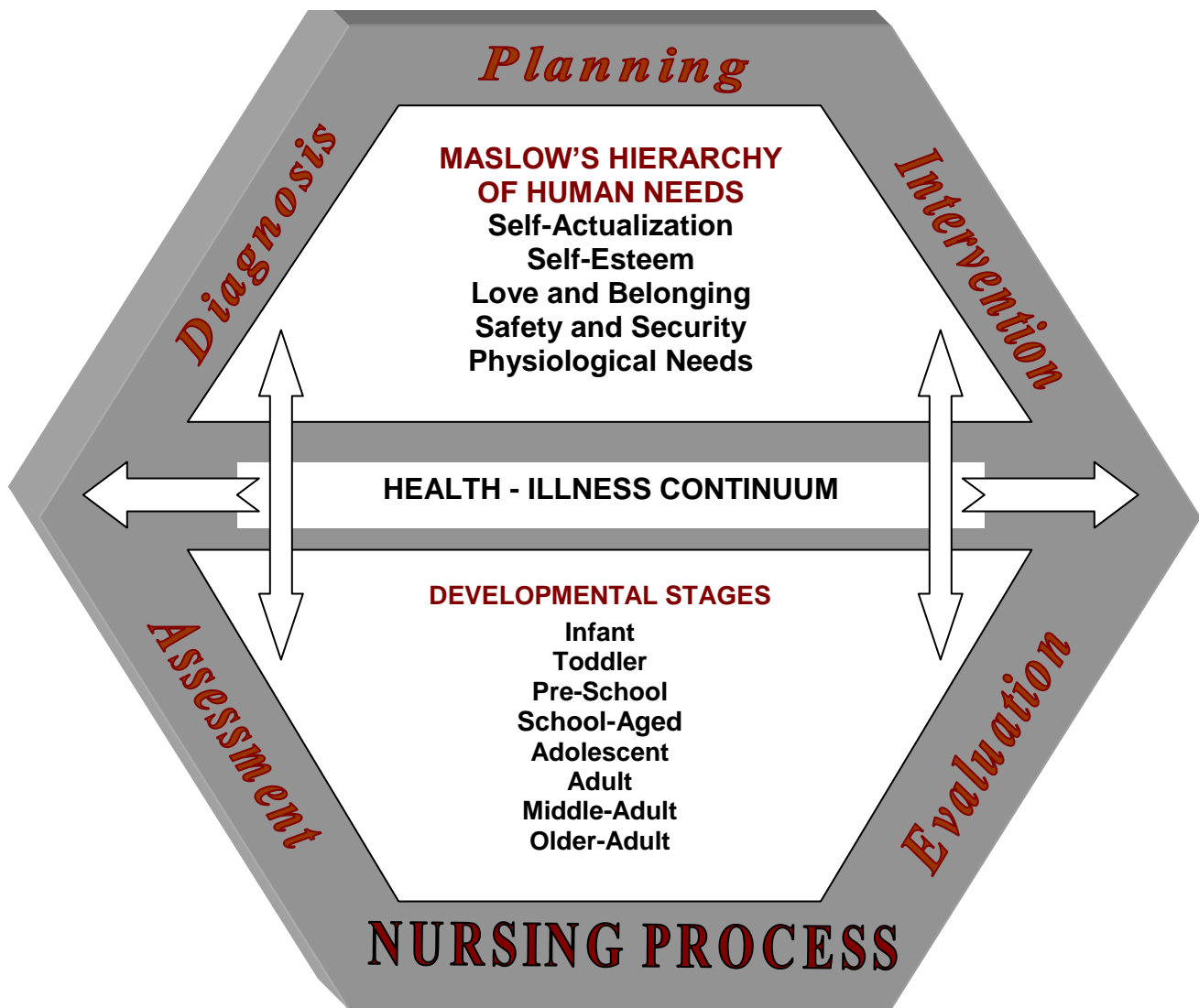
The nursing process as a critical thinking competency is a systematic approach used by nurses to gather patient information, critically examine and analyze data gathered, identify the patient's response to health problems, design expected outcomes and interventions, take action and then evaluate whether the actions were effective. This five-step systematic process is used in assessing, planning, implementing and evaluating therapeutic nursing intervention in order to provide comprehensive nursing care for patients across the health care continuum whether the health care needs are simple or complex. Communication is integral to nursing process.

Maslow's Hierarchy of Human Needs is a model used to understand the interrelationships of basic needs. It provides a method to assess patient needs and to determine whether the patient requires assistance in meeting these needs. This hierarchy can be used as a basis for prioritizing patient health problems and the delivery of nursing intervention.

The AAS Nursing conceptual framework provides a foundation which enables students to view patients and their families as unique, with specific human needs. The body of nursing knowledge added to knowledge of science and humanities is utilized within a guiding framework of professional standards for nursing practice, as well as ethical and legal principles in order to meet patient needs.

AAS Conceptual Framework Model

Associate of Applied Science Nursing Curriculum



ROLE OF THE AAS NURSING GRADUATE

The Associate of Applied Science in Nursing (AAS) graduate is prepared to function as a competent, entry-level, licensed registered nurse. The graduate is prepared to provide nursing care in structured health care environments following the identified guidelines and the state legal regulations. The AAS graduate utilizes critical thinking skills and the nursing process to provide nursing care. AAS graduates collect data from observation, interviews, physical assessments and consultations. Any changes observed in the person's health status are compared against established norms and reported to the appropriate health care provider. Graduates use assessment data to develop a plan for nursing care based upon evidence-based nursing diagnoses. While planning nursing care, interventions are selected from evidence-based nursing theory, biological and social sciences. The AAS graduate implements entry level technical and interpersonal skills to meet individual needs according to the person's current health status. The graduate identifies measurable outcomes for specific nursing interventions, implements and evaluates nursing care and then revises the plan utilizing *evidence-based* nursing knowledge for each step. Individualized health teaching and discharge planning are incorporated by the AAS graduate as an integral part of the comprehensive plan of care. Consultation and collaboration with other members of the health care team is utilized in designing health promotion activities.

OUTCOME BEHAVIORS OF THE AAS NURSING GRADUATE

AAS Nursing Program Outcomes

Upon completion of the AAS Nursing Program at UAA, the graduate will:

1. Utilize critical thinking skills to assess and diagnose nursing needs and to prioritize, plan, implement , and evaluate care for patients and their families in institutional and community based settings.
2. Effectively communicate verbally, in writing, and electronically with health team members, patients and their families in diverse settings.
3. Plan, implement and evaluate care that is safe, evidence-based, caring, and developmentally and culturally sensitive within ethical, legal, and professional standards.
4. Coordinate care of small groups of patients in collaboration with other members of the health care team.
5. Develop a plan for lifelong learning and continuing professional development.

UAA AAS Nursing Program Level Outcomes/Objectives for First Year Students	NURS 120	NURS 120L	NURS 125	NURS 125L	NURS 180
At the end of the first year the student will:					
1. Utilize critical thinking skills to assess and diagnose nursing needs and to prioritize, plan, implement, and evaluate care for patients and their families in institutional and community based settings.					
Apply nursing process in assessing health needs, planning and evaluating the care of patients.	X		X		X
Apply knowledge of developmental stages, cultural and other influences, in assessing, planning, implementing and evaluating nursing care.		X		X	
Identify the nurse's responsibilities for accurate medication administration including applying nursing process in pharmacologic intervention.					X
Explain how Maslow's Hierarchy of Needs is used to help determine priorities in planning, implementing and evaluating care of adult patients.	X		X		
Prioritize nursing diagnoses and interventions based on increasing comprehensive patient assessment and using Maslow's Hierarchy of Needs.		X		X	
Identify the nurse's responsibilities for accurate medication administration including prioritization of pharmacologic intervention.					X
Describe/explain the relationship between critical thinking and prioritization of nursing diagnoses and interventions.	X		X		
Apply beginning level (novice) critical thinking by using reflection in self evaluation, identifying options when caring for patients and evaluating clinical decisions then making adaptations appropriately.		X		X	X
Develop appropriate patient teaching, based on teaching and learning principles, that will meet the health education needs of patients	X		X		X
Use teaching/learning principles to assess, plan, implement and evaluate teaching to meet health needs of adult patients		X		X	
2. Effectively communicate verbally, in writing, and electronically with health team members, patients and their families in diverse settings					
Describe and plan various communication techniques that facilitate nursing care.	X		X		X
Utilize therapeutic communication techniques and goal-directed interactions to improve patient care and outcomes.		X		X	
3. Plan, implement and evaluate care that is safe, evidence-based, caring, and developmentally and culturally sensitive within ethical, legal, and professional standards.					
Identify developmental, cultural and psychosocial factors that influence assessment, and planning of care.	X		X		
Differentiate legal, ethical and professional responsibilities in nursing and utilize appropriately.	X		X		X
Apply ethical, legal, and professional nursing standards in providing nursing care in lab and clinical settings.		X		X	
Recognize and describe the impact of client diversities in culture, gender, and age (development) on drug therapy.					X
4. Coordinate care of small groups of patients in collaboration with other members of the health care team.					
Utilize therapeutic communication techniques, goal-directed interactions and <i>collaboration with healthcare team</i> to improve patient care and outcomes.		X		X	X
Provide continuity of care for patients including accurate, comprehensive documentation and reporting of patient status and response to nursing care.		X		X	
5. Develop a plan for lifelong learning and continuing professional development.					
Differentiate legal, ethical and professional responsibilities in nursing.	X		X		
Identify the nurse's responsibilities for accurate medication administration including applying nursing process and prioritization of pharmacologic intervention.		X		X	

UAA AAS Nursing Program Level Outcomes/Objectives for Second Year Students	NURS 225	NURS 225L	NURS 250	NURS 250L	NURS 255
By the end of the second year the student will:					
1. Utilize critical thinking skills to assess and diagnose nursing needs and to prioritize, plan, implement, and evaluate care for patients and their families in institutional and community based settings.					
Plan, implement and evaluate nursing care, for physiological and psychosocial health needs, based on assessment.	X	X	X	X	
Assess, diagnose patient needs and prioritize the physiological and psychological nursing care needs of patients.	X	X	X	X	
Apply Maslow's Hierarchy of Needs to identify and plan ways to meet the needs of self and coworkers.					X
Analyze how nursing care can be modified to enhance effectiveness by evaluating patient outcomes, and utilizing critical thinking skills, etc.	X	X	X	X	X
Analyze the patho-physiological consequences of acute disorders along with preexisting chronic disorders and aging in the adult.	X	X			
Formulate, implement and evaluate patient discharge and teaching plans that effectively meet the learning needs of patients and their families based on teaching/learning principles.	X	X	X	X	
2. Effectively communicate verbally, in writing, and electronically with health team members, patients and their families in diverse settings					
Consistently and accurately document/report patient care, patient response, and any data that influences patient care.		X		X	
Identify and describe staff RN level management responsibilities especially those related to collaboration, delegation and advocacy.	X	X		X	X
Implement and evaluate therapeutic communication principles in patient care		X	X	X	
3. Plan, implement and evaluate care that is safe, evidence-based, caring, and developmentally and culturally sensitive within ethical, legal, and professional standards.					
Critique how optimal care of patients can be provided with awareness and sensitivity for demographically diverse characteristics.	X		X		
Recognize ethical dilemmas which are frequently encountered by staff nurses in clinical practice and outline a strategy to use in resolving ethical conflicts.		X	X		X
Recognize aspects of patient care that can be safely delegated to health care team members and perform delegation with sound rationale, maintaining legal, ethical and professional standards of nursing care.		X		X	X
Assess, plan, implement and evaluate nursing care that is culturally sensitive. Utilize legal, ethical and professional standards of care with patients.		X		X	
4. Coordinate care of small groups of patients in collaboration with other members of the health care team.					
Participate in collaborative decision-making about and implementation of patient care.		X		X	
Identify and describe staff RN level management responsibilities especially those related to collaboration, delegation and advocacy.		X		X	X
Analyze how nursing care can be modified to enhance effectiveness by evaluating patient outcomes, utilizing critical thinking skills, and <i>collaborating</i> with other members of the healthcare team.	X	X	X	X	
5. Develop a plan for lifelong learning and continuing professional development.					
Describe the legal limits and responsibilities inherent in the Registered Nurse (RN) role.	X		X		X
Identify current professional issues and trends affecting health care and how these relate to the role of the staff RN.		X		X	X
Describe how to utilize professional nursing resources to analyze and resolve issues encountered in nursing practice.					X

SECTION IV – AAS SPECIFIC STUDENT POLICIES

GENERAL POLICIES

OUTREACH PROGRAMS: Students enrolled in programs based outside of Anchorage (Outreach) are usually required to attend some portion of their clinical experience in Anchorage. When this occurs, the student will be responsible for obtaining and paying for transportation, housing, and all other related expenses.

CLINICAL SITE VISITS: Students may not visit clinical sites in their capacity as a nursing student without the prior knowledge and approval of nursing faculty.

DEADLINES FOR REGISTRATION FOR CLINICAL COURSES: All students must be formally registered for clinical nursing courses of their particular major (NURS 120 and NURS 120L for entry AAS students) no later than August 1 for the fall semester, and no later than December 15 for the spring. You are required to either pay for enrollment in those courses or make appropriate arrangements with the Office of Financial Aid to defer payment so that your enrollment in planned course work is maintained. Students who have a financial constraint that precludes their registration by that deadline should consult with the Program Chair, Kathleen Stephenson, RN, MS, well in advance of whichever deadline applies.

If you are not formally registered for nursing courses on August 1 (for Fall), or December 15 (for Spring), it will be assumed that you are not intending to return to school in the Fall or Spring (whichever may apply) and the School of Nursing will take whatever steps are necessary to ensure that all clinical sections are filled to capacity. In some instances those steps may include the shifting of enrolled students to under-filled clinical sections and the cancellation of excess sections. Once canceled, additional clinical sections will not be added for that semester.

POLICY REGARDING ACADEMIC PROBATION WITHIN THE AAS NURSING PROGRAM

Students who do not continuously satisfy the requirements for maintaining “Good Standing” within the nursing program will be placed on Academic Probation within the program by the Director of Nursing. Specific situations that will result in the student being placed on Academic Probation will include the following:

1. Earned a grade of less than C in a required nursing course.
2. Withdrawal from a required nursing course(s) while earning a grade of less than C at the time of withdrawal.
3. A semester or cumulative GPA of less than 2.0 at any time.

Academic Probation within the nursing program will affect the student’s status only within the nursing program; it will not be communicated to other University Departments nor reflected on the student’s transcript.

During the time that the student is on academic probation within the nursing program, his or her status of being on probation will be communicated accurately to institutions/agencies to which the department is required to provide information regarding students’ status within the program (e.g., scholarship providers, other nursing programs requiring letters of reference, etc.). Such information will only be released with the students’ written permission; should a student decline to provide written permission, responses to such requests will simply state that such information cannot be provided without written permission by the student.

The action of placing a student on Academic Probation within the program is subject to the Academic Appeals Policy outlined in the UAA Catalog.

POLICY REGARDING DISMISSAL FROM THE AAS NURSING PROGRAM

Program Dismissal may result when the student:

1. has previously been placed on Academic Probation within the Nursing Program and is unable to satisfy the requirements for regaining "Good Standing" status within the specified time period (usually two semesters for nursing courses within the AAS program);
2. fails to consistently demonstrate adherence to standards of professional behavior;
3. Violates the UAA Student Code of Conduct or the Academic Dishonesty Policy as outlined in the UAA Catalog.

Initiation of Program Dismissals

1. The **Director** of the School of Nursing will **automatically initiate** a Program Dismissal when one or more of the following situations exist:
 - a) earned a semester GPA of less than 2.0 for a second consecutive semester;
 - b) earned a grade of less than C in a required AAS Program nursing course during a second attempt.
 - c) withdraws from a required nursing course in which a grade of less than C has been earned during a prior semester with a grade of less than C at the time of the withdrawal;
 - d) earned a grade of less than C in NURS A120/L during the first semester of enrollment in the nursing major;
 - e.) delay of progression in the AAS program - more than 8 sequential semesters to complete the 4 semester sequence of courses from NURS120 to NURS225/250/255.
2. A Program Dismissal may be anticipated by faculty and student during or at the end of the semester in extreme situations including, but not limited to, the following:
 - a.) violations of the Academic Dishonesty Policy outlined in the UAA Catalog;
 - b.) performance in the clinical setting that requires such intense supervision by the clinical instructor that it is impossible for that instructor to effectively instruct and/or supervise other students enrolled in the clinical section.

When a faculty member anticipates a program dismissal, it will be communicated to the Program Chair who will work with the faculty member to resolve the problem. When it is apparent that resolution is unlikely, the matter will be referred to the *AAS Admissions Committee*, which will review the matter and forward a recommendation to the *Director of Nursing* for final action.

Program dismissals will be forwarded to the Registrar's Office, with a request that the student's major be changed to "Undeclared".

All program dismissals are subject to the policy on **Resolution of Disputes Involving Academic Decisions or Actions** described on pages 37-45 of this Handbook.

POLICY REGARDING TRANSFER OF COURSES TO MEET NURSING DEGREE REQUIREMENTS

Nursing Courses: Basic nursing students (i.e., those students who have not previously completed a nursing program that qualified them to sit for the national licensure examination) who have been enrolled in nursing programs at other schools, colleges, or universities may request that previously completed nursing course work be applied to nursing program requirements at UAA. Only nursing courses completed at institutions accredited by the NLNAC or CCNE will be considered for transfer credit. Nursing courses taken in associate degree programs may only be considered for application to AAS Program requirements at UAA; nursing courses taken in baccalaureate nursing programs may only be considered for application to BS Program requirements at UAA. Nursing courses taken as part of LPN programs may not be used to satisfy course requirements in either the AAS or BS Nursing Programs. Only courses in which the student earned grades of C or higher or PASS may be used to satisfy UAA nursing course requirements.

Nursing courses taken at other nursing programs are evaluated by the faculty for comparability to UAA nursing courses via the process outlined below:

- student provides the full syllabus of the previously completed course to the Coordinator of Student Affairs or the Chair of the program to which application of the course is sought (AAS or BS);
- course syllabus is referred to the faculty member responsible for teaching the probable UAA equivalent for in-depth comparative evaluation of the completed course to the UAA equivalent;
- course syllabus forwarded with the faculty member's comparative evaluation is referred to the student's academic advisor (in the case of pre-nursing majors, to the Coordinator of Student Affairs), who will convey the results of the evaluation to the student and assist the student to submit any academic petitions that may be necessary;
- the academic petition is forwarded to the appropriate (AAS or BS/MS) Curriculum Committee for review and evaluation for a recommendation to approve or disapprove the petition;
- final action (Approval or Disapproval) on the petition comes from the Program Director, who forwards approved petitions to the Registrar's Office and disapproved petitions back to the student.

Transfer students must complete all academic petitions relating to the transfer of nursing courses from other schools, colleges, and universities prior to beginning UAA nursing courses; this ensures that the student has every opportunity to apply previously earned nursing course credit to their program of study at UAA. A student who fails to petition transfer of previously completed course work prior to enrolling in a UAA equivalent may not then substitute that course work for more advanced course work. Further, a student who fails to petition for application of transfer credit to UAA program requirements and fails to earn a satisfactory grade during enrollment in the UAA equivalent will not be allowed to apply the previous course to UAA Program requirements but will be required to re-enroll in the UAA equivalent and to earn a satisfactory grade prior to progressing into more advanced course work.

Transfer students who successfully petition to apply previously earned course work to UAA program requirements may, with special arrangements, audit theory courses for the purpose of review if space is available in the classroom in which the course is scheduled to be held.

Non-Nursing Courses: Students attempting to transfer non-nursing courses into UAA to meet specific requirements within the nursing programs will sometimes require special assistance to ensure correct application of those courses. The Enrollment Services Office automatically evaluates all transcripts of previous course work taken by transfer students to determine UAA course equivalents; on occasion, potentially applicable course work is accepted as elective credit rather than as being comparable to a specific UAA course. When this occurs, the student may need to formally petition the application of the course to meet a specific UAA requirement.

The student initiates academic petitions with the assistance of the Coordinator of Student Affairs and/or the faculty advisor. Generally the basis for approving petitions is that it is 1) comparable to the specific UAA equivalent and 2) student performance in the course has been at the level of C or higher (or Pass). For this reason a copy of the Catalog course description must accompany all petitions; in some instances, it may be necessary to attach a copy of the course syllabus to the petition. Students may obtain a copy of the catalog course description by using the college catalog microfiche files located in the UAA Library; the Reference Librarian can provide assistance in locating those files. It may be necessary to contact the college that offered the course to obtain catalog course descriptions of older courses; syllabi must generally be obtained directly from the college or school that offered the course unless the student has retained the syllabus s/he used when enrolled in the course.

The student's faculty advisor must sign completed petitions. In some instances, the petition may be forwarded for review and recommendation by the UAA department in which the UAA equivalent course is normally offered, after which it is reviewed by the relevant program Curriculum Committee. Final approval of academic petitions rests with the Director of the School of Nursing or designee, who forwards all such petitions to the Registrar's Office, which communicates decisions to the student.

Students who have completed a baccalaureate degree in another field are exempt from meeting the General Education Requirements specified in the University Catalog. However, those students must complete all specified requirements for the program. For all undergraduate nursing students, this includes Anatomy and Physiology I and II, Microbiology, Life Span Development, and Nutrition.

POLICY REGARDING ACCEPTABLE COURSES TO MEET REQUIREMENT FOR A LIFE SPAN DEVELOPMENT COURSE

Acceptable courses to satisfy the Life Span Development requirement within the UAA Nursing Programs are those that cover the entire life span. Courses that include consideration of only one age group (e.g., child development, adolescent development, or aging) are not acceptable. However, a student who has completed several age specific development courses that have, together, covered the entire life span, may petition to have the UAA requirement waived using the combination of development courses as justification. Petitions for such waiver must be accompanied by Catalog course descriptions of all courses being used to satisfy the UAA requirements and are processed as described above; waiver will not be granted unless there is evidence that all phases of the human lifespan have been covered. Credit may also be acquired by successfully completing the DANTES test Lifespan Development Psychology (SF490) which is available upon request from the UAA Advising and Testing Center (786-4500). There is a charge for this exam.

ACADEMIC POLICIES APPLICABLE TO STUDENTS ENROLLED IN THE AAS NURSING PROGRAM

AAS PROGRESSION AND RETENTION POLICIES

In order to progress within the AAS Program in Nursing, students must earn a satisfactory grade in all nursing courses; a satisfactory grade is either a C or a Pass, depending on the grading system being used in the particular course. Students who are unable to earn a satisfactory grade in a required nursing course are required to repeat that course before progressing to the next required course in the sequence; specific information regarding such situations is included in the section entitled "Withdrawal & Re-enrollment".

The clinical nursing major consists of four semesters of course work. Students must complete the four clinical semester sequence of study within eight sequential semesters; thus, a student who enrolls in NURS 120 in fall 2011 must complete all nursing requirements and graduate no later than May 2015.

Clinical nursing students enrolled in a course must always be concurrently enrolled in all courses with the common number; for example, a student enrolled in NURS 120 Nursing Fundamentals must also be enrolled in NURS 120L Nursing Fundamentals Laboratory. There are other courses which require concurrent enrollment when not already completed (see AAS Plan of Study).

Courses in which concurrent enrollment is **always** required include the following:

NURS 120 and NURS 120L	Nursing Fundamentals and Nursing Fundamentals Laboratory
NURS 125 and NURS 125L	Adult Nursing I and Adult Nursing I Laboratory
NURS 220 and NURS 220L	Perinatal Nursing and Perinatal Nursing Laboratory
NURS 222 and NURS 222L	Pediatric Nursing and Pediatric Nursing Laboratory
NURS 225 and NURS 225L	Adult Nursing II and Adult Nursing II Laboratory
NURS 250 and NURS 250L	Psychiatric Nursing and Psychiatric Nursing Laboratory

In addition, students must successfully complete all specified pre-requisites for each required nursing course before enrolling in subsequent nursing courses. Thus, students must complete NURS 180 Basic Nursing Pharmacology before enrolling in NURS 220 Perinatal Nursing and must complete NURS 221 Advanced Parenteral Therapy before enrolling in NURS 225. Specific non-nursing prerequisites for nursing courses completed after admission to the clinical nursing major include the following:

ENGL 111, BIOL 111, & PSY 150	prior to enrollment in NURS 125/L & NURS 180
BIOL 112 & BIOL 240	prior to enrollment in NURS 220/L, NURS 222/L and NURS 221
DN 203 & ENGL 211 or 212 or 213 and a Social Science Elective	prior to enrollment in NURS 225/L, NURS 250/L & NURS 255

In addition to the required nursing courses, students must successfully complete a number of non-nursing courses either prior to or during enrollment in the nursing courses; these courses are referred to as co-requisite courses. Students must have a C or higher in the co-requisite courses to progress in the nursing course sequence.

Students must maintain an overall UAA cumulative grade point average (GPA) of 2.0 or higher to remain enrolled in the AAS Nursing Program; student's whose cumulative GPA drops below 2.0 will be required to raise their GPA by repeating courses before enrolling in subsequent clinical courses. (see policy on Academic Probation)

AAS GRADING POLICY

Theory Courses: Performance in theory courses is graded using an A-F grading scale; a satisfactory grade in a theory course is a grade of C or higher. Since the ability to test successfully is crucial to becoming a Registered Nurse, students in the AAS Nursing program need to obtain a weighted **Exam** average of 75% in order to pass nursing courses. Other course assignments will be computed into a grade only after the student obtains a 75% weighted average on all the exams within any given AAS course. A grade of C or higher is assigned when the student achieves an overall course average of 75% or higher. In addition, to achieving an average grade of 75% or higher, the student must also achieve a grade of PASS in the clinical course with the same course number (e.g., NURS 120 and NURS 120L). A student who does not earn a clinical course grade of PASS will be assigned a grade of F in the theory course regardless of the average achieved in assignments included in the theory course.

Clinical/Laboratory Courses: Performance in clinical/laboratory courses is graded as Pass/No Pass. A grade of PASS is assigned when the student successfully achieves all clinical course objectives; in addition, a grade of PASS in a clinical course requires that the student also achieve a grade of C or higher in the associated theory course. A student who earns a grade of PASS in clinical and a theory course average of less than 75% in the associated course will receive a grade of NO PASS in the clinical course. Thus, students must earn a grade of PASS in the clinical course and a grade of C or higher in the associated theory course in order to progress to the next course in the clinical sequence.

AAS Nursing Program Grading Scale	A = 93 – 100%	D = 66 – 74.9%
	B = 84 – 92.9%	F = 65.9% or below
	C = 75 – 83.9%	

AAS WITHDRAWAL AND RE-ENROLLMENT POLICY

Students who anticipate a need to withdraw from any required nursing or co-requisite course or from the nursing program are strongly advised to consult with their AAS nursing faculty advisor and the Program Chair prior to making a final decision. This is critical if the student anticipates re-enrollment in the program at a future date. The advisor will assist the student to review possible alternatives to withdrawal and will work with the student to minimize potential negative consequences. Under no circumstances should a student simply exit the program without completing required paperwork and *submitting a plan for returning*. Should a student fail to complete withdrawal procedures, this will result in the student receiving grades of F in all course work - and would have a negative impact on their overall cumulative GPA.

Students who wish to withdraw from the AAS Program in Nursing are required to *submit a letter* to the Program Chair stating the reasons for the withdrawal (in general terms). Students who desire to re-enroll in the Program for any semester after the first one, will need to submit a written *request for re-enrollment* for the specific course(s), as well as stating the desired semester and location for reenrollment. This request should be submitted to the AAS nursing program administrative assistant. The *re-enrollment request* form must be filled out prior to the time a student desires any reenrollment in nursing courses, except for NURS 120. (Note: NURS 120/L admission is only by ranking, regardless of previous enrollment). Possible reenrollment will only be determined if there is space available in the desired courses at the desired location. Go to SECTION XII (P. 81) for Re-Enrollment Form.

A student who did not pass or withdrew from the first semester clinical nursing course, NURS 120/L Nursing Fundamentals, and wants to re-enter the AAS, Nursing program must request, in writing to the AAS Admission/Progression Committee, to have their file ranked in the next selection process. Students who are unsuccessful twice in any clinical nursing course will not be allowed to re-enroll for a third time and will be dismissed from the program (see policy on Dismissal from the Nursing Program). If a student in this situation feels there are unusual circumstances the student may petition the AAS Admission Committee for a waiver of this policy. The eight sequential semester policy will remain in effect.

Conditions for re-enrollment will be determined on an individual basis by the AAS Admission/Progression Committee and *is not* solely contingent on a space available basis. The AAS Admission/Progression Committee will review relevant information, including past performance in required courses and statements by the student and the faculty who have interacted with the student in previous coursework. Student and faculty input will be obtained utilizing the *request of reenrollment* form. Students seeking reenrollment will be required to have met all special conditions as stated on the *reenrollment request* form and on a reenrollment follow-up letter sent to each applicant. The *reenrollment request* form along with any reenrollment criteria are designed to facilitate/promote student success in the AAS Program. Any special conditions for reenrollment will be based on the specific learning needs of

the individual student and may include, but are not limited to: requirements for successful completion of additional course work, gaining experience in the health care field, and/or evaluation and determination of learning style, and depending on the outcome of the evaluation any further completion of prescribed follow-up activities. The Admission/Progression committee will have direct input and provide direction regarding reenrollment of students.

Drop or Withdraw from Co-requisite Courses

The student who plans to drop or withdraw from a required co-requisite (non-nursing) course must confer with their AAS Nursing faculty academic advisor to determine the potential impact of the withdrawal on their ability to progress into subsequent nursing courses. *Because many of the non-nursing co-requisite courses are specified as pre-requisites for nursing courses, withdrawal from those co-requisite courses may impede the students ability to progress into subsequent nursing courses;* hence consultation with assigned academic advisor is critical.

AAS ATTENDANCE POLICY

Attendance is required at all classes, video conferences, clinical and laboratory experiences. We realize there may be times when the student must be absent for legitimate reasons. However, being absent jeopardizes the student's ultimate goal of being a safe practitioner.

Attendance for the clinical and laboratory experience is mandatory. Students will be required to make up any missed time. Tardiness and leaving before the end of the day will be considered missed time. Missed time will be made up through either additional clinical days or through written assignments at the instructor's discretion. Students should be aware that excessive absence from clinical may make it impossible to meet course objectives leading to failure in the course.

AAS POLICY ON TESTING

Students must take exams at the scheduled times unless special arrangements have been made prior to the exam with the involved faculty person for extenuating circumstances. Tests, including the Final Exam, **cannot** be taken earlier than the scheduled date. Ten points per day, beginning with the test date, will be subtracted for every day the student is late taking a test without prior arrangement due to extenuating problems. Failure to take an exam without notifying faculty may result in a score of "0" for that exam.

AAS POLICY ON COURSE ASSIGNMENTS

Students are required to complete all assignments in each AAS nursing course. Failure to do so will result in an unsatisfactory grade for the course regardless of the average achieved on other assignments. This policy includes assignments for all AAS nursing courses including clinical laboratory courses.

AAS NURSING PROGRAM GUIDELINES FOR APA FORMAT FOR PAPERS

The AAS Nursing Program at UAA uses the *Publication Manual of the American Psychological Association*, 5th edition, as the primary guideline for formatting student papers. This style manual is also referred to as "APA format" or "APA style."

Instructors may specify additional or alternative formatting requirements for specific projects as needed to achieve course objectives. The APA style guide may be consulted for details on items not covered here.

Paper 5.01

8½ x 11, standard weight, white, single-sided printing

Margins 5.04

left margin, pages unbound	1 inch	
left margin, pages bound	1.5 inches	(e.g., for 3-hole punched, stapled, etc.)
right margin	1 inch	
top margin	1 inch	
bottom margin	1 inch	

Type Style or Font (used for most text, but figures can have Arial or other fonts) 5.02

Typeface: Times Roman or Times New Roman

Size: 12 points

Leading: (usually automatic—basic point size plus 2 points is typical)

Line spacing: double space

Paragraph Indent (for normal text paragraphs) 5.08

First Line: 0.5 inches (may use tab key or a defined paragraph indent)

Page Numbers 5.06

All pages of the paper are to include a page number at the top right area of each page, about 1/2 inch down from the top of the paper. The title page is page 1. Most word processing programs set up an additional area above the top margin for this purpose.

Manuscript Pages

5.05

Most papers submitted in the AAS program should include the following main components:

Title Page

Text Pages (the body of the paper)

References Page

In the AAS program, figures and tables will be included in the body of the paper. (Note: this is a deviation from strict APA format, which separates figures and tables, placing them at the end of the submittal.) If an abstract is required, it will be page 2.

Title Page

5.15

In addition to the page header defined above, the title page consists of the following main components:

Title of the Paper

Location on page: positioned generally centered in the upper half of the page

Spacing: double-spaced if the title takes more than one line

Alignment: centered

Capitalization: mix of upper and lower case (normal capitalization for titles)

Byline

Location: immediately below the title (normal double spacing)

Alignment: centered

Capitalization: upper and lower case (normal capitalization for proper names)

Contents: author's full name

Institutional Affiliation

Location: immediately below the author's name (normal double spacing)

Alignment: centered

Capitalization: upper and lower case (normal for proper names)

Content: University of Alaska School of Nursing

The above is in accordance with APA style. In addition, instructors can request additional information to appear in the lower area of the page, such as course name, instructor name, and date submitted.

First Page of Text Pages

5.15

The very top of the page will show the page number, as described above.

The title of the paper will be centered at the top of the page, double-spaced if necessary (same format and appearance as on the title page).

Immediately following the title (one double-spaced line) is the beginning of the body of the paper. Section 3.30 of the APA style guide states the following:

The introduction to a manuscript does not carry a heading labeling it the introduction (the first part of a manuscript is assumed to be the introduction). Therefore, if the introduction contains headings, the first heading and later equivalent headings within the section are assigned the highest level of heading (Level 1 for all but five-level papers). (p. 113)

This means that a normal, indented paragraph usually begins two lines (one double-spaced line) below the title. This paragraph is assumed to be the introduction. An introduction may consist of more than one paragraph. It is possible to have sections within an introduction, but this is not recommended in student papers.

After the introduction, the paper can be divided into sections and subsections by means of headings. Headings are defined below. Double spacing is maintained throughout (in other words, there is no additional spacing above or below headings).

References Page and In-Text Citations

5.18, 4.07–4.16

Information that has been drawn from other sources must be properly credited to that source. This is done by means of in-text citations and a list of the references cited.

The APA style guide covers a great many possibilities with regard to citations and references. A few of the more common forms are included here.

The in-text citations are in an author-date format. The following are examples of paraphrased material from the APA style guide:

One Author:	In a recent study of reaction times (Walker, 2000)
Two Authors:	In a recent study of reaction times (Walker & Smith, 2001)
Multiple Authors, first mention:	In a recent study of reaction times (Walker, Smith, Millburn, & Jacobs, 2005)
Multiple Authors, subsequent mention:	In a recent study of reaction times (Walker et al., 2005)
Organization as author, first mention:	Other subjects in the experiment had the same difficulty (National Institute of Mental Health [NIMH], 1999).

Material from other sources can also be quoted verbatim. Short quotations are enclosed in double quotation marks. Long quotations are in blocks of text 1/2 inch in from the left and right margins. If a long quotation consists of more than one paragraph, the second and all subsequent paragraphs in the quote have their first lines indented an additional 1/2 inch. Double spacing is maintained throughout. When material is quoted verbatim, the citation is included after the quotation mark and before the period. The example below is from the APA style guide, page 118.

Block Quotation (with embedded quotation)

Below is a description of the placebo effect, which influenced a number of authors:

The "placebo effect," which had been verified in previous studies, disappeared when behaviors were studied in this manner. Furthermore, the behaviors were never exhibited, even when reel [sic] drugs were administered. Earlier studies were clearly premature in attributing the results to a placebo effect (Miele, 1993, p. 276).

The references section begins on a new page. The word "References" is centered at the top of the page.

The first reference begins one double-spaced line below. Reference entries are double-spaced, but the paragraph format is changed to a hanging intent format. This means the first line of the reference is tight against the left margin, and subsequent lines of the reference are all indented 1/2 inch. However, the APA style guide states:

If a hanging indent is difficult to accomplish with your word-processing program, it is permissible to indent your references with paragraph indents. The chosen format should be consistent throughout the references. (p. 299)

In general, a reference is designed so other researchers can obtain and review the same materials used in the paper. The general form includes the following, when applicable:

- the author or originator [including organizations as originators; for edited compilations, editors are identified as (Ed.) following the name]
- date of publication [minimum necessary to make clear the date: a daily newspaper would be in the form of year, month day]
- title and subtitle of the item [separated by colon, with first word of subtitle capitalized]
- edition number, if applicable
- title of the publication in which the item appeared [with volume number and pages]
- the principle location where the item was published [applies to books more than periodicals]
- the publisher [applies to books more than periodicals]
- additional retrieval information [primarily for electronic sources]

The following are some typical reference formats and examples (from the APA style guide).

Periodicals ("xx" = volume number in italics, and "xxx-xxx" indicates the page numbers where the item appears):

Author, A. A., Author, B. B., & Author, C. C. (1994). Title of article. *Title of Periodical*, xx, xxx-xxx.

Mellers, B. A. (2000). Choice and the relative pleasure of consequences. *Psychological Bulletin*, 126, 910–924.

If there is a subtitle, it is separated from the title with a colon, and the first letter of the subtitle is capitalized.

Kandel, E. R., & Squire, L. R. (2000, November 10). Neuroscience: Breaking down scientific barriers to the study of brain and mind. *Science*, 290, 1113–1120.

Books

Author, A. A. (1994). *Title of work*. Location: Publisher.

Saxe, G. B. (1991). *Cultural and cognitive development: Studies in mathematical understanding*. Hillsdale, NJ: Erlbaum.

Ignatavicius, D. D., & Workman, M. L. (2006). *Medical-surgical nursing: Critical thinking for collaborative care* (5th ed.). Cleveland: Elsevier.

Web-based sources

The form of the reference depends on what information is available in the web-based source. In general, use the same elements that would be used for conventional publications whenever possible. Since web content is subject to frequent change, indicate when the information was gathered, and the exact web address used.

Author, A. A., Author, B. B., & Author, C. C. (2000). Title of work. Retrieved month day, year, from source.

Fredrickson, B. L. (2000, March 7). Cultivating positive emotions to optimize health and well-being. *Prevention & Treatment*, 3, Article 0001a. Retrieved November 20, 2000, from <http://journals.apa.org/prevention/volume3/pre0030001a.html>

More about reference online information:

Online information may be available in different formats. These include:

PDF

HTML

Regular web page or web site

If you have the choice, choose "PDF". An article that is in PDF format is in the same format as it appears in the journal it was taken from and you may reference it like a regular journal without including anything about the website.

An article that is in HTML format is more difficult to reference. You must include the data base (such as "Ovid", "CINAHL", "EbscoHost", etc.), not the URL address in the reference. There will be no page numbers; Therefore if you quote, you must identify sections and paragraphs.

Information you obtain from a regular website or webpage will require the URL address. When writing a URL address, do not put a period at the end.

Examples:

1. This is a reference for a pdf document/article within a website:

U.S. Census Bureau. (2003). *Disability Status: 2000: Census 2000 Brief*. Retrieved April 10, 2007 from <http://www.census.gov/prod/2003pubs/c2kbr-17.pdf>

2. This is a reference for a document that only exists in electronic form (HTML):

The Health Benefits of Pets. (1987). NIH Technology Assessment Statement Online, September 10-11. Retrieved May 1, 2007, from <http://consensus.nih.gov/1987/1987HealthBenefitsPetsta003html.htm>

3. This would be a typical web site reference:

Individuals with Disabilities Education Improvement Act of 2004. Public Law 108-446. Retrieved March 15, 2007, from <http://idea.ed.gov/>

General Information Regarding AAS Papers

- A. Nursing Care Plan introductions must follow all the above requirements. The main body of the care plan must be written utilizing the format that has been adopted by the program and which will be given to you at the beginning of the program. Although it is preferred that this portion also be typed, it is acceptable to submit this portion written in pencil. All other AAS Nursing course papers must follow APA format as outlined in the previous sections.
 - B. Papers are required to demonstrate proper grammar, correct spelling and to be neat and legible. If these requirements are not met, a minimum of five (5) points will be subtracted from the paper grade.
 - C. Submit all written assignments on or before the assigned due date. Late papers will automatically have five (5) points deducted for every day they are late, beginning with due date, unless permission is granted by the instructor prior to the due date.
-

SECTION V - FINANCIAL AID

GENERAL INFORMATION

Financial assistance is available through the UAA Office of Financial Aid in the form of federal and state loans and grants (Alaska and Stafford Student Loans, Pell Grant, etc.), as well as through private organizations. In addition there are a number of nursing-specific scholarships available to UAA nursing students. Information about nursing-specific scholarships is available on the UAA Student Financial Aid webpage, <http://www.uaa.alaska.edu/finaid/>. Information regarding statewide nursing-specific scholarships administered directly by the University of Alaska Foundation is available on the Foundation webpage, <http://www.alaska.edu/uafound/>. Information about some of the nursing-specific scholarships is posted on the Nursing Scholarship page on the SON Website or from the School of Nursing Receptionist.

NURSING SPECIFIC SCHOLARSHIPS

Nursing Scholarships Administered Through University Of Alaska Foundation

Two nursing specific scholarships are directly administered by the University of Alaska. They include the Joan C. Yoder Memorial Nursing Scholarship and the Pat and Cliff Rogers Nursing Scholarship.

Joan C. Yoder Memorial Nursing Scholarship

Background:	The Joan C. Yoder Scholarship was established in memory of Joan C. Yoder, an LPN who resided for many years in Fairbanks.
Eligibility Criteria:	Open to students enrolled in any nursing program; Must be a clinical nursing major; completion of one clinical nursing course; cumulative GPA of 2.5 and nursing GPA of 2.0 for undergraduate students; cumulative GPA of 3.0 and admission to a graduate specialty track for graduate students; enrollment in six or more credits during the semester in which the award is to be in effect.
Preferences:	Selection preference will be given to full-time students.
Application:	The UA Foundation Scholarship Application is used to apply for this scholarship. A complete application includes a personal essay and the submission of two letters of reference. Application can be downloaded from www.alaska.edu/uafound/ .
Application Deadline:	February 15
Minimum Award:	\$500

Clifford and Patricia Rogers Nursing Scholarship

Eligibility Criteria:	Full time student; junior or senior enrolled in a nursing program on any UA campus; good academic standing; demonstrated academic and leadership potential.
Preferences:	None specified.
Application:	The standard UA Foundation Scholarship Application is used to apply for this scholarship. A complete application includes a personal essay and the submission of two letters of reference. Application can be downloaded from www.alaska.edu/uafound/ .
Application Deadline:	February 15
Minimum Award:	\$500

David and Mary Carlson Memorial Nursing Scholarship

- Background:** David and Mary Carlson were long term residents of Dillingham Alaska. Mary was a Registered Nurse who worked at the local hospital in the community. Her husband was a successful businessman in Dillingham. They were concerned about the difficulty in attracting qualified nursing personnel to work in Bristol Bay communities and created an endowment to fund this scholarship.
- Eligibility Criteria:** Demonstrated motivation and academic and leadership potential; in good academic standing; nursing major at UAA (or pre-nursing major at UAA or pre-major at Bristol Bay campus who has received academic advising from UAA School of Nursing).
- Preferences:** First preference is to residents of the Bristol Bay Region; second preference is to students from rural Alaska communities of less than 7500; third preference is to the student who can plan a career in rural Alaska; fourth preference is other qualified nursing students.
- Application:** The standard UA Scholarship Application is used to apply for this scholarship. A complete application includes a personal essay and the submission of two letters of reference.
- Application Deadline:** February 15
- Minimum Award:** \$1,000

Bonnie Martin McGee Memorial Nursing Scholarship

- Background:** Bonnie Martin McGee was a pioneer nurse in Anchorage; she was one of the first Registered Nurse Anesthetists in the State and provided anesthesia services at clinics in both Anchorage and rural Alaska. She was also a nurse activist, serving as a member of the Municipal Health Planning Commission and as a President of the Alaska Nurses Association. Once retired from active employment, she provided home care nursing services to friends as a volunteer. This scholarship was established in her memory by grateful friends to memorialize her many contributions to health care in the State of Alaska.
- Eligibility Criteria:** Alaska resident for three years prior to receipt of award; minimum GPA of 2.0; nursing GPA of 2.5; financial need (primary criterion); full time student; demonstrated motivation, and academic and leadership potential; prior completion of a clinical nursing course; full time student.
- Preferences:** Financial need is primary selection criterion; preference is given to student enrolled in the baccalaureate nursing program; award is also open to AAS students who demonstrate severe financial need.
- Application:** The standard UA Scholarship Application is used to apply for this scholarship. A complete application includes a personal essay and the submission of two letters of reference.
- Application Deadline:** February 15
- Minimum Award:** \$1,000 (\$500 per semester)

Sylvia Berg Drowley Nursing Scholarship

Background:	The Sylvia Berg Drowley Scholarship was established by Grace Berg Schaible in honor of her sister Sylvia, a registered nurse currently residing in San Francisco, who was dismayed to see two of her own Nursing School classmates have to leave school due to the lack of sufficient funds.
Eligibility Criteria:	Full time student enrolled in the baccalaureate program; demonstrated financial need (the primary selection criterion); may be a new or continuing student.
Preferences:	None specified
Application:	The standard UA Scholarship Application is used to apply for this scholarship. A complete application includes a personal essay and the submission of two letters of reference.
Application Deadline:	February 15
Minimum Award:	\$500

TUITION WAIVERS

The School of Nursing receives a small number of credits of tuition waivers (approximately 30 credits) to award each Fall and Spring term. Due to the trimester schedule, the awards are usually given in the Spring (AAS students) and the Summer (BS students), rather than Fall and Spring. Because there are usually more applications for tuition waivers than there are credits to award, partial waivers for from 1-12 credits are common.

When tuition waivers become available at the beginning of the semester, signs announcing their availability are posted prominently in the School of Nursing reception area and on the Associate program Blackboard site. At that time, tuition waiver application forms can be obtained from the Associate program secretary in the Professional Studies Building, Room -103 or the Blackboard site..

Tuition waivers are submitted to the Director of the School of Nursing. The decision regarding recipients of tuition waivers is made by a committee composed of the School of Nursing Director, the Chair of the AAS Nursing Program, the Chair of the Baccalaureate Nursing Program, and the Chair of the Graduate Nursing Program. Eligibility criteria and the application process are described below.

Eligibility Criteria: You may be eligible to be awarded a tuition waiver if you:

1. Have already earned a passing grade in a nursing course (NURS 120 or higher level);
2. Completed or are currently earning passing grades in six or more UAA credits in the most recent term (i.e., term immediately prior to term in which waiver will be used);
3. Are currently registered for or have plan of study that includes six or more credits that will contribute to completion of your nursing degree in the term for which the waiver will be used;
4. Have a cumulative grade point average (GPA) of 2.8 or higher;
5. Have a nursing GPA of 2.0 or higher;
6. Demonstrate financial need;
7. Demonstrate community and/or university service.

Application Process:

1. Complete the application cover page;
2. Complete the following sections of the “official” tuition application form: Name, SID, home and work telephone numbers, current address & zip code, and degree (AAS or BS). Sign and date the application (Student Signature at the bottom). Do not fill-in any other information on the form.
3. Attach a letter that describes your financial need for the tuition waiver, your community and/or university service, and how receiving the waiver will facilitate your success in your nursing studies.
 - a. Letters are limited to two single-spaced typewritten pages and should be addressed to Dr. Jackie Pflaum, Associate Director of the School of Nursing.
 - b. Section on financial need should include a description of expenses during the school year as well as all sources of financial support (family/spouse assistance, work, grants, loans, scholarships, etc.). Special issues that relate to financial need or unusual anticipated expenses should be included in this section.
 - c. Section on community and university service can include any volunteer involvement in community or university organizations, including Student Nurses Association, as well as informal service to others; include leadership (e.g., offices held) in your description of service involvement.
 - d. Letter should end with a brief statement of how the tuition waiver will benefit you and enhance your success in your nursing studies.
4. **Do not** enclose your application in any type of folder and do not include any additional information. Application packets that exceed a total of four pages (cover page, the “official” application form, and a two page letter regarding need and service) will not be considered.

SECTION VI – STUDENT INFORMATION

PARTICIPATION ON COMMITTEES

Students are the reason the School exists. Every effort is made to encourage and facilitate student participation and input into all phases of the educational process. Students are included in the membership of the University of Alaska Board of Regents as well as on a variety of UAA committees. The School of Nursing encourages student participation in all aspects of campus life, in the Student Nurses’ Association (SNA) (of which all pre-major and clinical nursing students are a member), the National Student Nurses’ Association (NSNA), in formal and informal contacts with the Director of the School of Nursing and faculty, and in the committee work of the School.

Committees function to facilitate, coordinate, and develop the purposes of the School in an orderly fashion. Each faculty member serves on at least one standing committee. Broad student representation on selected standing committees is solicited each year by faculty. A School goal is to include at least one student representing each curriculum level on each of the following committees:

Student Affairs Committee (combined committee of AAS and BS programs)
 AAS Curriculum Committee
 BS/MS Nursing Science - Admissions Committee
 BS/MS Nursing Science - Curriculum Committee

Participation on these committees is an avenue by which students can provide input to the faculty, about curriculum and student concerns. Any student interested in serving on one of these committees may submit their name to a faculty member, Department Chair, or to Student Nurses’ Association officers. Initial solicitation for members on School of Nursing Committees is to the Student Nurses Association.

FACILITIES

Nursing Resource Center

The Nursing Resource Center (NRC) is divided into three areas. The Media Reference Lab and the Computer Lab areas are located in Professional Studies Building, Room 136, and the Nursing Skills and Simulation Labs in the Health Sciences Building.

The Media Lab houses over one thousand videotapes and DVD's on nursing subjects, and a limited library of nursing texts and reference books. Large screen TV monitors with connections for multiple earphones are provided so that up to six students may view a video at one time. Books and videotapes must be used in the Media Lab; they may not be checked out for personal use. Requests to use media in class, in a different area, or for other purposes should be directed to the Coordinator, Nursing Resource Center. Students should be aware that textbooks available in the library section do not include copies of all currently assigned texts for nursing courses.

The Computer Lab has individual workstations, all with Internet access and connection to a network printer. The computers will have Microsoft Windows XP operating system installed, with Microsoft Office XP programs. Office XP allows documents to be saved in a wide variety of older versions of Microsoft Office, so that students may continue to use older operating systems on their home computers.

The Basic Nursing Skills Lab is set up to function both as a classroom and as a mock hospital setting. Sophisticated manikins are used to simulate patients and can be used to practice a variety of nursing skills. Equipment and supplies are kept here for use by all three programs offered by the School of Nursing. The Basic Skills Lab is open during class time. Each semester 'open lab' times are set aside for student practice with faculty supervision. These times vary and are determined according to faculty and room availability at the beginning of each semester.

UAA Library Reference Service

The Health Sciences Information Service (HSIS) (formerly Alaska Health Sciences Library) is located on the second floor in the southeast corner of the Consortium Library. Specialized medical reference service is available from 8:00 AM to 5:00 PM, Monday through Friday (786-1870).

There is a charge for reference service for specific searches, but no charge to help students use computers to conduct their own searches. Students may use a computer work-station located outside the offices. The computer gives access to MEDLINE (Index Medicus Online) for journal publications back to 1966 and CINAHL (Cumulated Index to Nursing and Allied Health Literature) for publications from 1982 to present. Clinical medicine and nursing journal titles as well as health reference materials and indexes may also be found just outside the HSIS offices. The collection and work-station are available whenever the UAA/APU Consortium Library is open.

The UAA/APU Consortium Library has greatly expanded its electronic capabilities. New updated Web pages for indexes, databases, full text, and archives can be accessed at [.http://consortiumlibrary.org/](http://consortiumlibrary.org/)

UAA Reading-Writing Center (RWC)

The **UAA RWC** (SMH-118) provides reading - writing assistance to UAA students at all levels of writing. It is staffed by formally trained undergraduate and graduate students, as well as faculty. The Reading-Writing Center is open every day of the week and students may stop by any time the center is open for first come first serve walk-in sessions. There is no fee for UAA students to use the RWC. The following are ways the tutors can help you:

- Help writing/proofing your paper:
 - Bring the latest draft of the paper you want to discuss. Bring earlier drafts if you have any and if you'd like to us to look at the changes you've made.
 - Bring the assignment handout from your instructor to help us better understand the requirements of your assignment.
 - Bring questions you have for us, or be ready to let us know what kind of feedback you are requesting.
- Help with formatting your paper such as title page, margins, font, spacing, spell and grammar check, etc. They can also help with commonly used software.
- For more information, please contact Jonell Saucedo, LRC Director, at (907) 786-6829 or anjfs@uaa.alaska.edu.
- For distance students, contact the person above about how they can help you.

You can also hire a private tutor for a \$20-\$25/hour charge.

Website - <http://www.uaa.alaska.edu/ctc/programs/lrc/student-services.cfm>

Recruitment and Retention of Alaska Natives into Nursing (RRANN)

Located within the School of Nursing at the University of Alaska Anchorage, RRANN's purpose is to increase the number of Alaska Natives and American Indians graduating with an Associate of Applied Science or Baccalaureate of Science Degree from UAA. In 1996, Alaska Native/American Indians made up only 1.5% of the nursing workforce in Alaska, contrast to their being 16% of the population - confirming the fact that Alaska Native/American Indians are substantially unrepresented in Alaska's workforce. Although there is still a nation-wide shortage of nurses working in hospitals and clinics, the shortage is near crisis in Alaska and especially in the rural and more remote communities.

RRANN is dedicated to encouraging personal growth within an academic setting that recognizes individual strengths and cultural diversity. Alaska Native and American Indians interested in enrolling at UAA and seeking a degree in nursing are eligible to receive college preparation counseling from the RRANN program. For more information, go to <http://nursing.uaa.alaska.edu/RRANN/>

SECTION VII – GRADUATION INFORMATION

APPLICATION FOR GRADUATION/NCLEX-RN

Students are encouraged to make an appointment to meet with their faculty advisor and the Coordinator of Student Affairs one or two semesters prior to applying for graduation. This process is used to ensure that all program requirements are completed in a timely manner and to avoid delays in graduation.

If a student misses the UAA deadline for application for graduation, the student will need to submit a late application and pay a late fee of \$25. To view the schedule for late applications, go to:

http://www.uaa.alaska.edu/records/degree_Services/applications2.cfm.

In the end of final semester, NURS 225/250/255, the student should have completed all of the degree requirements for sitting for the NCLEX-RN and will be able to proceed with the NCLEX-RN application process. One of the requirements is to request an official transcript with the degree posted. The student can order an official transcript from the UAA Records Office to be submitted to Alaska State Board of Nursing. The student should submit the verification form from the RN application to the School of Nursing for completion. The student will also need to meet any other deadlines and submit all other requirements and fees that the RN-NCLEX application requires (see Section Ten - Licensure).

UAA COMMENCEMENT CEREMONIES

UAA Commencement ceremonies are held in May at the end of the Spring semester. All students are encouraged to participate in the Spring graduation ceremonies, regardless of when they actually complete their degree.

Students who will be graduating with honors will need to contact Enrollment Services to find out procedures for picking up honor cords the day of the commencement. Commencement is usually held on the first Sunday in May at the George Sullivan Sports Arena; students who officially graduate in Summer or Fall terms are encouraged to return to campus to participate in commencement festivities.

GRADUATION RECEPTION

The recognition ceremony for nursing graduates is a function separate from the formal University graduation (commencement ceremonies). It is held in December for associate, baccalaureate and graduate students completing their program at the end of fall semester, in April for the associate degree, baccalaureate, and graduate students completing their program at the end of spring semester, and in August for baccalaureate and graduate students completing their program in August. Graduates of all nursing programs are honored at these ceremonies.

The recognition ceremony provides graduates with an opportunity to celebrate their achievements with friends and family in a personal way. Participation in the graduation reception is optional. Planning the ceremony is the responsibility of the SON Student Affairs Committee, which is composed of faculty and student representatives. Graduating students fund costs associated with the recognition ceremony, generally by soliciting donations and by selling tickets to friend and family members.

At the graduation reception school pins and special awards are presented to graduating students. Student input is vigorously sought in the planning of the ceremony so that the event is a personally meaningful celebration. The Student Affairs Committee coordinates the ordering of pins for the baccalaureate degree. The Chair of the AAS, Nursing Program coordinates with AAS, Nursing class representatives in the ordering of pins for associate degree nursing students. Students must be eligible for graduation, having completed all required courses, before they may receive the nursing pin.

LETTERS OF RECOMMENDATION

quest, a letter of recommendation will be written for each graduating student by his or her respective faculty advisor. A copy of the letter will be placed in the student's file.

SECTION VIII – LICENSURE

Students enrolled in the LPN Option of the Associate nursing program must provide documentation of current and continuous licensure to practice as a Licensed Practical Nurse in the State of Alaska.

GRADUATING STUDENTS

A representative of the Alaska Board of Nursing will orient students graduating from their respective nursing program, in the semester they graduate, concerning application for licensure. There will be several fees involved: application fee, license fee, passport photo, transcript fee, fingerprint processing fee, and perhaps a notary fee. There is also a fee for an optional temporary license.

For advance or additional information you may contact the State of Alaska Board of Nursing Anchorage office located at 550 W. 7th Ave, #1500, Anchorage, Alaska 99501. Their telephone number is 1-907-269-8160. Website is <http://www.dced.state.ak.us/occ/pnur.htm>.

SECTION IX – STUDENT ORGANIZATIONS

UAA STUDENT GOVERNMENT ASSOCIATION (USUAA)

Students have the opportunity to be involved in the Union of Students at UAA (USUAA), the student governance organization on campus. The purposes of USUAA are to 1) broaden the educational perspective of students by instituting a structure of self-governance; 2) promote the educational needs, general welfare, and right of students; 3) serve as a forum for students to express their ideas for enhancing the quality of their educational experience through expanded and improved communications among students, faculty, and administration and beyond; 4) formulate policy and procedures concerning student life; and 5) serve all students equally, regardless of race, color, religion, national origin, sex, sexual orientation, Vietnam era or disabled veteran status, physical or mental disability, change in marital status, pregnancy, or parenthood.

All full and part-time students at UAA who pay the Student Government fee are automatically members of USUAA. Membership provides students with opportunities for involvement and leadership in a diverse array of campus activities.

Additional information about USUAA can be accessed on the Web at www.uaa.alaska.edu/unionofstudents/.

STUDENT NURSES ASSOCIATION (SNA)

The Student Nurses' Associate (SNA) is an organization whose membership is open to all student nurses registered at the University of Alaska. SNA is run entirely by students for the benefit of students. The general objective of SNA includes the following:

- To provide opportunities for student nurses to exercise their leadership and group communication skills through regular meetings and special events.
- To act as a liaison between students and to facilitate communication between various class levels.
- To plan and organize social events which are open to nursing students and the general community.
- To provide enriching extra-curricular educational programs in health-care-related areas.
- To serve as a model for professional organizations in which the student may participate later as a health care professional.

To meet these objectives SNA is involved in various activities through the year. Monthly meetings provide updates on SNA activities and opportunities for information. The Association is involved in a number of community and outreach activities, (e.g., health fairs). More recently, the SNA had developed a Student Mentorship Program for enrolled students and a Breakthrough to Nursing Project to encourage the enrollment of underrepresented minority students.

SNA welcomes input from all facets of the student nurse community. Do not hesitate to step forward and become involved in your organization.

SECTION X – SCHOOL OF NURSING FORMS

UAA School of Nursing
AAS PLAN OF STUDY

Date: _____

Student Name: _____

Advisor: _____

COURSE	CREDITS	COURSE	CREDITS	COURSE	CREDITS
FALL _____		YEAR I SPRING _____		SUMMER _____	
FALL _____		YEAR II SPRING _____		SUMMER _____	
FALL _____		YEAR III SPRING _____		SUMMER _____	
FALL _____		YEAR IV SPRING _____		SUMMER _____	

UAA SCHOOL OF NURSING						
100-299: \$154 per credit					300-499: \$187 per credit	
AAS PROGRAM IN NURSING – ESTIMATED COSTS						
SEMESTER 1						
Year One – Full Time						
Course	Per Credit	Credits	Tuition	Lab Fee	Total	Grand Total
Tuition & Course Fees						
NURS 120 – Nursing Fundamentals	154	3	462	0	\$462	\$ 462
NURS 120L – Nursing Fundamentals LAB	154	4	616	116	\$732	\$1,194
BIOL 111 – Anatomy & Physiology I LAB	154	4	616	50	\$666	\$1,860
ENGL 111 – Written Communication	154	3	462	25	\$487	\$2,347
PSY 150 – Life Span Development	154	3	462	0	\$462	\$2,809
Other Expenses						
Student Fees *					\$395	\$3,204
Annual Parking Fee					\$250	\$3,454
Books					\$675	\$4,129
Required immunizations @ Student Health Center					\$450	\$4,579
CPR Certification and Background Check					\$175	\$4,754
Uniforms & Special Equipment					\$400	\$5,154
Pepid Software & Electronic Device					\$355	\$5,509
Living Expenses						
Housing (Residence Halls)					\$2,540	\$ 8,049
Meal Plan					\$1,800	\$ 9,849
Miscellaneous Expenses (\$250/mo Estimated)					\$1,000	\$10,849

SEMESTER 2

Course	Per Credit	Credits	Tuition	Lab Fee	Total	Grand Total
Tuition & Course Fees						
NURS 125 – Adult Nursing I	154	3	462	0	\$462	\$ 462
NURS 125L – Adult Nursing I LAB	154	4	616	195	\$811	\$1,273
NURS 180 – Nursing Pharmacology	154	3	462	25	\$487	\$1,760
BIOL 112 – Anatomy & Physiology II LAB	154	4	616	50	\$666	\$2,426
BIOL 240 – Microbiology LAB	154	4	616	60	\$676	\$3,102
Other Expenses						
Student Fees *					\$395	\$3,497
Books					\$550	\$4,047
Uniforms & Special Equipment					\$100	\$4,147
Living Expenses						
Housing (Residence Halls)					\$2,540	\$6,687
Meal Plan					\$1,800	\$8,487
Miscellaneous Expenses (\$250/mo Estimated)					\$1,000	\$9,487

*Technology fee is \$5 per credit up to a maximum of 12 credits (\$60) per term.

Revised – 08/22/11

TOTAL COST – Year 1 – Without Living Expenses = \$ 9,656

With Living Expenses - \$20,336

UAA SCHOOL OF NURSING						
100-299: \$154 per credit					300-499: \$187 per credit	
AAS PROGRAM IN NURSING – ESTIMATED COSTS						
SEMESTER 3		Year Two – Full Time				
Course	Per Credit	Credits	Tuition	Lab Fee	Total	Grand Total
Tuition & Course Fees						
NURS 220 – Perinatal Nursing	154	3	462	0	\$462	\$ 462
NURS 220L – Perinatal Nursing LAB	154	1	154	116	\$270	\$ 732
NURS 221 – Advanced Parenteral Therapy	154	1	154	50	\$204	\$ 936
NURS 222 – Pediatric Nursing	154	3	462	25	\$487	\$1,423
NURS 222L – Pediatric Nursing LAB	154	1	154	0	\$154	\$1,577
ENGL 211, 212 or 213 – Written Communication	154	3	462	25	\$487	\$2,064
DN 203 – Nutrition for Health Sciences	154	3	462	10	\$472	\$2,536
Social Science General Education Requirement	154	3	462	0	\$462	\$2,998
Other Expenses						
Student Fees *					\$395	\$3,393
Annual Parking Fee					\$250	\$3,643
Books					\$500	\$4,143
CPR Recertification (If Expired)					\$100	\$4,243
Uniforms & Special Equipment					\$200	\$4,443
Living Expenses						
Housing (Residence Halls)					\$2,540	\$6,983
Meal Plan					\$1,800	\$8,783
Miscellaneous Expenses (\$250/mo Estimated)					\$1,000	\$9,783
SEMESTER 4						
Course	Per Credit	Credits	Tuition	Lab Fee	Total	Grand Total
Tuition & Course Fees						
NURS 225 – Adult Nursing II	154	3	462	0	\$462	\$ 462
NURS 225L – Adult Nursing II LAB	154	3	462	71	\$533	\$ 995
NURS 250 – Psychiatric Nursing	154	3	462	0	\$462	\$1,457
NURS 250L – Psychiatric Nursing LAB	154	1	154	31	\$185	\$1,642
NURS 255 – Staff Nurse: Legal, Ethical & Org. Issues	154	1	154	31	\$185	\$1,827
NURS 295 – Intensive Clinical Practicum (Optional)	154	2	308	11	\$319	\$2,146
COMM 111, 235, 237 or 241	154	3	462	3	\$465	\$2,611
General Education Requirement	154	3	462	0	\$462	\$3,073
Other Expenses						
Student Fees *					\$395	\$3,468
Books, Uniforms & Special Equipment					\$350	\$3,818
Application for Graduation (Required)					\$ 25	\$3,843
School of Nursing Graduate's Pin					\$125	\$3,968
Commencement Expenses					\$150	\$4,118
Living Expenses						
Housing (Residence Halls)					\$2,540	\$6,658
Meal Plan					\$1,800	\$8,458
Miscellaneous Expenses (\$250/mo Estimated)					\$1,000	\$9,458

*Technology fee is \$5 per credit up to a maximum of 12 credits (\$60) per term.

Revised 08/22/11

TOTAL COST – Year 2 – Without Living Expenses = \$ 8,561

With Living Expenses - \$19,241

SCHOOL OF NURSING
HEALTH/CPR/BACKGROUND CHECK REQUIREMENTS CHECKLIST

FAX # 907-786-4559

AAS ___ BS ___ MS ___ Semester ___

STUDENT NAME _____ PHONE NUMBER _____

REQUIREMENT	HEALTH PROVIDER STAMP OR SIGNATURE (INCLUDE CREDENTIALS & PHONE NUMBER)	DATE(S) & TITER RESULTS
Rubella Immunity	Ph.	Immune Titer: Pos or Neg Date:
Rubeola (measles) Immunity	Ph.	Immune Titer: Pos or Neg Date:
Tdap (<i>Tetanus/Diphtheria/Pertussis</i>) – <i>within last 10 years. If you have had Td</i> <i>(Tetanus/Diphtheria) within the last 5 years,</i> <i>you will not need to get Tdap.</i>	Ph.	Vaccine date:
Chicken Pox Immunity		Immunity Demonstrated By: Statement of History of Disease _____ (self report) Completion of Immunization Series _____ Immune Titer date: Pos or Neg
Hepatitis A Vaccination Series	Ph.	1. 2.
Hepatitis B Vaccination Series	Ph.	1. 2. 3.
Hepatitis B Immunity		Immune Titer date: Pos or Neg
Hepatitis B 2nd series (<i>if necessary</i>)		4. 5. 6.
Hepatitis B 2nd titer (<i>if necessary</i>)		Immune Titer date: Pos or Neg
Turn sheet over for more health requirements		

REQUIREMENT	HEALTH PROVIDER STAMP OR SIGNATURE (INCLUDE CREDENTIALS & PHONE NUMBER)	DATE(S) & TITER RESULTS
<p>*Annual proof of having had HIV blood test. Do not give results, only proof of having had test.</p> <p>*Annual proof of freedom from TB: Negative PPD. If PPD positive, then proof of negative chest x-ray.</p>		
<p>HIV Test Completed</p> <p>_____</p> <p>(write date of test) DO NOT INDICATE RESULTS</p> <p>Provider: Phone:</p>	<p>HIV Test Completed</p> <p>_____</p> <p>(write date of test) DO NOT INDICATE RESULTS</p> <p>Provider: Phone:</p>	<p>HIV Test Completed</p> <p>_____</p> <p>(write date of test) DO NOT INDICATE RESULTS</p> <p>Provider: Phone:</p>
<p>PPD Tine Test Date:</p> <p>Results Date:</p> <p>Positive ____ Negative ____</p> <p>Provider: Phone:</p>	<p>PPD Tine Test Date:</p> <p>Results Date:</p> <p>Positive ____ Negative ____</p> <p>Provider: Phone:</p>	<p>PPD Tine Test Date:</p> <p>Results Date:</p> <p>Positive ____ Negative ____</p> <p>Provider: Phone:</p>
<p>Criminal background checks will be required as specified by the UAA School of Nursing</p>		
<p>CPR certification: Cardiopulmonary Resuscitation for Infants, Children and Adults, Two-man Rescue and AED must be current throughout the entire clinical sequence. Provide copy of CPR card.</p>		
<p>Alaskan RN Licensure: Copy of current license. (RN-BS and MS students only)</p> <p>Alaskan LPN Licensure: Copy of current license. (LPN → AAS students only)</p>		

This check sheet must be stamped or signed by the health provider or original health documents may be copied. Documentation must be provided prior to beginning of your first clinical course.

The student is responsible for keeping their original health and CPR documents throughout the clinical sequence and for providing copies as requested.

All students enrolled in clinical courses are covered by liability insurance through University of Alaska Statewide Risk Management. The cost of the insurance is covered by fees for the clinical courses.

Deadlines: August 1st for Fall; December 1st for Spring; April 1st for Summer

UAA SCHOOL of NURSING
Request for Extension of Deadline for Health/CPR/Background Check Requirements

Name: _____ Date: _____

Mailing Address: _____ Phone: _____

SID: _____

Semester: _____ Clinical Classes: _____

Deadline (Circle one): August 1 December 15 _____

Extensions will not be granted solely for the mid-semester expiration of CPR Certification, PPD Tine Test, or HIV Test.

Please indicate the required documentation you are unable to provide by the deadline:

- | | |
|--|---------------------------------------|
| _____ Immune Titer (Circle all that apply): Rubella Rubeola Hepatitis B | |
| _____ Tdap vaccination (within last ten years) or
_____ Td (within last five years) | |
| _____ Hepatitis A vaccination series | _____ Hepatitis B immunization series |
| _____ Chicken Pox Immunity | _____ HIV Test |
| _____ PPD Tine Test | _____ Criminal-Background Check |
| _____ CPR Certification | |

Reason: _____

When do you expect the requirement(s) to be met? _____

It is the student's responsibility to comply with the Health/CPR/Background-Check requirements as specified in the School of Nursing Undergraduate Handbook. I understand that if this extension to the deadline is approved, all required documentation must be submitted prior to my entering the clinical environment, unless otherwise indicated.

Student Signature Date

Department Chair Approval Date

Comments: _____

See reverse side for instructions

Request for Extension of Deadline for Health/CPR/Background Check Requirements

Students are expected to meet all deadlines for submission of Health/CPR/Background-Check requirements. However, in the event that the deadline imposes undue hardship or if medical factors prevent the student from complying with the August 1 or December 15 deadline, and then the "Request for Extension" form must be submitted at least two weeks prior to the deadline.

1. Complete form on the reverse side.
2. Submit request to Program Chair or Associate Director of the School of Nursing

It is the student's responsibility to comply with the Health/CPR/Background-Check requirements. If the extension to the deadline is approved, all required documentation must be submitted prior to entering the clinical environment, unless otherwise specified.

Students who register for their clinical nursing classes but fail to provide the required health documentation and do not have an approved extension on file by the deadline will be administratively dropped from the clinical nursing classes. Clinical sections will be adjusted, and perhaps canceled, to ensure that all sections are filled. Students who are administratively dropped from clinical nursing classes cannot be guaranteed space if clinical sections are canceled.

UAA School of Nursing
UNUSUAL OCCURRENCE FORM

ATTENTION: This form is confidential and is used for the purpose of facilitating student learning and preventing future errors. Disposition of the Unusual Occurrence form, including copies, shall occur according to the UAA SON Unusual Occurrence Policy. If a client is involved in the incident, completion of this form should not be documented in his/her medical record.

Date and Time of Report: _____

Background Information:

Student Name: _____ Course: _____

Faculty Name: _____

Preceptor Name (if applicable): _____

Facility/Agency: _____

Total Number of Students Being Supervised by the Faculty Member at the time of the Incident: _____

Total Number of Units to Which Students Were Assigned by the Faculty Member at the time of the Incident: _____

Incident:

Nature of the occurrence (check as many as applicable):

- | | |
|--|--|
| <input type="checkbox"/> Patient Injury | <input type="checkbox"/> Medication Error |
| <input type="checkbox"/> Treatment/Procedure Error | <input type="checkbox"/> Equipment Damage |
| <input type="checkbox"/> Student Injury | <input type="checkbox"/> Instructor Injury |
| <input type="checkbox"/> Staff Injury | |

Describe, in detail, what occurred:

Name of Individual Recognizing Incident: _____

Position of Individual Recognizing Event: _____

Individuals Involved: Patient (hospital number only): _____

Staff Member(s): _____

Date and time of Incident: _____

Remedial Activity

Brief synopsis of prior "Unusual Occurrences" involving the student: _____

Factors contributing to this incident: _____

Plan for preventing future similar incidents: _____

Consequences of this incident: _____

Signatures:

Student

Date

Preceptor (if applicable)

Date

Faculty Member

Date

Program Chair

Date

Original to Office of the Director of Nursing

Copy to Student File or Faculty Personnel File (according to policy)

Copy to Student

UAA School of Nursing
RE-ENROLLMENT REQUEST
Associate Degree Nursing Program

Date: _____

Student Name: _____

Student ID#: _____

Address: _____

Phone: _____

Course: _____

Semester: _____

Student: Strategy for success if permission granted to re-enroll:

Student Signature: _____

Student Faculty Advisor: *Comments on student's potential for success in course.*

Faculty Advisor Signature: _____

Course Faculty: *Comments on the student's potential for success if course repeated.*

Course Faculty Signature: _____

Admissions Committee Recommendation:

_____ Approved

_____ Not Approved

Conditions:

Admission Committee Chair: _____

SECTION XI – CONSORTIUM OF ANCHORAGE STATEWIDE HEALTHCARE EDUCATORS

UAA STUDENT NURSE ORIENTATION

APRIL 2011

CASHE MEMBERS

Alaska Native Medical Center	Municipality of Anchorage
Alaska Psychiatric Institute	North Star Behavioral Health
Alaska Regional Hospital	Providence Alaska Medical Center
Anchorage Veterans & Pioneers' Home	Providence Extended Care Center
Bartlett Regional Hospital	St. Elias Specialty Hospital
Fairbanks Memorial Hospital	Alaska Veterans Affairs Health System
Mat-Su Regional Medical Center	Yukon Kuskokwim Health Corp
673 rd Medical Group DoD-Veterans Affairs Joint Venture Hospital	

INTRODUCTION

As a student nurse, as well as a nurse in professional practice after graduation, you will be working in an industry governed by numerous regulations. For a healthcare facility to be in regulatory compliance, students participating in clinical rotations must participate in an orientation, which includes specific components. To decrease duplication, thus saving you time, and to provide written documentation of the information presented to you, this self-study module below and checklist have been developed by the Consortium of Alaska Statewide Healthcare Educators (CASHE).

To complete the module:

- A. Complete review of all the Nursing Student Practice Objectives and Policies.
- B. Follow the directions exactly.
- C. On the check-list, date (month/day/year) and initial all boxes. ***Ditto marks or arrows in the boxes are not acceptable.***
- D. ***Print*** your name - - ***Sign*** and ***date*** the check-list at the bottom.
- E. ***Complete the post-test on Blackboard.***
- F. Submit your checklist to the course faculty as instructed.

Consortium of Alaska Statewide Healthcare Educators (CASHE) **Nursing Student Practice Objectives and Policies**

Please review each section to assure that you can meet the objectives

Objective: Demonstrate professionalism.

1. Adhere to the ANA Code of Ethics and Standards of Practice.
2. Demonstrate professional behavior: i.e. Report on time, informing unit and faculty appropriately regarding illness, reporting of Unusual Occurrences.
3. Adhere to the dress code of the clinical program and the facility unit(s) of assignment both for pre-clinical and clinical assignments.

Objective: Follow agency-specific policies.

4. Adhere to the facility's policies and procedures.
5. Adhere to the Patients' Bill of Rights as defined within the clinical institution.
6. Be aware of Advanced Directive status on all patients for whom care is given.
7. Recognize how student activities contribute to patient outcomes.
8. Follow facility policies on cell phone use while on clinical units. Limit personal telephone calls/text messages to assigned breaks. Use smart phones/personal devices for educational purposes only.
9. Accomplish an orientation at the facility and specific units(s) of assignment (prior to the first patient assignment day) and documents the orientation on the Nursing Student Orientation Checklist.
10. Obtain and appropriately charge for patient supplies following facility policy.
11. Be responsible for personal items brought to the facilities. While the facility will designate an area for coats, boots, etc., they will not be responsible for them.
12. Take meals and breaks in the facility cafeteria or staff lounge.
13. Park only in designated parking areas at the facility using the necessary temporary parking permits if indicated.

Objective: Maintain patient and personal safety.

14. Adhere to facility infection control policies including Standard Precautions, Bloodborne Pathogens and FIT testing.
15. Recognize and understand the importance of National Patient Safety goals
 - a. Use only approved abbreviations
 - b. Use two patient identifiers for any patient activity
16. Dispose of medical waste using proper procedures.
17. Report defective equipment as required per the Safe Medical Devices Act and facility policy.
18. Report and manage hazardous chemicals and spills according to the Material Safety Data Sheets (MSDS).
19. Observe radiation precautions.
20. Promote and maintain patient safety and describe actions to minimize medical/health care errors.
21. Promptly communicate unsafe practices (errors or near misses) to the clinical instructor.
22. Practice good ergonomic work habits to prevent injury.
23. Report injuries per facility and School of Nursing policies.

Objective: Engage in proper clinical communication.

24. Communicate patient information to the assigned nurse as well as the clinical instructor. This should include patient assessment data (critical lab values), patient progress and patient-related problems such as complaints, physician concerns, patient incidents, adverse drug reactions, etc.
25. Communicate information concerning assigned patients to the appropriate nursing staff responsible for the patient(s) prior to leaving the unit for any reason.
26. Contact the clinical instructor (not facility staff) for supervision of skills/procedures that must be observed prior to performing the skill unsupervised.
27. Identify self appropriately when answering the telephone in a facility.
28. Refrain from accepting telephone or verbal orders from physicians unless guidelines for such activity are within the scope of a particular clinical course (preceptorship).
29. Discuss the patient plan of care with the primary nurse, to include the teaching plan and discharge education plan.

Objective: engage in effective clinical activities.

30. Perform within the guidelines of the clinical course in which presently enrolled.
31. Be aware that the facility-employed registered nurse is responsible ultimately for patient care when nursing students provide patient care.
32. Participate in nursing unit activities during clinical assignments: shift reports, in-services, and "Codes", both practice and actual.
33. Adhere to special clinical policies in your assigned clinical agency (e.g., falls precautions, suicide precautions, pressure ulcer prevention, etc.).
34. Perform clinical procedures under the direct supervision of the clinical instructor or staff RN: i.e. Inserting intravenous catheters, maintaining IV therapy, administering high risk medications, administering IV medications via piggyback route, administering IV push medications and performing central line care.
35. Participate as a member of the multidisciplinary team by accompanying physicians and other disciplines visiting your assigned patient(s).
36. Refrain from carrying facility keys (e.g., narcotic keys, patient-controlled analgesia keys) on clinical units.

Objective: Maintain confidentiality and security of patient information.

37. Maintain client confidentiality according to HIPAA regulations.
38. Adhere to computer security policies per facility guidelines.
39. Do not post any information about your clinical experiences, patients, peers, nurses/physicians or instructors to any social network medium.
40. Adhere to documentation policies at the assigned facility, documenting all care in a timely manner.
41. Do not take photos in the clinical setting.

Objective: show respect and sensitivity for all.

42. Provide routine patient care for assigned patient(s), adapting to the special needs of individual patients or groups.
43. Provide care to patients and families that encompass their age, spiritual beliefs, and cultural heritage and value systems.
44. Recognize and report disruptive interpersonal behavior to a safe person through proper communication channels.

Consortium of Anchorage Statewide Healthcare Educators
NURSING STUDENT ORIENTATION CHECKLIST

NAME: _____ DATE: _____

Semester / Class: _____

1. Fill out in blue or black ink only. DO NOT use pencil.
2. On the check-list, date (month/day/year) and initial all boxes. *Ditto marks or arrows in the boxes are not acceptable.*
3. **Print** your name -- **Sign** and **date** the check-list at the bottom.
4. **Complete the post-test on Blackboard.**
5. Submit your checklist to the course faculty as instructed.

	Date	Initials
Objective: Demonstrate professionalism.		
1. Adhere to the ANA Code of Ethics and Standards of Practice.		
2. Demonstrate professional behavior: i.e. Report on time, informing unit and faculty appropriately regarding illness, reporting of Unusual Occurrences.		
3. Adhere to the dress code of the clinical program and the facility unit(s) of assignment both for pre-clinical and clinical assignments.		
Objective: Follow agency-specific policies.		
4. Adhere to the facility's policies and procedures.		
5. Adhere to the Patients' Bill of Rights as defined within the clinical institution.		
6. Be aware of Advanced Directive status on all patients for whom care is given.		
7. Recognize how student activities contribute to patient outcomes.		
8. Follow facility policies on cell phone use while on clinical units. Limit personal telephone calls/text messages to assigned breaks. Use smart phones/personal devices for educational purposes only.		
9. Accomplish an orientation at the facility and specific units(s) of assignment (prior to the first patient assignment day) and documents the orientation on the Nursing Student Orientation Checklist.		
10. Obtain and appropriately charge for patient supplies following facility policy.		
11. Be responsible for personal items brought to the facilities. While the facility will designate an area for coats, boots, etc., they will not be responsible for them.		
12. Take meals and breaks in the facility cafeteria or staff lounge.		
13. Park only in designated parking areas at the facility using the necessary temporary parking permits if indicated.		
Objective: Maintain patient and personal safety.		
14. Adhere to facility infection control policies including Standard Precautions, Blood Borne Pathogens and FIT testing.		
15. Recognize and understand the importance of National Patient Safety goals		
a. Use only approved abbreviations		
b. Use two patient identifiers for any patient activity		
16. Dispose of medical waste using proper procedures.		
17. Report defective equipment as required per the Safe Medical Devices Act and facility policy.		
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	Date	Initials
19. Observe radiation precautions.		
20. Promote and maintain patient safety and describe actions to minimize medical/health care errors.		
21. Promptly communicate unsafe practices (errors or near misses) to the clinical instructor.		
22. Practice good ergonomic work habits to prevent injury.		
23. Report injuries per facility and School of Nursing policies.		
Objective: Engage in proper clinical communication.		
24. Communicate patient information to the assigned nurse as well as the clinical instructor. This should include patient assessment data (critical lab values), patient progress and patient-related problems such as complaints, physician concerns, patient incidents, adverse drug reactions, etc.		
25. Communicate information concerning assigned patients to the appropriate nursing staff responsible for the patient(s) prior to leaving the unit for any reason.		
26. Contact the clinical instructor (not facility staff) for supervision of skills/procedures that must be observed prior to performing the skill unsupervised.		
27. Identify self appropriately when answering the telephone in a facility.		
28. Refrain from accepting telephone or verbal orders from physicians unless guidelines for such activity are within the scope of a particular clinical course (preceptorship).		
29. Discuss the patient plan of care with the primary nurse, to include the teaching plan and discharge education plan.		
Objective: engage in effective clinical activities.		
30. Perform within the guidelines of the clinical course in which presently enrolled.		
31. Be aware that the facility-employed registered nurse is responsible ultimately for patient care when nursing students provide patient care.		
32. Participate in nursing unit activities during clinical assignments: shift reports, in-services, and "Codes", both practice and actual.		
33. Adhere to special clinical policies in your assigned clinical agency (e.g., falls precautions, suicide precautions, pressure ulcer prevention, etc.).		
34. Perform clinical procedures under the direct supervision of the clinical instructor or staff RN: i.e. Inserting intravenous catheters, maintaining IV therapy, administering high risk medications, administering IV medications via piggyback route, administering IV push medications and performing central line care.		
35. Participate as a member of the multidisciplinary team by accompanying physicians and other disciplines visiting your assigned patient(s).		
36. Refrain from carrying facility keys (e.g., narcotic keys, patient-controlled analgesia keys) on clinical units.		
Objective: Maintain confidentiality and security of patient information.		
37. Maintain client confidentiality according to HIPAA regulations.		
38. Adhere to computer security policies per facility guidelines.		
39. Do not post any information about your clinical experiences, patients, peers, nurses/physicians or instructors to any social network medium.		
40. Adhere to documentation policies at the assigned facility, documenting all care in a timely manner.		
41. Do not take photos in the clinical setting.		

Objective: show respect and sensitivity for all.		
42. Provide routine patient care for assigned patient(s), adapting to the special needs of individual patients or groups.		
43. Provide care to patients and families that encompass their age, spiritual beliefs, and cultural heritage and value systems.		
44. Recognize and report disruptive interpersonal behavior to a safe person through proper communication channels.		

I understand my responsibilities for the above criteria.

Signature

Date

Printed Name

Test Score

Clinical Instructor Signature _____

Student Nurse Responsibilities Related to Patient Safety Goals

Casie Williams, RN,BC, MEd
Alaska Native Medical Center
July, 2007

In 2002, the Joint Commission issued their first set of Patient Safety Goals, in response to the Institute of Medicine report *To Err is Human: Building a Safer Health System* (January 25, 2000). The purpose of these goals is to focus organizations on specific areas safety initiatives. Each goal includes one or two evidence-or expert-based requirements to achieve the goal. The goals and requirements are reviewed annually and updated, revised, or replaced. You can find the most current list of Patient Safety Goals for hospitals, clinics, and long-term care facilities on the Joint Commission's website <http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/>.

The goals offer members of the health care team specific activities and interventions to minimize risks inherent in health care organizations. Because some old goals are converted to standards of care and new ones are added, the numbers of the goals are not consecutive.

Identification. The first goal relates to improving the accuracy of patient identification. At least two patient identifiers other than the patient's room number must be used when taking blood or administering blood products or medication. Identifiers must be specific to that patient. Examples of identifiers that can be used include name, patient identification number, phone number, birth date, social security number, and bar code. Facility policy may require using different identifiers in outpatient settings than inpatient. Check with hospital staff to see which patient identifiers are being used in the setting you are working in.

Communication. The second goal stresses the importance of improving communication among caregivers. The first requirement relates to assuring accurate verbal or telephone orders and reporting critical test results via telephone. Check hospital policy in the facility to see if student nurses are allowed to take verbal or telephone orders. All verbal or telephone orders and critical test results must be read back to confirm their accuracy. The nurse taking the order should document on the medical record that he or she read back the order. The second requirement addressed in the second goal relates to use of abbreviations in medical records. Review the hospital policies for abbreviations, acronyms and symbols that are allowed and those that are not to be used. One of the most important requirements for communication for student nurses is related to "hand off" communications. When transferring responsibility for a patient, e.g. at the beginning or end of your clinical time or when a patient is transferred into or out of the nursing unit, it's important to use a standardized approach to reporting information about the patient, including an opportunity to ask and respond to questions.

Medications. The third goal addresses the importance of improving the safety of medication administration. The first requirement for this goal discusses the importance of removing concentrated electrolytes, such as potassium chloride or sodium chloride in concentrations greater than 0.9%, from patient care areas. The second requirement addresses the need to standardize and limit the number of medication concentrations available in the organization. IV medications should be prepared in the pharmacy unless commercially available premixed IV solutions are available. Another requirement is related to look alike/sound alike medications. Hospitals have developed lists of look-alike/sound-alike drugs used in the facility and are working to reduce errors caused by interchange of these drugs. Check with staff to see if such a list is available and identify what methods are used to reduce errors. Another way to enhance patient safety addresses labeling of medications. All medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field must be labeled.

Wrong site, patient, or procedure. The fourth goal relates to eliminating wrong-site, wrong-patient, and wrong-procedure surgery/procedures. The first requirement for this goal mandates creating and using a preoperative verification process, such as a checklist, and confirming that appropriate medical records and imaging studies are available. The second requirement addresses the need to implement a process to involve patients in marking their surgical site. Additionally, a “time out” should be implemented just prior to any procedure requiring informed consent. This should be implemented any place that such a procedure is performed, not just the Operating Room. A “time out” provides healthcare providers involved in the procedure the opportunity to make one final check using active communication.

Health care-acquired infections. The seventh goal relates to reducing the risk of health care-acquired infections. Complying with current Centers for Disease Control and Prevention hand hygiene guidelines is required. Review and follow the attached CDC guidelines.

Coordinating care. The eighth goal is intended to assure that information about a patient’s medications and treatments is communicated across the continuum of care. When admitting a patient to a new setting, a physician or mid-level provider (e.g. nurse practitioner, physician’s assistant) will obtain and document a complete list of the patient’s medications and treatments and compare them with those from the previous setting. This information may need to be obtained from a nursing home, home health care provider, and/or physician’s office. The complete list of medications is also provided to the patient on discharge from the facility.

Falls The ninth goal is intended to reduce the risk of patient harm resulting from falls. This goal requires that patients be assessed for risk to fall and a fall reduction program be implemented. Included in the plan is a modification of the environment of care to minimize harm to patients if they fall, installing bed alarms and using low beds for patients at high risk to fall, and discontinuing use of full-length bed rails. Check with the facility to learn more about their fall risk assessment and fall reduction protocols.

Patient Involvement in Care The thirteenth goal highlights the importance of patient involvement in their care. Patients who are actively involved in their care are more likely to notice something that’s out of the ordinary or usual such as a different medication or treatment. Encourage the patient and family to report any concerns about safety.

Risk for Suicide The fifteenth goal relates to patients at risk of suicide. Identifying a patient at risk for suicide requires vigilance on all our parts. Let the unit nurses know if you have any concerns that a patient may be considering harming him or her self.

Requesting Assistance The sixteenth goal, new for 2008, validates the positive effects seen in hospitals that initiated a medial assistance team or rapid response team as part of the Institute for Healthcare Improvement’s 10,000 Lives campaign. When a patient’s condition appears to be worsening, a caregiver should request assistance from a specially-trained individual or team to assess and intervene on the patient’s behalf.

References: Joint Commission. (2007). *2008 National Patient Safety Goals: Hospital Program*. http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/08_hap_npsqs.htm. Accessed 7/9/07

CDC Hand washing Recommendations

Reprinted from *MMWR Recommendations and Reports*, October 25, 2002, 51(RR16);1-44. Available on-line at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm>. Accessed 5/27/04.

Categories

These recommendations are designed to improve hand-hygiene practices of HCWs and to reduce transmission of pathogenic microorganisms to patients and personnel in health-care settings. This guideline and its recommendations are not intended for use in food processing or food-service establishments, and are not meant to replace guidance provided by FDA's Model Food Code.

As in previous CDC/HICPAC guidelines, each recommendation is categorized on the basis of existing scientific data, theoretical rationale, applicability, and economic impact. The CDC/HICPAC system for categorizing recommendations is as follows:

Category IA. Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies.

Category IB. Strongly recommended for implementation and supported by certain experimental, clinical, or epidemiologic studies and a strong theoretical rationale.

Category IC. Required for implementation, as mandated by federal or state regulation or standard.

Category II. Suggested for implementation and supported by suggestive clinical or epidemiologic studies or a theoretical rationale.

No recommendation. Unresolved issue. Practices for which insufficient evidence or no consensus regarding efficacy exist.

Recommendations

1. Indications for hand washing and hand antisepsis

- A. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water (IA) (66).
- B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations described in items 1C--J (IA) (74,93,166,169,283,294,312,and 398). Alternatively, wash hands with an antimicrobial soap and water in all clinical situations described in items 1C--J (IB) (69-71,74).
- C. Decontaminate hands before having direct contact with patients (IB) (68,400).
- D. Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter (IB) (401,402).
- E. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure (IB) (25,403).
- F. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) (IB) (25,45,48,and 68).
- G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled (IA) (400).
- H. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care (II) (25,53).

- I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient (II) (46,53, and 54).
- J. Decontaminate hands after removing gloves (IB) (50,58, and 321).
- K. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water (IB) (404-409).
- L. Antimicrobial-impregnated wipes (i.e., Towelettes) may be considered as an alternative to washing hands with non-antimicrobial soap and water. Because they are not as effective as alcohol-based hand rubs or washing hands with an antimicrobial soap and water for reducing bacterial counts on the hands of HCWs, they are not a substitute for using an alcohol-based hand rub or antimicrobial soap (IB) (160,161).
- M. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if exposure to *Bacillus anthracis* is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores (II) (120,172, 224,225).
- N. No recommendation can be made regarding the routine use of nonalcoholic-based hand rubs for hand hygiene in health-care settings. Unresolved issue.

2. Hand-hygiene technique

- A. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry (IB) (288,410). Follow the manufacturer's recommendations regarding the volume of product to use.
- B. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet (IB) (90-92,94,411). Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis (IB) (254,255).
- C. Liquid, bar, leaflet or powdered forms of plain soap are acceptable when washing hands with a non-antimicrobial soap and water. When bar soap is used, soap racks that facilitate drainage and small bars of soap should be used (II) (412-415).
- D. Multiple-use cloth towels of the hanging or roll type are not recommended for use in health-care settings (II) (137,300).

3. Surgical hand antisepsis

- A. Remove rings, watches, and bracelets before beginning the surgical hand scrub (II) (375,378,416).
- B. Remove debris from underneath fingernails using a nail cleaner under running water (II) (14,417).
- C. Surgical hand antisepsis using either an antimicrobial soap or an alcohol-based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures (IB) (115,159,232,234,237,418).
- D. When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2--6 minutes. Long scrub times (e.g., 10 minutes) are not necessary (IB) (117,156,205, 207,238-241).
- E. When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol solution, prewash hands and forearms with a non-antimicrobial soap and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves (IB) (159,237).

4. Selection of hand-hygiene agents

- A. Provide personnel with efficacious hand-hygiene products that have low irritancy potential, particularly when these products are used multiple times per shift (IB) (90,92,98,166,and 249). This recommendation applies to products used for hand antisepsis before and after patient care in clinical areas and to products used for surgical hand antisepsis by surgical personnel.
- B. To maximize acceptance of hand-hygiene products by HCWs, solicit input from these employees regarding the feel, fragrance, and skin tolerance of any products under consideration. The cost of hand-hygiene products should not be the primary factor influencing product selection (IB) (92,93,166, and 274,276-278).
- C. When selecting non-antimicrobial soaps, antimicrobial soaps, or alcohol-based hand rubs, solicit information from manufacturers regarding any known interactions between products used to clean hands, skin care products, and the types of gloves used in the institution (II) (174,372).
- D. Before making purchasing decisions, evaluate the dispenser systems of various product manufacturers or distributors to ensure that dispensers function adequately and deliver an appropriate volume of product (II) (286).
- E. Do not add soap to a partially empty soap dispenser. This practice of "topping off" dispensers can lead to bacterial contamination of soap (IA) (187,419).

5. Skin care

- A. Provide HCWs with hand lotions or creams to minimize the occurrence of irritant contact dermatitis associated with hand antisepsis or hand washing (IA) (272,273).
- B. Solicit information from manufacturers regarding any effects that hand lotions, creams, or alcohol-based hand antiseptics may have on the persistent effects of antimicrobial soaps being used in the institution (IB) (174,420,421).

6. Other aspects of hand hygiene

- A. Do not wear artificial fingernails or extenders when having direct contact with patients at high risk (e.g., those in intensive-care units or operating rooms) (IA) (350--353).
- B. Keep natural nails tips less than 1/4-inch long (II) (350).
- C. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur (IC) (356).
- D. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients (IB) (50,58,321,and 373).
- E. Change gloves during patient care if moving from a contaminated body site to a clean body site (II) (50,51,and 58).
- F. No recommendation can be made regarding wearing rings in health-care settings. Unresolved issue.

7. Health-care worker educational and motivational programs

- A. As part of an overall program to improve hand-hygiene practices of HCWs, educate personnel regarding the types of patient-care activities that can result in hand contamination and the advantages and disadvantages of various methods used to clean their hands (II) (74,292,295,299).
- B. Monitor HCWs' adherence with recommended hand-hygiene practices and provide personnel with information regarding their performance (IA) (74,276,292,295,299,306,310).
- C. Encourage patients and their families to remind HCWs to decontaminate their hands (II) (394,422).

8. Administrative measures

- A. Make improved hand-hygiene adherence an institutional priority and provide appropriate administrative support and financial resources (IB) (74,75).
- B. Implement a multidisciplinary program designed to improve adherence of health personnel to recommended hand-hygiene practices (IB) (74,75).
- C. As part of a multidisciplinary program to improve hand-hygiene adherence, provide HCWs with a readily accessible alcohol-based hand-rub product (IA) (74,166,283,294,312).
- D. To improve hand-hygiene adherence among personnel who work in areas in which high workloads and high intensity of patient care are anticipated, make an alcohol-based hand rub available at the entrance to the patient's room or at the bedside, in other convenient locations, and in individual pocket-sized containers to be carried by HCWs (IA) (11,74,166,283,284,312,318,and 423).
- E. Store supplies of alcohol-based hand rubs in cabinets or areas approved for flammable materials (IC).

COMMUNICATION ACROSS CULTURES

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Revised March, 2002

OBJECTIVES:

After reading this document, the student will be able to:

- A. Describe three ways verbal communication can be enhanced with the Alaska Native.
- B. Incorporate one insight into Alaska Native culture in your professional practice.

Use the Platinum rather than the Golden Rule when interacting with others.
The Golden Rule says "Do unto others as you would want them to do unto you";
The Platinum Rule says " Do unto others as they'd like done unto them." (Alessandra, 1996).

PREFACE

I would like to preface this document with a very important caveat. These are generalizations that do not apply to every individual Alaska Native. Culture is the sum total of the way people live including, among other things, values, language, basic communication, social structures, environment, ways of earning a living, ways of spending leisure time, level of technology, and climate. All cultures are alive and changing -- they are not fixed. Relevance is often affected by life experiences. To illustrate this point, I would like to share with you a selection from a humorous pamphlet, **Caucasian American: Basic Skills Workbook** written by Beverly Slapin:

"Caucasian American women were forced to wear tight clothing, and sometimes their shoes were very pointed (poin'-ted) at the front and had long sticks at the bottom. This made it very difficult to walk, and often, they hurt their backs. Caucasian American women also painted their faces in strange ways, to prepare for mating rituals, usually on weekends (wék'-endz).

"Another thing Caucasian American women were forced to do, especially just before mating rituals, was to remove almost all their body hair. This was done with sharp implements, and the ritual was called shaving and plucking (sháv'-ing and pluk'-ing). Another custom was reserved for the hair on Caucasian American women's heads. Women with long hair usually cut it, and women with short hair wanted it to be long. Women with light hair darkened it, and women with dark hair lightened it. Women with straight hair curled it, and women with curly hair straightened it."

Although I'm sure that you can identify some individual women who fit portions of the above, you'd be hard pressed to find anyone which it is totally relevant for, nor would you necessarily agree with the assumptions made as a result of apparent observation of the Caucasian American culture.

Most people will have problems adjusting from one culture to another because customs and traditions vary. It is important to be aware of history and its impact and to recognize differences in prioritizing values.

CULTURAL VALUES

Value -- the relative worth or importance of an item -- is a main component of culture. The following table compares some mainstream American cultural values with traditional Inupiat values.

IMPORTANT MAINSTREAM AMERICAN CULTURAL VALUES	IMPORTANT INUPIAT VALUES
Ownership	Sharing
Equality in social relations	Respect for others
Competitiveness	Cooperation
	Respect for elders
Love for children	Love for children
Achievement	Hard work
	Knowledge of family tree
Directness in communication	Avoid conflict
Human superior to nature	Respect for nature
	Spirituality
Humor	Humor
Nuclear family	Extended family
Material possessions	Hunter success
	Domestic skills
Achievement-oriented	Humility
Individualism	Responsibility to tribe

HEALTH FROM A NATIVE AMERICAN PERSPECTIVE

In the book **The Real History of the Conquest of Spain**, Bernal Diaz del Castillo (1984) the official historian of the conquistadors, relates that the Indians of what is now Mexico believed that Europeans were gods because the conquistadors were greeted with flowers, perfumes and incense wherever they went. No one bothered to ask the Indians what they really thought. In fact, the Indians were forbidden to either write or speak their own version of these events. Five hundred years later, a Mexican anthropologist named Miguel Leon-Portilla (1988) compiled a collection of Indian writings in the book **The Reverse of the Conquest**. It contains the following account of the Indians in their first encounters with the Europeans: "They say, 'And we smell them even before we saw them. And not even with flowers, perfume or incense could we get close to them.'"(Dansie, 1997, p.116)

As you can see, there were two different interpretations of the same event. The bottom line is, if you want to know what someone (or some group) thinks you need to ask them! What is the Native American perspective?

Roberto Dansie (1997), Executive Director of Pit River Health Service in Burney, California tells us that there are common characteristics that most Native Americans, as well as other ethnic groups, share when it comes to healing and health. These include the following:

- Life comes from the Great Spirit, and all healing begins with Him.
- Health is due to the harmony between body, heart, mind, and soul.
- Our relationships are an essential component of our health.

- Death is not our enemy, but a natural phenomenon of life.
- Disease is not only felt by the individual, but also the family.
- Spirituality and emotions are just as important as the body and the mind.
- Mother Earth contains numerous remedies for our illnesses.
- Some healing practices have been preserved throughout the generations.
- Traditional healers can be either men or women, young or old.
- Illness is an opportunity to purify one's soul.

Are these characteristics common to your Alaskan Native clients? The only way to know for sure is to ask them!

TIME ORIENTATION

The non-native society's view of time is linear. It is viewed in the context of a beginning, a middle and an end. For example, when viewing life, it is seen beginning at birth and continuing to infant, toddler, pre-school age, school age, adolescent, young adulthood, middle age, old age, and death. The work week usually begins on Monday and ends on Friday, with non-work days occurring on the weekend. The day is oriented to the linear concept of time on a clock with a time to wake up, a time to be at work, a time to take a lunch break, a time to leave work, a time to play, and a time to go to bed. This orientation is used for planning time use, and punctuality is rewarded.

The traditional Alaska Native view of time is circular. Life is a circle that continues after death as people who live after you remember the good things you did in your life. The subsistence life-style is oriented to the seasons -- it is time to gather plants and berries, fish, hunt, and trap when the food is available. You pick berries until you have enough berries to last until the next time berries are plentiful. The ability to provide adequately for your family and share with the people in your village is rewarded.

Major conflicts related to time today are related to priority of value systems, transitional stress, perpetuation of the myth of "Indian time", ingrained values of time concepts, family and community influences, and rural and urban living needs.

COMMUNICATION

Communication Patterns and Language

Patterns of communication and behavior are learned at a very early age. The following table (Shavanda, 1989) compares key differences in communication patterns between natives and non-natives:

NON-NATIVES:	NATIVES:
Early demonstration of learning Seek to please	Early age -- respect through silence, observation
Speaks to many people who give perspective to life; no need to talk to those he is close to; companionship	Converse at length with those he's close to; watch and give respect to those he does not know well
Values conversation as a way to get to know others	Values observance as a way of getting to know others
Learn through trial and error	Children: listen and learn; don't answer question or demonstrate skills unless know the answer or are adept at the skill
Teacher expects native students to demonstrate knowledge	Unable to meet expectations of non-native teachers due to way of learning
"Puts best foot forward." Presents positive self- image and high hopes for the future	Not acceptable to "boast" nor to speak of future (makes it difficult for job interviews)
Interprets native's not boasting or speaking of future as lack of self-confidence	
Rapid communication	Thinking before answering Longer pauses
Must have closure for courtesy	No closure (e.g. May hang up at the end of a telephone conversation without saying good-bye)
Direct messages	Indirect messages

English is a second language to many Alaska Natives. Processing a second language may result in additional time needed when answering questions. In addition, the pace of language is often slower than in non-native society, resulting in longer pauses between speakers. It is considered impolite to speak without allowing a sufficient pause to assure that the previous speaker is finished. Although there are variations in pace within non-native speakers of English (compare the New Yorker to the Georgian, for example) the comfortable pause period for most (3-5 seconds) is much shorter than the pause allowed by the Alaska Native (5-10 seconds). When the pause period exceeds the comfort level, silence is filled with speech. This may result in rephrasing questions and making assumptions such as that understanding hasn't occurred, the speaker is being ignored, or that the individual spoken to is "shy" or "quiet".

Silence in social interaction may feel uncomfortable to non-natives. While visiting, the Native person may not feel a pressing need for conversation. It is enough to enjoy the visitor's presence. Non-natives who do not understand this practice may make erroneous assumptions such as that the two people sitting in silence are angry with each other or that one is being rude to the other.

The following table, from Noland and Gallagher (1989) may be helpful in illustrating the results of these differences in communication patterns and language between Alaska Natives and non-natives.

What's Confusing to English Speakers About Athapaskans	What's Confusing to Athapaskans About English Speakers
The Presentation of Self	
They do not speak.	They talk too much.
They keep silent.	They always talk first.
They avoid situations of talking.	They talk to strangers or people they don't know.
They play down their abilities.	They brag about themselves.
They act as if they expect things to be given to them.	They don't help people even when they can.
They deny planning.	They always talk about what is going to happen later.
The Distribution of Talk	
They avoid direct questions.	They ask too many questions.
They never start a conversation.	They always interrupt.
They talk off the topic.	They only talk about what they are interested in.
They never say anything about themselves.	They don't give others a chance to talk.
They are slow to take a turn in talking.	They just go on and on when they talk.
The Contents of Talk	
They are too indirect, too inexplicit.	They aren't careful about how they talk about people or things.
They don't make sense.	
They just leave without saying anything.	They have to say good-bye even when they see you are leaving.

Body language

Communication can be viewed as an iceberg. Verbal language transmits approximately 35% of the message, while nonverbal communication transmits the remainder. Nonverbal communication is culturally-specific and affected by beliefs, values, social rules and communication premises. Because body language is culturally specific, miscommunication can occur when definitions of another culture are used for interpreting meaning. The following examples from Wolcoff (1989) help to illustrate this:

BODY LANGUAGE	NON-NATIVE MEANING	NATIVE MEANING
Nodding head	"I understand what you are saying"	"I hear what you are saying"
Raised eyebrows	"I'm surprised by what I am seeing or hearing"	"Yes" "I agree with what you are saying"
Furrowed brow	"I'm listening very carefully to what you are saying" "I question the truth in what I am seeing or hearing"	"No" "I'm displeased with you"
Tapping pencil	"I am distracted"	"I am impatient"
Sighing	"I am tired"	"I am bored"
Arms tight to body	"I am cold"	"I want to maintain an impersonal distance"
No eye contact	"I am lying to you"	"I respect you"

Interviewing Clients and Providing Patient Teaching

Wolcott (1989) shares the following hints to improve communication with Alaska Native clients:

- Take a few minutes to visit to set the person at ease.
- Talk about common ground: art, music, recreation, weather, dancing, and fun things.
- Don't talk down.
- Don't speak in a loud tone of voice to elders unless you know they are hard of hearing.
- The spoken language is traditionally quiet. Speaking loudly may be interpreted as anger or rudeness.
- Listen, listen, listen.
- Don't talk so much or so fast.
- Allow time for questions.

It is important to consider the cultural context of the topics being discussed. There may not be words for some actions in the Native language (e.g. rape) yet there are some words that have many meanings – in some dialects there are more than 30 different words for snow. In addition, words may have different meanings (e.g. "Are you hurt?" may mean to a woman "Are you menstruating at this time?"). The Alaska Native who has spent a life-time preparing fish and animals to be eaten may have a better knowledge of anatomy than the non-native who has always obtained food from a super market. This increased knowledge of anatomy does not necessarily transfer, however, to an understanding of physiology.

Sex is a taboo subject in many Alaska Native homes. Words for sexual body parts may have little meaning. The client may use euphemisms (e.g. an Alaska Native woman may say chest for breast; may even point to her arm or shoulder when her pain is in her breast). Asking questions about sexual areas may cause embarrassment. Wolcott (1989) offers the following suggestions:

- Have little or no eye contact so the client can maintain his or her sense of dignity.
- Allow the client to be covered up so he or she doesn't feel exposed while you are talking to him or her.
- Don't write at the time of talking with the client; just listen. If the client feels that you are going to write down what he or she is saying, he or she may not give you the whole picture.
- Give the client space. Don't stand too close to him or her; rather in front of him or her, off to the side and turned slightly.
- Don't interrupt; speak in a softer tone of voice. It puts the client more at ease. Alaska Native people in crisis may not react well to loud voices.

ELDERS

The role of an elder in a village is significant. Not to be understated, the elder is considered wise by virtue of age and survival and should be treated with the utmost respect. If an elder is treated in an undignified manner, the whole village may be offended and use passive methods to indicate their disapproval.

DEATH AND SUICIDE

As discussed above under time orientation, death is seen as part of the circle of life rather than a final ending. Wolcott (1989) tells us that an Alaska Native who has done enough good things and has lived a good life will be remembered. If you are remembered, then in essence you do not die. Often loved ones will name the next child born after the person who has died and thus, the spirit of that person is passed on. The grieving process may be different from that expected. It may be quiet emotion.

At a funeral, it is enough that you attended and gave honor to the person who has died. It is not necessary and may be seen as intrusive for a person to say more than a few words to the family. In many villages a family will have a potlatch for the deceased one year after the death. It is appropriate at this time to bring up all the funny stories and good memories.

Suicide may be seen as the more honorable way out. If a person has lived his or her life and things begin to go wrong, he or she may think it is better to end his or her life then, while there are still good memories, than to live longer and “mess up so bad that no one will remember” (Wolcott, 1989). Elders are beginning to address this problem, particularly with the youth.

CONTEMPORARY HEALTH PROBLEMS

Negative factors contributing to health problems in the contemporary world (1945-2000) include urban migration, alienation and hopelessness (especially the young), cultural isolation, a continuing decline in subsistence with a worsening diet, unemployment, and break-up of families. Positive factors include improved health measures such as drugs, vaccines, surgery and hospitals; primary health care provided by public health nurses, community health aides, an increasing number of Nurse Practitioner/Physician Assistants in rural clinics, and specialty physician clinics arranged in rural communities; improved environmental health such as village sanitation, safe water supply and waste disposal; improved medical transportation and communication network; and Alaska Native involvement in health. Newly added are use of computerized resources such as the internet, telehealth and teleradiology programs. The health problems seen today are often complicated by substance abuse, psychosocial problems, and violence. Substance abuse continues to involve alcohol and tobacco but has expanded to include marijuana, cocaine, heroin and inhalants. Psychosocial problems include increased suicide (particularly in the young), alienation, and changing family relationships. Violence – particularly fights, rape, and domestic violence – is increasing, related to substance abuse and psychosocial problems. Trauma is one of the leading causes of death and disability among Alaska Natives.

The continuing decline in subsistence and worsening diet have contributed to an increase in obesity and the incidence of Type 2 diabetes seen today. Related problems include an increase in the incidence of cardiovascular disease with myocardial infarction, angina, hypertension and stroke.

The move to modern preparation methods for traditional food has resulted in an increase in the occurrence of botulism. Traditionally, fish heads, roe, and seal fins were fermented in wooden containers which were not airtight. Using plastic containers with airtight seals allows anaerobic organisms to flourish.

Infectious diseases have also resulted in additional health care problems. The increased frequency in the occurrences of all types of hepatitis, as well as alcohol abuse, are related to a high incidence of liver diseases including cirrhosis and hepatocellular cancer. *Helicobacter pylori* has been shown to be associated with an increased incidence of peptic ulcer disease in this population. Sexually transmitted diseases such as chlamydia, herpes simplex II, and gonorrhea may be implicated in the increase in health problems such as ectopic pregnancy, pelvic-inflammatory disease, cervical cancer, and infertility. Additional pregnancy-related problems include fetal alcohol syndrome and teenage pregnancy.

SELECTED HISTORICAL CULTURAL FEATURES

Inuit (Eskimo) people occupied the entire coast of Alaska except Aleutian Islands and Southeast Alaska. The major Inuit groups are Inupiat, Yupik, and Siberian Yupik. Traditional homes were dug underground (snow houses or igloos were only built in emergencies). Transportation was via kayaks and umiaks (boat covered with animal skin).

Inupiat Inuit inhabited the far northern Arctic Ocean coasts along the Beaufort Sea, Chukchi Sea and Kotzebue Sound and the Arctic tundra of the Brooks Range. Traditional marine foods included bowhead whales, seals, walrus, and polar bear. Tundra foods included caribou, salmon, bird eggs, berries and wild plants and roots.

The Yupik Inuit inhabited inland forested areas along the Lower Yukon and Kuskokwim Rivers and along the Bering Sea. Traditional foods from the tundra and forest included moose, caribou, salmon, trout, bird eggs, berries, and wild plants and roots. Marine foods included seals and walrus.

Siberian Yupik Inuit inhabited the St. Lawrence Island (only 38 miles east of Russia), with Gambell and Savoonga the largest villages. Their traditional tundra foods included reindeer, salmon, bird eggs, berries and wild plants and roots. Marine foods included bowhead whales, seals and walrus.

Aleuts inhabited Kodiak Island (the Alutiiq people) and the Aleutian Islands (the Aleuts). They were maritime people, with settlements located on bays where there was good gravel beach for landing skin-covered boats. Traditional marine foods included whale, seal, sea otter, sea lion, halibut, salmon and mollusks. Traditional island food included birds, bird eggs, berries and wild plants and roots.

The Athapaskan Indians, called Den'a (the people), traditionally inhabited the interior of Alaska, the area south of the arctic regions made up of coniferous forests, mountains and treeless tundra. The nine major groups include the Ingalik, Koyukon, Holikachuk, Gwich'in, Han, Upper Tanana, Ahtna, and Tanaina. Athapaskan Indians were nomadic hunters and fisherman who invested artistic effort in their clothing, jewelry and weapons. Transportation was via dog sled, kayak and canoe. Traditional foods included moose, caribou, Dall sheep, brown and black bear, porcupine, beaver, wolf, fox, martin, wolverine, mink, river otter, rabbit, muskrat, salmon, trout, ducks, geese, berries, wild plants and roots.

Tlingit are the northernmost of the North coast people. Others include Haida, Tsimshian, Kwakiutl, Nootka, Salishan, Chemakum, Chinook and Makah. They traditionally inhabited islands and mainland rain forests of southeastern Alaska. Because of the availability of lumber from the forests, they built large red cedar plank houses, totem poles and ocean-going dugout canoes. Their traditional marine foods included seal, sea otter, sea lion, halibut, salmon and mollusks. From the forest they obtained deer, brown and black bears, ducks, geese, berries, wild plants and roots.

Exercise: Values Illustrated Through Art and Traditional Stories

The following text was given to me by Vernon Bavilla, an ivory carver from Good News Bay. It was provided as an explanation of the meaning of a pair of masks he had carved. He gave me permission to use it in educational programs. Read the explanation of the meaning behind the masks and the story. What native values do you find illustrated in the text?

Meaning Behind the Masks (both)

The Creator Mask: Representative of the Creator always watching, always knowing, who created the human and the seals, and the world they live in. The small masks represent His helpers, or angels who watch over His work.

The Seal Mask: Representative of a Seal in Human Form, with the beginning of the transformation to a bearded seal taking place in the forehead of the mask. The Black Tongue is representative of the seal giving up its life to the Good hunter, so that the hunter and his family may live to see another day. The hunter with kayak is on top of the food chain. The flippers are symbolic of the change to a seal flipper from a man's hand. The bearded seal on the bottom is representative of the true form of the mask, when the transformation to a seal is complete.

Circles around the masks - Symbolic of the Universe, Life in and of itself, and time not being linear.

The Four Sections Representative of the Body, Mind, Heart and Soul. All must be in balance in order for a person to be a complete (whole) healthy person. Or it could be for a whole community as well. Everyone in the community had their fair share of work to do for the benefit of the whole community.

The Attachments All the pieces (figurines, symbols, etc) are tied into the universe of a particular setting. It could be the seal hunter's life, the fishermen, etc, or whatever world one is working in or participating in. The attachments tie everything together, and therefore complete the picture.

Story Behind the Masks

The masks are considered Paired Masks, because they tie in with each other and must be kept together to complete the story.

In Yup'ik lore, there is a Creator who made anything and everything we see on this earth and in the heavens. The Creator made the sea and all living things in it, as well as Man and all land dwellers. He also created many spirit helpers to oversee all that He created. He also made sure that everything He created had a Yua, or a man-spirit, including the animals as well. The feathers are light and can float, and therefore for me, represent the one great spirit and his helpers.

Back in the days when the wall dividing different worlds was very thin, man was able to change himself into animal form, and animals were able to take on the form of humans, by traveling in the portals or windows between these dimensions.

One day there was a young Yup'ik hunter out in the big water searching for seals near some ice floes. As he was paddling along, he came upon a lone human form who was on an ice flow all by himself. As the young Nukall'piak (extremely successful hunter) got near the seemingly human person, he called out to the person, asking if he would like some help. The person on the ice did not respond, but simply turned around and dove into the water. The young hunter was caught off guard, and then quickly pursued the person thinking he needed help. Yet each time the human form surfaced from under the water, he appeared more and more like a seal, until the transformation was complete.

Now, this hunter was well received every where he went. He treated everyone with respect, especially the elders. He shared everything he got, and was therefore richer for it. He treated all the animals with respect. He heeded all the instructions of the day and he followed the advice of all the wisdom before him. Then the seal came up one last time and saw that the spirit of goodness was emanating from this hunter, and as a sacrifice of his own life, the seal gave himself up to the good hunter, so that the hunter and his family may live to see another day. After the seal was taken to an ice floe, the young hunter said a prayer to the Creator. He thanked the creator and the spirit of the seal for giving up his life to him. As a final gesture, out of respect to the seal's Yua, the young hunter gave it fresh water to drink for its final journey, and told the spirit of the seal to tell his brothers and sisters that he had treated him well, so in the future, the hunter may not starve, and live to see another day.

This story is handed down from generations ago, and I have told it as best as I could to recount it.

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**SUMMARY OF MAJOR BELIEFS AND HEALTH CARE IMPLICATIONS OF
SELECTED RELIGIOUS CULTURES/SUBCULTURES**

<u>Religion</u>	<u>Beliefs</u>	<u>Worship Practices</u>	<u>Effects Of Religion On Life Style</u>	<u>Food Preferences</u>	<u>Views On Organ Donation/ Practices Re: To Death</u>	<u>Nurse's Responsibility Re: Client Belief/Need</u>
Buddhism Zen (sect of Buddhism) Shintoism (Japan's state religion)	Deity Gautama, Buddha, and Kwannon, the Goddess of compassion Strive to reach Nirvana, divine state of release, ultimate reality, and perfect knowledge. Reach Nirvana by eight rights: knowledge, intentions, speech, conduct, livelihood, effort, mindfulness, and concentration. Values of happiness: goodness, beauty and profit Zen: Seek absolute truth in honesty and simple acts	Meditation books. Two god shelves in Home: One has wooden tablet with name of household's patron saint, symbolic forms of goodness of rice, texts, and prized objects. Second shelf is a Buddha shelf. Different sects emphasize different values and rituals in worship. Believe in reincarnation, either immediate or after 49 days Zen: Meditation and word puzzles Shintoism: Worship of emperor, ancestor or heroes	Moral code of life comes from religion. Lying or killing is not condoned. Emphasize beauty and cleanliness. Discourage use of tobacco Zen: Simple acts are emphasized Shintoism: Intense loyalty to every aspect of nature; ancestral spirits are in nature	Vegetarian. No intoxicants. Moderation in eating and drinking	No prohibition to donation; decision left to the individual Last right chanting is often practiced at beside soon after death. Contact the deceased's Buddhist priest or have the family make contact	Family help care for all ill members and give emotional support. Religion discourages use of drugs; assess carefully for pain. Cleanliness is important. Question about feelings regarding medical or surgical treatment on holy days. Prepare for death; help patient remain alert, resist confusion or distraction, and remain calm.
Christianity	All worship God the Father and Jesus Christ.	Sunday is day of worship unless specified otherwise	Most feel religion is important support that guides life style. Knowledge is gained from reading the Bible			Most wish to see spiritual advisor when ill, to read Bible or other religious literature and to follow usual practices

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Information verified with Anchorage church/synagogue

<u>Religion</u>	<u>Beliefs</u>	<u>Worship Practices</u>	<u>Effects Of Religion On Life Style</u>	<u>Food Preferences</u>	<u>Views On Organ Donation/ Practices Re: To Death</u>	<u>Nurse's Responsibility Re: Client Belief/Need</u>
*Roman Catholic	Venerate Virgin Mary and Saints Authority of Church in the Scriptures, Pope, and Bishops. Believe in heaven, hell, purgatory, resurrection, and second coming of Christ	Mass and Holy Communion may be celebrated daily. Sacraments of Confession, Holy Communion, and Sacrament of Sick may be received more than once. Sacraments of Baptism, Confirmation, and Matrimony received only once. (Tell family/priest if you baptize baby). Ritual and tradition are important in worship	Infant baptism and adult baptism when join church. Oppose abortion	Fasting or avoiding from meat on Ash Wednesday and Good Friday.	Donation is an act of fraternal love, charity and self-sacrifice. Ethically and morally acceptable to the Vatican In sudden death priest is called to anoint and administer Viaticum, if possible, or special prayers are said. Baptism should be performed if aborted fetus may not be clinically dead	Clients find comfort in having rosary, Bible, prayer book, crucifix, medals. Infant baptism mandatory, especially urgent if prognosis is poor. Inquire re: dietary preferences and fasting. May want information on natural family planning.
Orthodox	Similar to Roman Catholic; no Pope	Divine Liturgy, Eucharistic Service, in native language and possibly also in English				
Eastern (Turkey, Egypt, Syria, Cyprus, Bulgaria, Rumania, Albania, Poland, Czechoslovakia)			Infant baptism by immersion, followed by Confirmation. Feel inspiration and insight directly from God. Blessing for the sick is not last rite but a form of healing by prayer.	Fasting each Wednesday, each Friday, Lent and Advent; avoid meat, dairy products, and olive oil	Last rites if death impending; cremation discouraged	Prayer book and icons important. Infant baptism if death imminent. Fasting not required when ill.

* Information verified with Anchorage church/synagogue

<u>Religion</u>	<u>Beliefs</u>	<u>Worship Practices</u>	<u>Effects Of Religion On Life Style</u>	<u>Food Preferences</u>	<u>Views On Organ Donation/ Practices Re: To Death</u>	<u>Nurse's Responsibility Re: Client Belief/Need</u>
*Greek			Infant baptism significant; to be done anytime after 40 days after birth. Oppose abortion	Fasting periods on Wednesday, Friday, and during Lent; avoid meat and dairy products	Holy Unction administered to the dying; cremation and autopsies that cause dismemberment discouraged. Oppose euthanasia; every reasonable effort should be made to preserve life until terminated by God	Prayer book and icons important. Infant baptism if death imminent. Prepare for Holy Communion and Holy Unction by fasting (not required when ill).
*Russian				Fasting on Wednesday, Friday, and during Lent and Advent; no meat or dairy products	Do not believe in cremation. Traditionally, after death, arms crossed, fingers set in a cross.	Prayer book and icons important. Infant baptism if death imminent. Check consequences of fasting on health. Cross necklace important; should be replace immediately when patient returns from surgery
Protestant (many denominations and sects)	Bible ultimate authority, unless otherwise noted.	Read Bible for knowledge and spiritual guidance, unless noted otherwise. Practices vary with denomination or sect				
*Baptist	Oppose infant baptism; only believers are baptized by immersion	Liturgically free		Most avoid alcohol and tobacco		No infant baptism

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<u>Religion</u>	<u>Beliefs</u>	<u>Worship Practices</u>	<u>Effects Of Religion On Life Style</u>	<u>Food Preferences</u>	<u>Views On Organ Donation/ Practices Re: To Death</u>	<u>Nurse's Responsibility Re: Client Belief/Need</u>
*Brethren (Grace), (Plymouth)		Liturgically free; fundamental		Most avoid alcohol and tobacco	No last rites	No infant baptism. Anointing with oil for physical healing and spiritual uplift
*Church of Christ	Church is body of Christ, with Christ as head	No official congregational leader, but a group of local elders are authority		Most avoid alcohol and tobacco	No specific position is taken on organ donation. Decision left up to the individual No last rites	No infant baptism
*Church of Christ Scientist (Christian Scientist)	One infinite God, good. Spirit is real and eternal. Illness and pain exist only as conditions of thought, and are treated spiritually through prayer alone.	Sunday and Wednesday services (with elected readers). Daily Bible study. Daily deeds more important than public worship. Follow example of Jesus Christ	Avoid most medical treatment, physical examinations, immunizations (unless required by law), biopsies, psychotherapy or hypnotism Practice of religion essential to wellness	No alcohol or tobacco	No specific position is taken on organ donation. Decision left up to the individual No last rights. No autopsy, unless sudden death	No infant baptism. Parents may decline eye drops, injections, or tests for infants. Use nursing measures to alleviate pain. Patient may refuse blood transfusion as well as IV fluids and medications
Church of God		Identified by geographical headquarters; about 200 independent church groups in the US use this name in their title		Most avoid alcohol and tobacco		No infant baptism

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*Church of Jesus Christ of Latter Day Saints (Mormon)	Inspiration from Bible, Book of Mormon, and other scriptures. Body is "temple of God." Believe dead can hear Gospel	No official paid ministry. Central leadership from the General Authorities in Salt Lake City directing and advising local leadership in different geographical areas	Marriage in temple seals relationship for eternity. Church attends to spiritual and temporal needs of members. Personal health and prevention of disease highly valued	Eat in moderation; limit meat. Avoid coffee and tea. No alcoholic beverages. Avoid use of tobacco	Church does not object to the individual's decision regarding organ donation and transplantation If no LDS family available, LDS bishop notification recommended	No infant baptism. Laying on of hands and anointing with oils for healing are optional, as decided by the individual or family. Ask permission before removing white undergarment with special marks at navel and right knee
*Episcopalian		Liturgically formal. Holy Communion may be received daily. Ministration to sick for healing	Most believe in spiritual healing.	May fast from meat on Friday	No specific position is taken on organ donation. Decision left up to the individual Ministration at Time of Death suggested	Infant baptism if death imminent. Patient fasts in preparation for Holy Communion (not required if ill)
Friends (Quakers)	God is in every person and is approached directly. Follow ten commandments and the teaching of Jesus as fully as possible	No minister, no religious symbols, no formal creed. Follow inner spirit to share inspiration	Pacifists; conscientious objectors in wartime; obeys inner light in daily living. Simplicity, honesty, physical and mental health, and harmonious living with family and others is valued. Relates to all people as equals	Moderation in eating. Most avoid alcohol and tobacco		No infant baptism. Health teaching important. Give explanations about medical technology used in care. Share information about condition as indicated

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<u>Religion</u>	<u>Beliefs</u>	<u>Worship Practices</u>	<u>Effects Of Religion On Life Style</u>	<u>Food Preferences</u>	<u>Views On Organ Donation/ Practices Re: To Death</u>	<u>Nurse's Responsibility Re: Client Belief/Need</u>
*Jehovah's Witnesses	Opposed to the use of blood or blood products	Liturgically free. Use Bible and other literature	Conscientious objector in wartime. Individual does not take oath or participate in national holidays or ceremonies	Avoid food to which blood is added, e.g. certain sausages and lunch meats	While church does not encourage organ donation, they believe the individual has the right to choose according to his/her conscience, with the provision that all organs are completely drained of blood before being transplanted No last rites	No infant baptism. Opposed to use of blood and blood products. Will accept any blood substitute. Hospital Liaison Committee will work with physician regarding identifying options to blood administration. Active hospital visitation program.
Mennonite		No sacraments	Deep concern for individual dignity and self-determination	Most avoid alcohol		No infant baptism. Shock therapy, psychotherapy, and hypnotism conflict with individual will and personality
*Nazarene		Liturgically free	Believe in divine healing through prayer	Avoid alcohol	Stillborn is buried. No last rites	No infant baptism. Laying on of hands for healing.
Pentecostal	Many different groups, which have specific beliefs	Liturgically free	Believe in divine healing through prayer			No infant baptism. Prayer, anointing with oil, laying on of hands for healing
*Unitarian/ Universalistic	No special status given to Bible or other single scripture	No official sacraments	Reason/practicality emphasized. Individual responsibility important		No specific position is taken on organ donation. Decision left to individual	No baptism

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<u>Religion</u>	<u>Beliefs</u>	<u>Worship Practices</u>	<u>Effects Of Religion On Life Style</u>	<u>Food Preferences</u>	<u>Views On Organ Donation/ Practices Re: To Death</u>	<u>Nurse's Responsibility Re: Client Belief/Need</u>
*Seventh-Day Adventists	<p>Believe in man's choice and God's sovereignty. Believe in imminent second coming of Christ.</p> <p>Recognize validity of biblical commandments while believing that eternal life not earned, but rather attained through faith in the grace of Jesus</p>	<p>Spiritual literature important</p> <p>Sabbath day is Friday sundown until Saturday sundown for most groups</p>	<p>Body is temple of Holy Spirit and should be protected. Value health and healthy living. Religion strongly affects values, behavior, and life style</p>	<p>Recommend vegetarian (no meat or animal byproducts) or lacto-ovo-vegetarian (may eat eggs and milk, but no meat) diet. Pork and fish without fins and scales prohibited. Avoid coffee, tea, alcohol, and tobacco</p>	<p>No prohibition to donation; decision is left to the individual</p> <p>No last rites</p>	<p>No infant baptism. Health measures, disease prevention, and health education important. Some believe in divine healing and anointing with oil. Check on food preferences. May refuse medical treatment and use of secular items such as TV on Sabbath</p>
Hindu	<p>Trinity; Brahma (Creator), Vishnu (Preserver) (God of love), and Siva (Destroyer)</p> <p>To unite real and inner self (atman) with Brahman is greatest desire. Reincarnation depends on knowledge, past deeds, past experience. Every birth a rebirth</p>	<p>Read literature. Meditate by shrine in home with pictures of incarnations and burning incense. Prayer for freedom is best. Prayer for bodily cure is low form of prayer</p>	<p>Live in moderation. Death is accepted, a rebirth; the atman (basic self) remains the same. Yoga is the training course to reach God. Strive for self-control, self-discipline, cleanliness, contentment. Avoid injury, deceit, stealing. Religion pervades life style</p>	<p>Vegetarian. No alcohol. Other restrictions conform to sect doctrine. Fasting is important part of religious practice, with consequences for person on special diet or with diabetes or other diseases regulated by food</p>	<p>No prohibition to donation; decision is left to the individual</p> <p>Prescribed rites followed after death. Priest may tie a thread around neck or wrist to signify blessing (should not be removed); pours water into the mouth of corpse. Family washes body; particular about who touches dead. Bodies cremated.</p>	<p>Medical care is last resort; client considers help will come from own inner resources. Assess carefully for pain. Assist to maintain religious practices. Cleanliness and dietary preferences important.</p>

* Information verified with Anchorage church/*

Information verified with Anchorage church/synagogue

<u>Religion</u>	<u>Beliefs</u>	<u>Worship Practices</u>	<u>Effects Of Religion On Life Style</u>	<u>Food Preferences</u>	<u>Views On Organ Donation/ Practices Re: To Death</u>	<u>Nurse's Responsibility Re: Client Belief/Need</u>
Islam	<p>Allah is deity; Mohammed is the prophet</p> <p>Direct relationship with Allah. Believe in heaven and hell and eternal soul. Necessary to live good live</p>	<p>Use Quran (Koran) (scriptures) and the Hadith (traditions) for guidelines in devotional life, thinking and social obligations. Pray five times daily, need water for ritual washing before prayer and a prayer rug. Face Mecca or east when praying. No worship images</p>	<p>Daily prayer and affirmation of Allah. Emphasize good life, responsibility to society. Ramadan is month of fasting; no eating from sunrise to sundown. Moderation in eating and drinking. Submission to Allah is important. Moderation in all activities</p>	<p>Avoid pork and products with pork in them. No intoxicants</p>	<p>Leaders have reversed their 1983 opposition to organ donation, provided that donors provide consent in writing prior to their death and that the organs are transplanted immediately rather than being stored in an organ bank</p> <p>Resigned to death, but encourage prolonging life. Patient must confess sins and beg forgiveness before death, and family should be present. Family washes and prepares body, folds hands, turns body to Mecca. Only relatives or friends may touch the body. Unless required by law, no postmortem</p>	<p>Excused from religious practices when ill but may still want to pray to Allah and face Mecca. No spiritual advisor to call. Family visits important. Cleanliness important. After 130 days, fetus treated as fully developed human..</p>
Black Muslim (Nation of Islam)			<p>Moderation in all activities</p>		<p>Carefully prescribed procedure for washing and shrouding dead and performing funeral rites.</p>	<p>No baptism. Cleanliness important</p>

* Information verified with Anchorage church/synagogue

<u>Religion</u>	<u>Beliefs</u>	<u>Worship Practices</u>	<u>Effects Of Religion On Life Style</u>	<u>Food Preferences</u>	<u>Views On Organ Donation/ Practices Re: To Death</u>	<u>Nurse's Responsibility Re: Client Belief/Need</u>
*Judaism	Orthodox--literal interpretation; Conservative--in between; Reform--Old Testament is written by inspired men but can be interpreted. Believe soul lives on in memory of others, memorials, good works	Use Torah, first five books of Bible, and its enlargement, and Talmud. Sabbath is from Friday sundown to Saturday sundown. Sabbath and morning prayer--use prayer book and may use phylacteries (leather strips with boxes containing scriptures). Holy days: Rosh Hashanah (New Year); Yom Kippur (Day of Atonement); Passover (celebrates deliverance from Egyptian bondage)	Orthodox males wear yarmulke (skull cap) continuously. Value family, education, and sense of community. Value enjoyment of life now and share with God. Emphasize social concern and each person contributes according to ability. Year of mourning after death, with intensity of mourning decreasing with time--3 days, 7 days, 30 days, and anniversary memorials	Orthodox eat only kosher (ritually prepared) foods. Milk consumed before meat, or meat eaten six hours before milk consumed. Do not eat pork, shrimp, lobster, crab, oyster, birds of prey if Orthodox; others may restrict diet. Special utensils and dishes for Orthodox. Fast on Yom Kippur and Tisha Babb; may fast other times but excluded if ill	Teachings on organ donation maintain that saving a human life takes precedence over maintaining the sanctity of the human body. Family or friends to be with dying person. No artificial means to prolong life if patient vegetative. Confession by dying person is like a rite of passage. Human remains ritually washed by members of Ritual Burial Society. Burial should take place as soon as possible. Cremation not permitted. All Orthodox Jews and some Conservative oppose autopsy. Fetus and amputated limbs to be buried, not discarded.	No infant baptism. Circumcision of baby on eighth. Disease prevention measures, avoiding illness, are important. On Sabbath, Orthodox may refuse freshly cooked foods, medicine, treatment, surgery, and use of radio or TV. Orthodox male may not shave. Arrange for kosher or preferred food; may serve on paper plates. Visits from family members important. If no family, notify synagogue so others may visit.

Adapted by Casie Williams, RN, MEd, Alaska Native Medical Center, 1996, from table in Murray, Ruth Beckman and Huelskoetter, M. Marilyn Wilson. (1991). Psychiatric/mental health nursing: Giving emotional care, 2nd edition. Norwalk, CT: Appleton & Lange. pp. 256-263. Verified with local churches/synagogue, as indicated. Views on organ donation from "Religious views on organ donation." (1988). American Council on Transplantation; verified with local churches/synagogue, as indicated

SPECIAL NEEDS POPULATION

CENTER FOR DEAF ADULTS

Alaska Center for Deaf Adults (CDA)

The Center for Deaf Adults (CDA) is one of the programs of the Alaska Center for Blind and Deaf Adults, a private non-profit 501(c)(3) organization. CDA provides rehabilitation services to Alaskans who are Deaf, Hard-of Hearing and Deaf-Blind to help these individuals become more independent.

- Independent Living Skills
- Pre-Vocational Skills
- Work Adjustment
- Communication Skills

CDA also provides:

- Information and Referral
- Assistive Devices
- Service Planning Management
- Sign Language Classes (ASL)

People who are deaf and hard of hearing—Who are They?

About 40 millions Americans experience hearing loss. The people who receive services through CDA are people like you! All experience some impact on their lives due to hearing loss.

A person who is hard of hearing may recently have lost his or her hearing and just become aware of problems at work or home. CDA provides personal adjustment counseling and information services. While most persons who are hard of hearing use speech, speech-reading and assistive listening devices, some may use an oral interpreter for complete communication. A significant group of Alaskans who are deaf use American Sign Language. They generally make use of interpretation services to function independently in various situations.

At CDA, persons who are deaf learn about their rights as American citizens through the Americans with Disabilities Act. Learning more about deaf culture, history and American Sign Language is also encouraged. A strong emphasis is placed upon learning the skills needed for life transitions: from school to work, from rural to urban and from a single person to parenthood.

The Services that the Center for Deaf Adults Provides Include:

- Public information sessions and seminars on deafness. Presentations are designed to broaden community understanding about the aspects of Deafness.
- Training seminars and workshops for clients to provide information, group process experience and skill development.
- Opportunity for family members of program participants to meet and share their concerns, information and understanding of CDA's functions.
- Awareness information, technical assistance, training referrals to other agencies and DVR may be provided.

People who are Deaf, Hard of Hearing and Deaf-Blind:

- Raise families
- Have jobs and careers
- Pay taxes
- Belong to groups
- Vote
- May communicate differently than hearing people

Training available at the Center for Deaf Adults

Independent Living Skills

- Cooking
- Food Management
- Nutrition
- Money Management
- Health Education
- Community Resources
- Transportation
- Social Activities

Prevocational and Post Employment

- Awareness of the world of work
- Developing a resume
- Interviewing skills
- Entering employment
- Assistance on the job sites
- Assessment of work performance

Communication Skills

- Information about hearing loss
- Use of interpreter services
- Basic writing and reading skills
- Aspects of sign language system
- Assistive devices

CDA Services Costs

The revenue which supports the programs of the Center comes from fees for services. In addition, some grants and contracts with public and private agencies also provide funding. While the Alaska Division of Vocational Rehabilitation (DVR) has the responsibility for providing rehabilitation services to people with disabilities, clients are often referred to the Center for services and evaluation.

How to Contact the Center

To make a referral or for more information about the Alaska Center for Deaf Adults, contact the Program Director at the numbers listed below:

Alaska Center for Blind and Deaf Adults

731 Gambell, Suite 200
Anchorage, Alaska 99501-3754
(907) 276-3456 Voice
(907) 258-2232 TTY
(907) 770-8255 RELAY Alaska
(907) 279-0341 Fax
(800) 77—3456 Toll Free in Alaska (outside Anchorage)

Interpreter Referral Line

Alaska Center for Blind and Deaf Adults

Interpreter Referral Line

731 Gambell, Suite 200
Anchorage, Alaska 99501-3754
(907) 277-3323 Voice
(907) 277-0735 TTY
(907) 244-0505 Emergency V/TTY
(907) 244-0506 Emergency V/TTY

What is the IRL?

The Interpreter Referral Line (IRL) is one of the services offered by the Alaska Center for Blind and Deaf Adults. It was established in 1980 for the purpose of scheduling sign language interpretation and transliteration services in the Anchorage Bowl area. The IRL bridges the communication barrier between persons who are Deaf and persons who are hearing.

How Does the IRL Work?

When an interpreter is needed by a person who is either Deaf or hearing, call the IRL Referral Specialist at (907) 277-3323 (Voice) or (907) 277-0735 (TTY). The Referral Specialist will identify and schedule qualified interpreters for each request. When the match-up has been made and the service has been provided, the IRL will bill the party responsible for payment of services.

What is Interpretation?...Transliteration?

Interpretation is a process whereby the source language (English) message is immediately changed into the target language (American Sign Language). The task requires comprehension of the source language input, immediate discarding of words from the source language, analysis of the source message into the target language output. The source language can also be the visual language, American Sign Language, used by many Americans who are Deaf.

Transliteration is more than a simple recording of spoken English into signed English. It is a complex combination of features from American Sign Language (ASL) and English.

Why does a person who is deaf need an interpreter?

Some persons who are Deaf communicate with hearing persons by writing notes; some do not. Some use sign language interpreters and some use a combination of the various communication techniques. A qualified interpreter is often the best and most accurate choice.

Who is an interpreter?

There are two types of sign language interpreters. There are sign language interpreters and relay interpreters.

A sign language interpreter:

- Possesses fluency in American Sign Language and English.
- Acts as linguistic and auditory link as well as a cultural bridge between people who are Deaf and people who are hearing.
- Ensures that people who are Deaf and people who are hearing have equal access to needed information.

A relay interpreter:

- Possesses fluency in ASL and natural gestures.
- Acts as a link between people who are Deaf and the sign language interpreter.
- Ensures that both people who are Deaf and people who are hearing have equal access to needed information.

Interpreter Qualifications

IRL interpreters are certified through the National Registry of Interpreters for the Deaf (RID) or have been assessed to determine proficiency by the Interpreter Referral Line. Some interpreters are certified to provide interpretation services in courts of law.

Interpreter Challenges

The process of transforming the spoken language into a sign language and gestures, and sign language and gestures into a spoken language requires skill and stamina. The peak performance output for a sign language interpreter is 30 minutes, after which efficiency levels drop drastically. Breaks are needed and will increase interpretation efficiency. For assignments lasting more than two hours, two interpreters should be used.

Interpreting Profession

The sign language interpreting profession is a new and growing one. Most people do not realize the amount of schooling and training involved in becoming an interpreter. Approximately 4-6 years of training focusing on Deaf culture, American Sign Language, interpersonal aspects of communication, ethics of interpreting, and English, tactile, oral and relay interpreting, to name a few, are required preparation for a person to fully qualify as an interpreter.

An Interpreter works in a variety of settings:

Job Interviews	Hospital and Medical
Vocational Rehabilitation	Performing Arts
Law Enforcement	Religious
Education	Legal
Television	Emergency
Mental Health	Counseling

How to Schedule an Interpreter

Schedule an interpreter as far in advance as possible. Two weeks advance notice is preferred for short appointments. One month in advance is preferred for all-day events or conventions.

The IRL has community interpreters on staff and the Anchorage service pool has an average of 15-20 free lance interpreters.

Interpreters are required to maintain strict confidentiality.

When you call the Interpreter Referral Line you will be asked some basic questions such as:

- The service date and time.
- The name and phone number of the consumer who is Deaf.
- The service address and phone number.
- The topic of the appointment.
- The contact person's name and phone number.
- The preferred sign language system of the consumer who is Deaf (if known).
- Billing information such as who to bill, the address, purchase order numbers (if needed) and any special billing instructions of forms that will need to be included with the bill.

When the IRL confirms an interpreter we will:

- Notify the contact person and the consumer who is Deaf and the interpreter scheduled for the interpretation service.
- The interpreter will bill the IRL. The IRL will process payment and bill the appropriate party for services rendered.

Precautions for Pregnant and Lactating Caregivers

Caregivers who are pregnant, who may become pregnant, or who are lactating must consider hazards in the health care setting that put the fetus or infant at risk. The student has the responsibility to prevent these risks by not putting herself in the following care situations. This might involve notifying the clinical instructor to prevent assignment to high risk patient care situations and/or not assisting with care in these high risk situations.

Antineoplastic Drugs and Radiation Implants

Students who are pregnant, who may be pregnant, or who are lactating should not be involved in direct care of patients receiving antineoplastic drugs (chemotherapy) or radiation implants. These therapies are used most often in treating patients with cancer.

Ribavirin Therapy

Students who are pregnant or lactating, or who may become pregnant during or within four weeks after exposure to ribavirin, should not enter the room of a patient receiving ribavirin therapy. Ribavirin is an aerosol therapy used in treating patients with Respiratory Syncytial Virus (RSV).

Infectious Diseases

Pregnant students should not be assigned to care for patients with:

1. Known or suspected Acquired Immune Deficiency Syndrome (AIDS).
2. Known Hepatitis B or who are carriers, unless the student has received three (3) doses of Hepatitis vaccine and has been documented to have anti-HBs.
3. Rubella or infants with congenital rubella syndrome.
4. Cytomegalovirus infections (CMV).
5. Active tuberculosis infection (TB).

Age-Specific Considerations: The Pediatric Client

In accordance with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the special needs and behaviors of specific age groups need to be considered when defining the qualifications, duties and responsibilities of staff.

What this means for you is that you should modify the care you provide based on knowledge of the clients' growth and development, and their unique safety, biophysical, and social needs.



The pediatric client (generally those under age 18) have the following safety, physical and psychosocial needs (consult other readily available references for more detailed information):

Developmental Characteristics	Examples of Care Responsibility
Infancy: Developing a Sense of Trust	
Attachment to parent	Involve parent in procedure if desired
Stranger anxiety	Have usual caregivers perform or assist with procedure
Sensimotor phase of learning	During procedure use sensory soothing measures (e.g. stroking skin, talking softly, giving pacifier)
Increased muscle control	Expect older infants to resist
Memory of past experiences	Realize that older infants may associate objects or persons with prior painful experience
Imitation of gestures	Model desired behavior (e.g. opening mouth)
Vital Signs	HR: 100-160 BP: 74-100/50-70 R: 30-60

Developmental Characteristics	Examples of Care Responsibility
Toddler: Developing a Sense of Autonomy	
Egocentric	Explain procedure in relation to what child will see, hear, taste, smell, and feel
Negative behavior	Use firm, direct approach
Limited language skills	Communicate using behaviors
Limited concept of time	Prepare child shortly or immediately before procedure
Striving for independence	Allow choices whenever possible but realize that child may still be resistant and negative
Vital Signs	HR: 90-140 BP: 80-112/50-80 R: 24-40

Developmental Characteristics	Examples of Care Responsibility
Preschool: Developing a Sense of Initiative	
Preoperational thought: egocentric	Demonstrate use of equipment
Increased language skills	Encourage child to verbalize ideas and feelings
Concept of time and frustration tolerance still limited	Implement same approaches as for toddler but may plan longer teaching sessions (10-15 minutes); may divide information into more than one session
Illness and hospitalization often viewed as punishment	Clarify why all procedures are performed, such as "This medicine will make you feel better"
Fears of bodily harm, intrusion, and castration	Point out on drawing, doll or child where procedure is performed
Striving for initiative	Give choices whenever possible but avoid excessive delays
Vital Signs	HR: 80-110 BP: 82-110/50-78 R: 22-30

Developmental Characteristics	Examples of Care Responsibility
School-age: Developing a Sense of Industry	
Increasing language skills: interest in acquiring knowledge	Explain procedures using correct scientific/medical terminology
Improved concept of time	Plan for longer teaching sessions (about 20 minutes)
Increased self-control	Gain child's cooperation
Striving for industry	Allow responsibility for simple tasks, such as collecting specimens
Developing relationships with peers	Provide privacy from peers during procedures to maintain self-esteem
Vital Signs	HR: 70-100 BP: 84-120/54-80 R: 20-26

Developmental Characteristics	Examples of Care Responsibility
Adolescent: Developing a Sense of Identity	
Increasingly capable of abstract thought and reasoning	Supplemental explanations with reasons why procedure is necessary or beneficial
Conscious of appearance	Provide privacy
Concerned more with present than future	Realize that immediate effects of procedure are more significant than future benefits
Striving for independence	Impose as few restrictions as possible
Developing peer relationships and group identity	Same as for school-age child but assumes even greater significance
Vital Signs	Adult levels

References:

- The Lippincott Manual of Nursing Practice, 5th Edition, J.B. Lippincott Company, 1991
- Wong and Whaley's Clinical Manual of Pediatric Nursing, The C.V. Mosby Company, 1990
- Alspach, JoAnn Grif (ed). Staff Competencies & Program Design Strategies: A Framework for Assessing Age-Related Competency, Part Two, National Nurses Staff Development Organization, 1997.
- Document written by Major Carol Umstead-Raschmann, 3rd Medical Group, Elmendorf Air Force Base, August, 1995. Modified by Casie Williams, Alaska Native Medical Center, 1998.

Age-Specific Considerations: The Elder Client



- The special needs and behaviors of specific age groups need to be considered when defining the qualifications, duties and responsibilities of staff.
- What this means for you is that you should modify the care you provide based on knowledge of the patient's growth and development, and their unique safety, biophysical, and social needs.

The geriatric patient (generally those over age 65) have the following special safety, physical, and psychosocial needs (consult other readily available references for more detailed information):

Health Maintenance and Preventive Care

- Promote accident prevention among the elderly and their families
- Increased risk for falls and increased mortality from falls due to age, pathologic conditions (osteoporosis), dysmobilities, decline in posture control, environmental risks and medication.
- Protect from infectious diseases by encouraging immunizations (e.g. flu shots) and to contact health care provider with low grade temperatures

Mental Health Aspects/Psychological Needs

- The elderly person is vulnerable to emotional and mental stress from many losses
- Losses through death of spouse, loss of social roles and resources, decreased income, and loss of work role

Psychiatric and Cognitive Disorders

- Disorders include depression, paranoid reactions and dementias. An estimated 15% of elderly persons in the US suffer from a psychiatric disorder
- Depression is the most common emotional disorder (older people account for about 25% of the reported suicides)
- Paranoia may be related to depression, neurologic disorders, and is highly correlated with sensory deficits and loneliness
- Dementia (Alzheimer's is the most common irreversible type)

Nutritional Considerations for the Aged

- Modest weight gain may be associated with decreased mortality in the elderly
- Loss of weight and vitamin deficiencies are common problems in the frail elderly
- There are a number of factors affecting nutritional habits of the elderly
- Social factors (e.g. eating alone)
- Dental problems (e.g. ill fitting dentures)
- Decreased appeal of food (e.g. related to less acute sense of smell)
- Drug-induced malnutrition (e.g. related to changes in taste)
- Need to determine the patient's ability to chew food, prepare food, and feed self

Drug Therapy and the Aged

- Age-related changes predispose elderly to problems with medication side effects
- Absorption, distribution, metabolism, and excretion are all affected by aging
- Be aware that the potential for adverse reactions, interactions and medication induced disease is greater in older persons
- Usually the health care provider will hold the dose to the lowest effective amount. "Start low, go slow" is the guiding axiom
- Reinforce verbal instructions with written instructions. Use large print and simple wording
- Carry out a periodic drug review and assess for patient problems with compliance

Hygienic Care

- Skin Care
- Aging skin is dry, thin and inelastic. Sweat gland and sebaceous gland activity and water-binding capacity of skin are decreased. Avoid soaps that dry the skin, gently pat skin dry and apply lotion (unless contraindicated) and handle skin gently (e.g. increased risk of skin tears when removing tape)
- Oral Care
- Common oral complaints include loss of teeth, dry mouth, abnormal taste, and burning sensations in mouth.
- Encourage increased fluid intake in persons with decreased salivary flow
- Foot Care
- One third of the elderly have foot disorders. Degenerative and systemic diseases, trauma, neglect and misuse cause foot problems in the elderly
- Systemic diseases such as diabetes mellitus, arterial insufficiency, and arthritis often are compounded by loss of sensation, abnormal gait patterns, and impaired vision; the assessment made by the nurse is of prime importance

Other General Considerations

- Speak clearly and directly to assist the patient to discriminate sounds (may have hearing loss). Avoid talking in a high pitched voice and avoid shouting
- Ensure there is adequate light in the patient's surroundings (may have decreased visual acuity)
- Elderly are more susceptible to heat exhaustion (related to decreased ability to sweat) and hypothermia (related to decreased subcutaneous fat)
- Increased time needed for healing after injury or surgery
- Decreased ability to handle physiological stress (i.e. increased heart rate, even mild physical exertion may lead to dyspnea)
- May sleep less as they get older, but feel less rested and may awake at least once during the night
- Increase threshold for pain which may prevent them from recognizing the early signs of disease and/or injury

References

The Lippincott Manual of Nursing Practice, 5th Edition, 1991

Toward Healthy Aging, Ebersol and Hess, 1985)

Illustration ©Katy Dibble Taylor. Used with permission.

Document written by Major Carol Umstead-Raschmann, 3rd Medical Group, Elmendorf Air Force Base, August, 1995.

Modified by Casie Williams, Alaska Native Medical Center, 1998.

QUALITY IMPROVEMENT IN HEALTHCARE ORGANIZATIONS

The State of Alaska and the Joint Commission for the Accreditation of Health Care Organizations, (JCAHO) require hospitals to have quality improvement programs. This has evolved from quality control mechanisms to quality assurance and now to continuous quality improvement.

The JCAHO calls this improving organizational performance. Hospitals may pick the format this takes. The overall action steps are plan, design, measure, assess, and improve. The organization's mission is important as a first step in planning the improvement process. The approach involves a team of multidisciplinary members who work together to improve the quality of an identified process or service. These teams use a quality process such as the FOCUS-PDCAE process for improvement. This acronym is described below:

- Find the process to improve
- Organize a team that understands the process
- Clarify current knowledge of process
- Uncover the root cause of variation and decreased quality
- Start the "Plan-do-check-act" cycle
- Plan the process improvement
- Do the improvement, data collection, analysis
- Check the results and lessons learned
- Act by adoption, adjustment, or abandoning change
- Evaluate effectiveness

Lab proficiency checks and equipment skill checks are two ways that clinical competency are assessed. Clinical chart reviews for appropriateness and pertinence are additional quality activities. Clinical pathways are quality tools being developed and utilized to standardize patient care for a given diagnosis or procedure.

Quality is assessed based on the dimensions of performances. These nine dimensions include efficacy, appropriateness, availability, timeliness, continuity, safety, efficiency as well as respect and caring. Quality is also assessed based on the eleven important functions identified by JCAHO. These include improvement of organizational performance, infection control, coordination of care, assessment of patients, care of patients, management of the environment of care, management of human resources, leadership, management of information, education of patient and family patient rights and organizational ethics.

HOW DOES THIS AFFECT YOU, THE STUDENT?

If you find a problem, or have a great idea for improvement of the organization where you are in clinical rotation, please submit your idea to an RN or manager in the organization for consideration. You may be asked to be a member of an interdisciplinary team who works on an organizational improvement. This way you may bring your own special problem solving skills and creativity to the table.

When State or JCAHO surveyors are in an organization, you may be asked questions about your work there. These may include questions about your interactions with patients such as what have you taught a patient or what care have you learned to provide to a patient. You may also be asked how you have taken the age of the patient into consideration for the delivery of care. The surveyor may also ask you questions about the environment, such as, where is the nearest fire extinguisher, what is the evacuation route for patients in a fire, or what is your role in the various emergency codes?

Putting Your Best Foot Forward: Communication in the Healthcare Setting

As a student working in the health care setting, you are representing the facility. The clients and visitors will look to you for assistance as they would any facility employee. Please keep the following “customer service” concepts in mind when you are in the facility:

1. If patients or visitors ask you a question you can not answer or ask for assistance that you are unable to provide (e.g. directions to a location in the facility), offer to help them find an answer rather than simply saying that you don't know the answer.
2. Don't wait for a patient or visitor to approach you. If you see someone walking around as if they are lost or trying to locate someone or something, offer assistance. If directions to the location are complicated, please consider accompanying the individual to assure that they find their destination without further difficulty.
3. Please refer patients or visitors with complaints to the appropriate staff person. Again, we would ask you to consider accompanying the individual and introducing him or her to the appropriate staff person.
4. Assure that you are providing a positive impression of the facility by your appearance while on duty as well as when visiting the facility to obtain your assignment. You should always be dressed in an appropriate professional manner. When in patient care areas you should be in uniform, following the dress code of the nursing unit and the UAA clinical program, or wearing a clean, neat lab coat over street clothes.
5. When answering the telephone, please identify the unit, provide your name and identify yourself as a student. It helps to smile when you answer the telephone -- it really makes a difference in the sound of your voice.
6. If you are not able to provide the caller with the information he or she is seeking, explain your planned actions. For example, “I am going to put you on hold while I locate Nurse Smith. It should not take more than two minutes.” If there is a delay, return to the phone, explain the delay, and provide the individual with the option of continuing to hold or to leave a message.
7. When using a pager system, follow the instructions provided by the facility. If the pager allows a verbal message, speak slowly and clearly. Identify the unit, provide your name, identify yourself as a student, and provide the telephone number the individual should call. The telephone number should be repeated.
8. After leaving a telephone or pager message asking for a return call, notify the unit staff. This will allow them to easily refer the call to you when the individual calls back.

The Identification of Abuse (Domestic Violence)

**Deb Hansen, RN, BSN
Alaska Native Medical Center
June, 2001**

This self-study module will assist health care providers to be able to identify victims of abuse, or domestic violence. After completing this self-study series each participant will be able to:

- Recognize 5 of the common threads in identifying abuse
- Distinguish 3 identifiers of abuse in children 0 to 5 years of age, children 6 to 12 years of age, children 13 years of age and older, adults, and elders, and
- Integrate the ABCDE Model of Intervention into your practice

This self-study module incorporates an assessment of your current knowledge of abuse, abusers and their victims, reading material found below, and links to websites to further your knowledge on the subject of abuse.

After completion of this program, please complete the post-test and complete the evaluation. This self-study has been approved for 3 hours of continuing education credit.

Fact or Fiction: What beliefs do you have about abuse? *[answers on page 133]*

- | | | |
|---|------|---------|
| 1. Approximately 10% of women are subjected to abuse, or domestic violence (DV)..... | Fact | Fiction |
| 2. Abuse or domestic violence only happens within poor or working class families..... | Fact | Fiction |
| 3. The offender can be a loving partner..... | Fact | Fiction |
| 4. Violent men cannot control their violence..... | Fact | Fiction |
| 5. Violent men are mentally ill or have psychopathic personalities..... | Fact | Fiction |
| 6. Women who don't leave violent relationships enjoy being abused..... | Fact | Fiction |
| 7. Women can leave violent relationships anytime, if they really want to..... | Fact | Fiction |
| 8. Women who are abused many times provoke the abuse..... | Fact | Fiction |
| 9. Alcohol or drug abuse causes abuse..... | Fact | Fiction |
| 10. Low self-esteem causes victims to get involved in abusive relationships..... | Fact | Fiction |
| 11. Even if a victim leaves an abusive relationship, they will just get involved in another abusive relationship..... | Fact | Fiction |
| 12. Abusers abuse because they are under a lot of stress or unemployed..... | Fact | Fiction |
| 13. Children are not affected when one parent abuses the other..... | Fact | Fiction |
| 14. DV involving only the parents is irrelevant to parental fitness..... | Fact | Fiction |

A Brief Review of Domestic Violence and Screening

Domestic violence occurs when one person uses direct or threatened physical, sexual, economic or psychological violence in order to establish and maintain power and control over another person.

These activities also result in fear.

Due to the emotional impact of domestic violence, and the frequency of its occurrence, the stress that this program might elicit for some participants must be acknowledged. Some participants:

- might experience a heightened fear of violence and increased vulnerability
- may feel uncomfortable, angry or disbelieving
- might remember past violence they were affected by
- may feel distressed by the training if they are living in a violent relationship, and/or
- might choose to disclose their experience of DV within the group.

We must always remember that abuse, or DV, affects many people. It may have touched your life or the lives of people you work with or socialize with. Nearly one in three adult women experiences at least one physical assault by a partner during adulthood. Within each person's social or work group, it is highly likely that there will be people who have had either direct or indirect experience with domestic violence.

If personal issues arise during this program, participants are encouraged to take a break from the material.

Health Care Providers (HCPs) have the responsibility to educate themselves about the dynamics of DV, the safety and autonomy that abused patients require, and cultural competency as it relates to domestic violence. They need to become trained on how to ask about abuse, and to then intervene with identified victims of abuse. When this occurs, HCP will be able to participate in Universal Screening.

Screening should occur with every patient over the age of 14, whether or not symptoms or signs of DV are present, and whether or not the HCP suspects abuse has occurred. The HCP must also be aware that people and organizations will deny the incidence and impact of DV on the quality of the service delivery; this is also known as Levels of Resistance.

Identifying Victims of Abuse: Common Threads

Some of the known common threads of abuse that health care providers should be aware are:

- injuries are difficult to account for as accidental
- injuries on an area of the body normally covered by clothing
- accompanying individual wants to speak for patient and insists on staying close
- substantial delay between time of injury and presentation for treatment
- depression in the injured person
- sleep disturbances in the injured person
- medical history reveals many "accidents" with injuries of suspicious origin
- multiple sites of injury
- physical assault followed by an increase in general medical symptoms and emotional problems

The knowledge of these common threads is vital for health care providers; when any of these are noted, a thorough screening for abuse must occur. When assessing patients it is also important to have the knowledge of what different age groups might exhibit if they are living in an abusive household, or are a victim of abuse.

Children 0 to 5 years of age who are living in abusive situations, or who are victims of abuse, may have

- physical complaints
- sleep disturbances
- bed wetting
- excessive separation anxiety
- be clingy and anxious
- failure to thrive

Children six to twelve years of age may

- behave in ways to reduce tension
- attempt to control parental violence
- fear being abandoned
- fear being killed or fear themselves killing
- fear their own anger and other's anger
- have eating disturbances
- are insecure and distrustful of their environment

BOYS

- act out
- have tantrums
- participate in fights
- have low frustration levels
- are bullies

GIRLS

- have somatic complaints
- are withdrawn and passive
- are approval seeking
- are mother's little helper
- have low frustration levels or infinite patience

Children 13 years of age and older who live in abusive homes, or are victims or abuse may

- abuse alcohol and/or drugs
- run away
- have early pregnancies and marriages
- have suicidal thoughts and actions
- have homicidal thoughts and actions
- participate in criminal activities

Adults also have specific symptoms that can be observed. Some of these are they

- have higher stress levels
- have poor eye contact, are nervous
- seem evasive, embarrassed, ashamed of injuries
- have higher levels of anxiety, depression and psychiatric illness
- are 5 times more likely to commit suicide
- frequently present to medical caregivers with somatic complaints such as headaches and a variety of gastrointestinal disorders
- experience twice as many miscarriages
- have reduced coping and problem-solving skills
- appear frightened of partner
- are more likely to be socially isolated, use alcohol and drugs, and abuse dependent children
- have chronic illnesses such as asthma, seizure diabetes and hypertension that are difficult to manage.

Women suffering from abuse, or DV, present a range of injuries, physical complaints, and psychological symptoms that are suggestive of abuse. The injuries could be

- concussions, broken bones
- scars from burns or knife wounds, bruises, cuts: these injuries have what is called a “central pattern”, occurring on the head, face, neck, throat, chest, breasts, abdomen and genitals.
- bruises in patterns resembling hands, belts, cords, or other weapons
- injuries that indicate a defensive posture, such as bruises to the ulnar aspect of the forearm, the back, the back of the head
- multiple injuries in various stages of healing, especially those that the victim might attempt to conceal, suggest physical violence occurring over a period of time
- “spontaneous” abortions, miscarriages and premature labor

The physical complaints could be

- pelvic pain, stomach pain, headache, chronic pain and gynecologic problems
- partial hearing loss; complaints of ringing in their ears

The psychological symptoms of abuse these women might exhibit are

- feelings of hopelessness
- distress and anxiety, which when severe may lead to depression and suicide attempts

Elders can show signs of abuse and neglect with the symptoms of

- bruises
- urine burns
- excoriation

Identifying Victims of Abuse: Screening

When a Health Care Provider is screening a patient to discover if they live in an abusive household, or are a victim of abuse, they must be aware that perpetrators, or abusive personalities, tend to

- hover over their victim, the patient
- show concern
- answer for the patient
- constantly blame everyone but oneself
- exhibit obsessive behavior
- have threatening behavior
- present oneself as the victim
- claim powerful associations (having friends in important places)
- exhibit paranoia/hypersensitivity
- demonstrate belligerence towards authority figures
- have access to weapons
- abuse substances

It is important therefore that health care providers understand how to screen for abuse. This knowledge will allow them to be effective in their practice.

One model that is used to screen is The ABCDE Model of Intervention

A- Ask to be alone. All screenings should take place apart from the patient's partner or other family member/visitor to create an environment of safety and privacy. This is to ensure that the victim is able to disclose if they choose to do so. A disclosure is highly unlikely if health staff attend to the victim with their partner present.

- Before asking questions about DV, preface questions with
 - ⇒ "We know that DV is a national problem, so I ask all my patients this/these question(s)."
 - ⇒ "Any information given is confidential and will not be revealed to anyone, including the batterer" (unless the injury is a mandatory reportable injury such as gunshot wound, etc.).
- You can also ask
 - ⇒ "When I see this type of injury, it may be due to domestic violence."
- This question should be asked of everyone on admission to the ER or hospital:
 - ⇒ Do you have a safe place to go at discharge?
- Optional questions to ask:
 - ⇒ Are you currently in a harmful physical or emotional relationship?
 - ⇒ Have you been hit, kicked, punched, shoved or otherwise hurt by someone in the past year?
 - ⇒ Are you in a relationship in which you are treated badly? In what way?
 - ⇒ Do you feel your partner controls or tries to control you too much?
 - ⇒ Does your partner threaten to harm you in anyway?

B- Believe the disclosure. No matter how unbelievable or bizarre the story, believe it as victims rarely lie about the violence that they have endured; if anything they minimize it.

Acknowledge the courage: "I know it took a lot of courage for you to tell me what you just did and I am glad you told me."

Validate: "I believe what you told me is true. No one deserves to be treated this way."

Empathize: "I am sorry this happened to you, it should not have. I do not believe it is your fault and I care about what has happened to you."

Generalize: "I am glad you have told me about this. Abuse happens to many people, and yet people may often feel as if they are the only one who is experiencing this.

Empower: "Talking to someone about your experiences can be very supportive. I may be able to give you some information that may be helpful to you now or in the future. I believe that only you know what is best for you and your children. Whatever decisions or choices you make today are the choices that are best for you now."

- C- Call in resources. Be aware of agencies who can assist the victim, such as women's refuges, DV counselors, sexual assault referral centers.
- D- Document history and injuries. This is vitally important as this documentation may be used in court to support a victim's case.
- E- Ensure safety. The safety of the victim and any children involved is paramount. The HCP should ask the victim if they fear for their safety or for the safety of any children. The HCP should always be aware that the severity of previous violence is no indicator of future violence, and than many victims minimize the violence. Research has clearly shown that violence generally escalates both in frequency and severity. Never treat any threat that a perpetrator makes as idle.

What To Do During Discovery

Key concepts to remember when trying to discover if someone is living in an abusive household or a victim of abuse are the following:

DO

- Ask about violence.
- Listen.
- Believe.
- Acknowledge the seriousness of DV as a health problem.
- Stress that no one deserves abuse; they are not responsible for the violence.
- Communicate to the victim that their survival means that they did the right thing.
- Explore and dispel myths.
- Have a short list of local resources that can be given to DV victims (must be business card size so it can be hidden easily).
- Ensure the victim has the opportunity to make decisions about events which affect their life, such as whether to report the crime, tell family and friends.

DO NOT

- Blame or shame.
- Moralize.
- Ignore the disclosure of abuse.
- Put yourself in the rescuing role; instead appreciate the victim's strengths.
- Align yourself with the abuser.
- Ask "Why don't you leave?"

Discovery in the Pediatric Setting

In the pediatric setting screening for abuse is clearly appropriate, but raises important and complex questions including when and how mothers of pediatric patients should be screened. Screening mothers in pediatric settings will reach women who may be victims of abuse and who come in contact with HCP only through their children's care. Screening mothers in this setting will also indicate to HCP whether the pediatric patient may be at risk for direct abuse or as a children witness to DV.

Histories given by children are the most important factor in assessing possible abuse. The results of physical examination are shown to be normal or nonspecific in 83% to 94% of cases. When physicians refer children to specialists for suspicious physical findings, without any verbal history from the child, only 14% of them will have suspicious genital or anal findings on examination.

Discovery in Elders

When an elder visits an emergency unit with bruises, urine burns, excoriations or other unusual presentations, those symptoms are many times attributed to disease in old age. If HCP's are to make a difference in the lives of the elderly who suffer from the effects of abuse and neglect, this must change. A mistreatments assessment question needs to be included into the clinical evaluation of all elderly patients. HCP need to be able to discern what can be attributed to disease, medication or simply neglect in older people.

As with other ages, interview the elder alone so he or she may speak openly. Ask the elder if there is any family violence he or she wishes to discuss, and consider cultural sensitivities when asking. And, just with other ages, many elders are relieved to be asked a straightforward question. Clinically note any signs and symptoms inconsistent with the person's history; take color photographs of unusual bruises. Finally, be sure to discuss a safety plan with the elder, providing phone numbers of resources that can be accessed.

If an elder is being mistreated, evaluate the entire family system. Other family members may be at risk for harm as well.

Conclusion

Violence is a learned behavior. In this country we teach ourselves to be violent at a young age. Criminal violence and socially legitimate physical violence, or punishment, are visible parts of contemporary culture. Violence permeates society through graphic media, movies, and television. Health care providers, like everyone, are susceptible to the resulting pervasive desensitization.

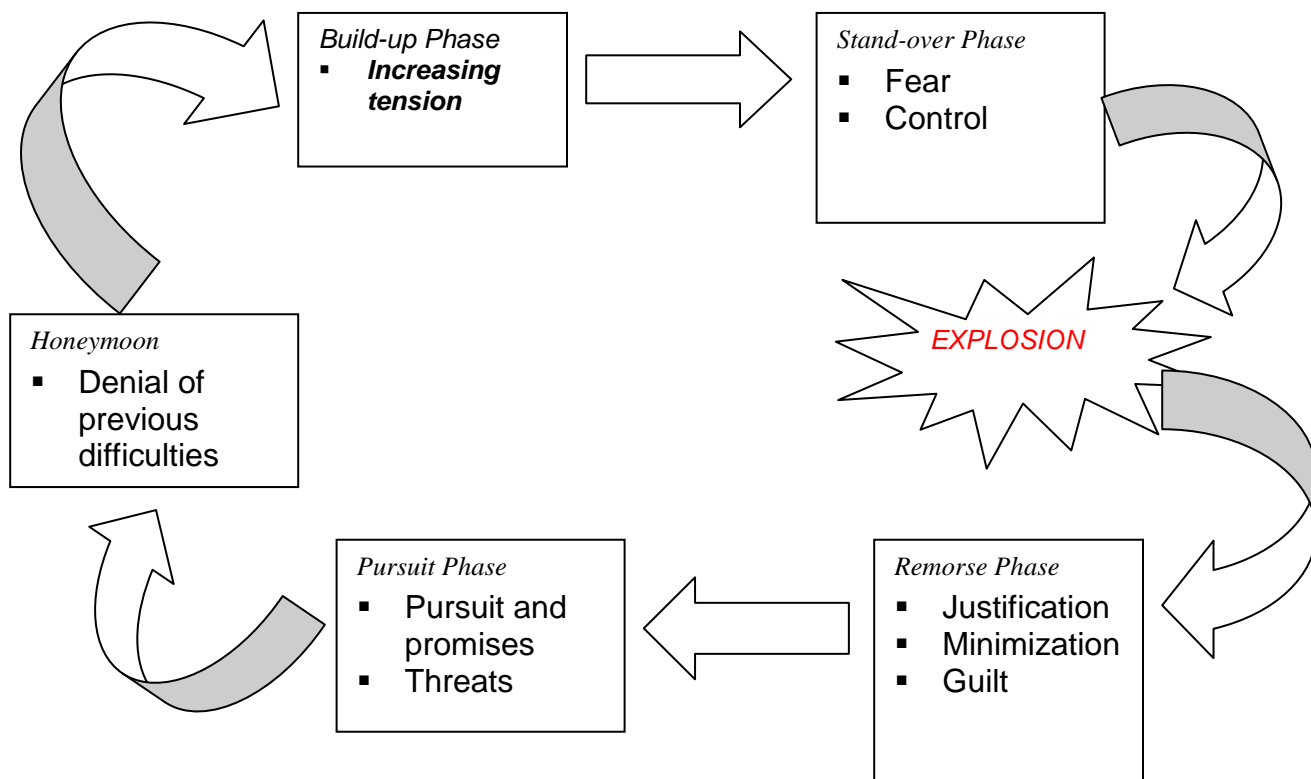
We have to ask what we can do to intervene. The primary role of the HCP is to assess and treat any medical trauma, recognize an abusive situation and prevent further injury to the victim.

Hope and fear are the common denominators in keeping women trapped in abusive situations. They are fearful of the greater danger to herself and her children i.e. retaliation, fear of the court process, fear of losing the children, fear of an inability to obtain work and/or housing, cultural and religious constraints, social isolation, lack of information regarding resources available to her and hope that he might change.

Seventy-eight percent of patients in one survey favored routine inquiry. Battered individuals report that one of the most important parts of their interactions with their HCP was being listened to about the abuse they have suffered. Just as victims strategically manage or contain a violent episode with the use police calls, it is likely that many patients acutely use the emergency department visit itself as temporary shelter to successfully de-escalate the violence.

Domestic violence is a major cause of injury, disability, homicide, homelessness, addiction, attempted suicide, and child abuse. DV is also responsible for a range of physical and mental health problems associated with recurring injuries and ongoing abuse. As a result, victims and perpetrators of battering command a substantial proportion of a community's health, criminal justice, and social service resources.

THE CYCLE OF VIOLENCE



Statistics of Domestic Violence

- DV of women is statistically consistent across socioeconomic, racial, ethnic, religious, or age boundaries.
- The risk of DV of women increases during pregnancy and after separation or divorce.
- In the US, studies indicate that DV victims comprise 22-55% of women seeking care for any reason in emergency departments, 14-28% of women seen in ambulatory medical clinics, and 23% of women seeking routine prenatal care.
- The greatest risk factor in being a victim of DV is being female. 90-95% of DV victims are women.
- Nearly 1 in 3 adult women experience at least one physical assault by a partner during adulthood.
- Female victims of violence are 2.5 times more likely to be injured when the violence is committed by an intimate than when committed by a stranger.
- Women ages 19-29 report more violence by intimates than any other age group.
- 40% of teenage girls aged 14-17 report knowing someone their age who has been hit or beaten by a boyfriend.
- Violence against women occurs in 20% of dating couples.
- An average of 28% of high school and college students experience dating violence.
- 4 to 14% of adult pregnant women experience physical violence from an intimate partner.
- 19% of Alaska Native report experiencing physical abuse during pregnancy.
- 20 to 26% of pregnant teens reported being physically abused by their boyfriends.

- Abuse during pregnancy has been linked with maternal health problems such as smoking, decreased weight gain and substance use.
- Abuse during pregnancy has been linked with infant problems such as low birth weight, miscarriage, and fetal distress.
- Femicide (homicide of pregnant women) is now the leading cause of maternal mortality (death immediately before or after delivery) in at least 2 US cities, rather than the traditional causes like toxemia.
- Perpetrators have at least two common traits-the majority have witnessed domestic violence in their family or origin, and are male.
- 95% of domestic violence perpetrators are male.
- The age of abusers ranges from 17-70. 66% of abusers are between the ages of 24-40.
- Of women who reported being raped and/or physically assaulted since the age of 18, 76% were victimized by a current or former husband, cohabitating partner, date or boyfriend.
- 47% of men who beat their wives do so at least 3x per year.
- In Boston, at least 1/3rd of the DV victims the EMS department treats refuse to be transported to the hospital.
- 15-50% of abused women report interference from their partner with education, training or work. (*Abusers sabotage their victims' attempts to work.*)
- 6 months after obtaining a protection order: 8% of victims reported post-order physical abuse; 26% reported the batterers came to or called their home or workplace; 35-65% reported no further problems.
- Protection orders do not appear to deter most types of abuse, but they do significantly reduce the likelihood of acts of psychological abuse such as preventing the victim from leaving their home, going to work, using a car or telephone, and stalking and harassing behaviors.
- Female victims of domestic violence are 6x less likely to report crime to law enforcement as female victims of stranger violence.
- In 1996, among all female murder victims in the US, 30% were slain by their husbands or boyfriends.
- 65% of intimate homicide victims are physically separated from the perpetrator prior to their death.
- 88% of victims of DV fatalities had a documented history of physical abuse.
- 44% of victims of intimate homicides had prior threats by the killer to kill the victim or self, 30% had prior police calls to the residence.
- In 1994, 38% of domestic homicides were multiple-victim, usually combining a spouse homicide and suicide, or child homicide.
- When there are multiple victims in a domestic homicide, 89% of perpetrators are male.
- 40-60% of men who abuse women also abuse children.
- In homes where a male abuses a female, children are 15 times more likely to be abused.
- When a woman is living in a violent relationship, she is 8 times more likely to abuse her children than when she is safe.
- A child's exposure to the father abusing the mother is the strongest risk factor for transmitting violent behavior from one generation to the next.
- When children are killed during a domestic dispute, 90% are under the age of 10; 56% are under the age of 2.
- The prevalence of DV among Gay and Lesbian couples is around 25-33%.
- Abuse in relationships is the third largest health problem for gay men.
- 7 states define DV in a way that excludes same-sex victims; 21 states have sodomy laws that may require same-sex victims to confess to a crime in order to prove they are in a domestic relationship.
- Many of the 1500 shelters and safe houses for battered women routinely deny their services to victims of same-sex battering.

- DV is thought to be more prevalent among immigrant women than among US citizens.
- Many immigrant batterers and victims believe the penalties and protections of the US legal system do not apply to them.
- Less than 3% of women visiting emergency rooms disclosed or were asked about domestic violence by a nurse or physician.
- The use of emergency room protocols for identifying and treating victims of domestic violence has been found to increase the identification of victims by medical practitioners from 5.6% to 30%.

Identifying Victims of Abuse: Follow-through

Before a health care provider can put closure to this topic, they must also have the knowledge to:

- Document their findings.
- Refer to the appropriate agencies.
- Ensure follow-up for the victim and/or family is in place.

These are topics that will need to be researched independent of this self-study module.

More Information

Further information regarding abuse, and the identification of abuse can be found at the following websites:

- Family and domestic violence. Mar. 1998. Health Department of Western Australia. <http://www.health.wa.gov.au/publications>. Go to the these links:
 - Family and Domestic Violence – what it is and how health services can provide assistance
 - Family and Domestic Violence Training package Participants' Kit
 - Family and Domestic Violence Training package Trainers' Kit
- Myths and facts about domestic violence. 1997. The Commission on Domestic Violence. <http://www.abanet.org/domviol/myths.html>
- National Domestic Violence, 1999. National Domestic Violence Hotline. <http://www.ndvh.org/> Go to these links:
 - Hotline Services
 - Are You or is Someone You Know Being Emotionally or Physically Abused?
 - Domestic Violence Statistics for U.S.
- Who is most likely to be affected by domestic violence? 1999. The Commission on Domestic Violence. <http://www.abanet.org/domviol/whois.html>

After completion of this self-study module which includes 1) an assessment of your current knowledge of abuse, abusers and their victims, 2) reading this document, and 3) linking on to the above websites and then synthesizing the information, you will need to complete the post-test and course evaluation to obtain the 3 hours of continuing education credit. The objectives that each participant should be able to meet after completing this self-study series are:

- Recognition of the 5 of the common threads in identifying abuse.
- Distinguishing 3 identifiers of abuse in children 0 to 5 years of age, children 6 to 12 years of age, children 13 years of age and older, adults, and elders.
- Integrating the ABCDE Model of Intervention into your practice.

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Identification of Abuse Self-Study - Answer Sheet

Fact or Fiction: What beliefs do you have about abuse?

- | | |
|---|---------|
| 1. Approximately 10% of women are subjected to abuse, or domestic violence (DV). | Fiction |
| 2. Abuse or domestic violence only happens within poor or working class families. | Fiction |
| 3. The offender can be a loving partner. | Fact |
| 4. Violent men cannot control their violence. | Fiction |
| 5. Violent men are mentally ill or have psychopathic personalities. | Fiction |
| 6. Women who don't leave violent relationships enjoy being abused. | Fiction |
| 7. Women can leave violent relationships anytime, if they really want to. | Fiction |
| 8. Women who are abused many times provoke the abuse. | Fiction |
| 9. Alcohol or drug abuse causes abuse. | Fiction |
| 10. Low self-esteem causes victims to get involved in abusive relationships. | Fiction |
| 11. Even if a victim leaves an abusive relationship, they will just get involved in another abusive relationship. | Fiction |
| 12. Abusers abuse because they are under a lot of stress or unemployed. | Fiction |
| 13. Children are not affected when one parent abuses the other. | Fiction |
| 14. DV involving only the parents is irrelevant to parental fitness. | Fiction |

ABUSE OF ADULTS AND ELDERERS

Dorothy Kinley RN, July 2004

What is considered abuse of elders? For the purpose of this discussion the definition of abuse is “The intentional or reckless non-accidental and non-therapeutic infliction of pain, injury, mental distress or sexual assault.”

Federal definitions of elder abuse, neglect and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act. These definitions were provided in the law only as guidelines for identifying the problems and not for enforcement purposes. Currently, elder abuse is defined by state law, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes the abuse, neglect or exploitation of the elderly. Broadly defined, however, there are three basic categories of elder abuse:

- Domestic elder abuse.
- Institutional elder abuse.
- Self-neglect or self-abuse.

In most cases, state statutes addressing elder abuse provide the definitions of these different categories of elder abuse, with varying degrees of specificity. Domestic and institutional elder abuse may be further categorized as follows:

Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. It may include, but is not limited to, such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, it may also include the inappropriate use of drugs and physical restraints, force-feeding, and physical punishment.

Sexual abuse is defined as non-consensual sexual contact of any kind with an elderly or disabled person or with any person incapable of giving consent. It includes but is not limited to unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

Emotional or psychological abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, treating an older person like an infant; isolating an elderly person from his/her family, friends, or regular activities; giving an older person the "silent treatment;" and enforced social isolation are examples of emotional/psychological abuse.

Neglect is defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder. Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care. Neglect typically means the refusal or failure to provide an elderly person with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials included in an implied or agreed-upon responsibility to an elder

Exploitation is defined as misusing the resources of an elderly or disabled person for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

What is self-neglect? Self-neglect occurs when individuals fail to provide themselves with whatever is necessary to prevent physical or emotional harm or pain. The reasons that vulnerable adults neglect their own needs are often complicated, and frequently people are unaware of the severity of their situation.

What are the signs? Some common signs that may indicate self-neglect include obvious malnutrition; being physically unclean and unkempt; excessive fatigue and listlessness; dirty, ragged clothing; unmet medical or dental needs; refusing to take medications or disregarding medical restrictions; home in a state of filth or dangerous disrepair; unpaid utility bills; lack of food or medications.

What are the causes? Depression can cloud a person's view of the world and their circumstances, leading to self-neglecting behavior. Often, elderly people lose their motivation to live due to their loneliness and isolation. Other reasons that elders neglect themselves can include unexpressed rage, frustration or grief; alcoholism or drug addiction; and sacrificing for children, grandchildren or others at the expense of their own unmet needs. Finally, mental or physical illness can quickly result in the deterioration of an elder's ability to adequately provide for his or her own needs.

What can be done to help? Respectfully involve the elder in the effort to determine the cause of their particular case of self-neglect if at all possible. Sometimes understanding and cooperation can be reached simply by having someone acknowledge and discuss their situation with them. If appropriate, ask the question, "What would make life meaningful for you again?" Allow them to express their feelings; this could reveal both the cause of the problem as well as its solution. Depending upon the circumstances, other helpful actions could include: medical or dental treatment; anti-depressant medications; helping them get involved in a favorite old hobby or providing transportation to a social group; getting them a pet; confronting them with their self-neglect; getting family members involved. When drug or alcohol addiction is the issue, hospital-based treatment is frequently the best solution. Sometimes the cause of elders neglecting themselves is directly related to the influence of someone else in their life. Perhaps the elderly individuals are sacrificing their needs in order to care for grandchildren or an ill spouse. Intervening in such situations often requires extreme caution, as the elder may be resistant to any change which threatens the relationship. Use your judgment to weigh the options, and involve professionals if it seems appropriate.

Facts about Maltreatment

In 1996, Adult Protective Services across the nation received 293,000 reports of abuse, neglect, or exploitation involving persons over the age of sixty living at home, excluding reports of self-neglect. Of these, over 188,000 confirmed that some type of maltreatment did occur.

Abused elderly or disabled persons may be isolated, ill, without a capable person to care for them, or without resources to meet basic needs. If Adult Protective Services has determined that they are in a state of abuse, neglect, or exploitation, they are eligible for adult protective services.

If clients are competent enough to consent to services, they have the right to:

- Receive protective services.
- Participate in all decisions about their welfare.
- Choose the least restrictive alternative(s).
- Refuse medical treatment.
- Withdraw from protective services.

Assessment — Possible Indicators

The following descriptions are not necessarily proof of abuse, neglect, or exploitation. But they may be clues that a problem exists, and that a report may need to be made to law enforcement or Adult Protective Services.

Physical Signs

- Injury that has not been cared for properly.
- Injury that is inconsistent with explanation for its cause.
- Pain from touching.
- Cuts, puncture wounds, burns, bruises, welts, rope burns on the extremities, sprains or dislocations.
- Multiple injuries or fractures in various stages of healing.
- Injuries to the trunk, abdomen, genitals, buttocks or upper thighs.
- Bruises in clusters or regular patterns appearing over several planes of the body.
- “Wraparound” injuries that occur when someone is struck with a belt.
- Bilateral or parallel injuries that suggest control marks or forceful restraining. (Shaking, for example will cause bruising on both upper arms.)
- Unusual hair loss, redness or swelling of the scalp, or hemorrhaging below the scalp line.
- Dehydration or malnutrition without illness-related cause.
- Poor coloration.
- Sunken eyes or cheeks.
- Inappropriate administration of medication.
- Soiled clothing or bed.
- Frequent use of hospital or health care/doctor-shopping.
- Lack of necessities such as food, water or utilities.
- Lack of personal effects, pleasant living environment, personal items.
- Forced isolation.
- Presence of lice or fleas.
- Pressure ulcers or contractures.
- Urine burns.
- Glasses, dentures, hearing aids and walking devices are in poor repair or missing.
- Any indication that the patient was left unsafe or alone for long periods of time.

Signs by Caregiver

- Prevents elder from speaking to or seeing visitors.
- Anger, indifference, aggressive behavior toward elder.
- History of substance abuse, mental illness, criminal behavior or family violence.
- Lack of affection toward elder.
- Flirtation or coyness as possible indicator of inappropriate sexual relationships.
- Conflicting accounts of incidents.
- Withholds affection.
- Talks of elder as a burden.

Behavioral Signs

- Fear
- Anxiety
- Agitation
- Anger
- Isolation
- Withdrawal
- Depression
- Non-responsiveness, resignation, ambivalence
- Contradictory statements, implausible stories
- Hesitation to talk openly

Signs of Financial Abuse

- Frequent expensive gifts from elder to caregiver.
- Elder's personal belongings, papers, credit cards missing.
- Numerous unpaid bills.
- A recent will when elder seems incapable of writing will.
- Caregiver's name added to bank account.
- Elder unaware of monthly income.
- Elder signs on loan.
- Frequent checks made out to "cash."
- Unusual activity in bank account.
- Irregularities on tax return.
- Elder unaware of reason for appointment with banker or attorney.
- Caregiver's refusal to spend money on elder.
- Signatures on checks or legal documents that do not resemble elder's signature.

Verbal Reports

As you listen to what the patient says is happening, does the explanation make sense? Has the caregiver threatened the patient, withheld medical care, meals, hydration or hygiene? How are the patient's financial affairs handled? How do they get what they need?

Many elderly persons fear that if they become bothersome, they will be thrown out-of the home by the caretaker of the nursing home. So they try to hide that they are becoming incontinent for example. They may also try to hide any onset of reduced functionality, such as evidence of Alzheimer's, memory loss or an inability to perform routine tasks. The key is to get the person to open up. Relatives may be unaware of difficulties. By bringing family members in on the discussion health care providers can help clear the air as well as discuss options that the elder can accept.

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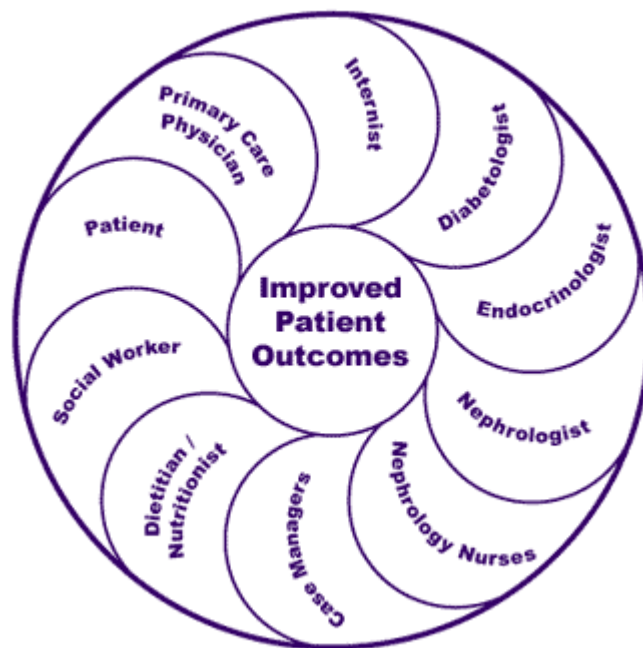
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TEAMWORK IN HEALTHCARE

A multidisciplinary team approach is vital in the management of complex patients to assure that they receive comprehensive and coordinated care, ensuring their health and well-being and diminishing the negative outcomes of care.

An effective team approach includes collaboration among the primary physician, physician specialists, patient, family members and all other team members. Depending on the patient's individual needs, in addition to nurses, other team members may include case managers, social workers, mental health professionals, dietitians, pharmacists, physical and occupational therapists.

Multidisciplinary Team Members



Example of multidisciplinary team members involved in care for a patient with chronic kidney disease. ©Ortho Biotech Products, L.P. 2002 <http://www.beactive.info> Accessed 8/13/02.

All team members should participate in development of the individual plan of patient care to help improve outcomes for the patients. Team members must define roles early and communicate often.

Nursing students can serve as important members of the multidisciplinary team. When caring for patients they should:

- follow the individual plan of care designed for the patient by the team;
- communicate changes in patient condition to team members, as appropriate; and
- participate in multidisciplinary care conferences, when possible.

GENERATIONS AND HEALTHCARE

Taking care of the different generations and their different expectations for the healthcare they receive throughout their lives

Master Sergeant Amy S. Fierro
3rd Medical Group
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Generations Defined

A “generation” is based on the range of birth years of a group of people. Generations can span many years; not all members of a generation exhibit the same traits. Traits develop during the formative growth years of that generation. Someone born in 1966 would be influenced by an early-1970s childhood and a 1980s young adulthood. These influences affect people’s values and attitudes throughout their lives. A generation is largely influenced by the social, political, historical, and economic context in which they grow up.

Understanding the values that people have and putting people into their “comfort zones” can help open the lines of communication. Note that generations are defined by the birth dates of their members and that later factors are what influenced them. The following information is generalizations that describe some specific traits of each generation. Each individual’s values and beliefs may differ. These descriptions help to show how each group gained its core knowledge and beliefs.

The Silent or Traditional Generation (born 1909-1945)

The Traditionalists (also known as Matures, Seniors, Builders, Silent Generation) are over the age of 59 years old. Comprising 26% of our population, they include the depression-era kids and the war babies. They were influenced by the Great Depression, World War II, and the atom bomb. They remember the Kennedy assassination, Watergate, Vietnam and the radical 70s. They lived through severe economic upheaval and frightening dangers. They grew up in tough times when simple things were rationed, when saving for a rainy day was considered prudent, and when morals and ethics defined the character of an individual. They appreciate discipline, hard work, and self-denial.

Traditionalists are slow to embrace anything new. They distrust change and would prefer the status quo. They saved their money, learned to do without, and consider retirement and leisure time suitable rewards for sacrifices made earlier in their lives. They appreciate and buy products that satisfy their basic values. Their credo is “use it up, fix it up, make it do, or do without”, avoid debt, save and buy with cash. They are overall social and financial conservatives.

The Baby Boomers (born 1946-1964)

Baby Boomers or “Boomers” are between 40 and 59 years old. This generation represents the largest population group ever born in the U.S. at 78 million (30% of our population) and is the most influential group of all. They were born to post-WWII prosperity when the economy expanded rapidly. Boomers have enjoyed unprecedented opportunities in education and in employment. They are the “feel good” generation, who take good things in life for granted. They are the “me” generation, who feel entitled to a “good life”. They are self-righteous and self-centered. They want to do it by themselves, and they want to be individual. To them, autonomy is key. Boomers are the “spoiled” kids of this century, their parents dedicated their lives to giving their children more than they had. They are more self-absorbed, and typically seek instant gratification. “Buy it now and use credit.” They are more tolerant than other generations. They expect prosperity, yet they believe they have a right “to do their own thing”. Boomers embrace social programs easily. Most seek purpose and personal fulfillment in their lives. Despite this “feeling good” attitude, this generation is the hardest working. They invented the “Thank God, it’s Monday!” and the 60-hour work week.

Generation X (born 1965-1980)

The Generation Xers (also known as Baby Busters, Generation 13-ers) are between 24 and 39. This is the smallest generation in terms of numbers due to birth control and working moms. At 45 million strong, they comprise 17% of our population. They see new technology rapidly changing their world, and to them, nothing is permanent. They crave feedback and flexibility, yet despise close supervisor. They expect immediate recognition. They saw the Berlin Wall crumble and were directly affected as political, corporate and social structures imploded worldwide. They watched their parents suffer devastating job losses, and they became wary and uncertain about their own future. Busters are disillusioned with almost everything. They have been called the "why me" generation and the "whiners". They feel they are reaping the sins of the generations before them. Thus, some call them "Gen 13-ers" after a medieval fable where the 13th generation is the last to suffer from a curse on their predecessors.

Where the Boomers are idealists, the Busters are pessimistic and blame Boomers for today's problems. Busters are reactive, yet introverted. They appreciate "cocooning" and "getting away." Gen-Xers are very clear about the meaning of the word "balance" in their lives; work is work. They work to live, not live to work. "It's just a job" is an oft-heard mantra for Xers. Their loyalties revolve around themselves and their friends/families, not their jobs. Yet they are quite social with their own generational group. They think communally and often make decisions together

They are short on loyalty and weary of commitment. This generation grew up a skeptical group due to fractured family systems. Over half of them come from broken homes or live in a "blended" family. The Busters are the first of the "latch key" kids. They've been jostled, jolted and pushed back and forth by everyone and everything around them; this has taught them independence. With a very low trust level, they fear that you too, aren't sincere. They are late to marry and quick to divorce. They desperately want something real in their lives, something lasting. They seek truth in life and in others around them.

Generation Y (Why) (born 1981-present)

Rapid change IS the way of life for the Generation Y born since 1980. This generation, (also referred to as Nexters, Mosaics, Millennials, Net Generation) is under 24 and represents a refreshing mindset as they join Boomers and Busters in society. Having watched their parents and grandparents deal with change, Millennials are growing up in a world that is constantly in motion, constantly revising and restructuring itself. To them, change is normal and visual. They experienced the Gulf War through the video arcade realism of television.

Through it all, Millennials are developing an amazing optimism and a conviction that the future will indeed be better for all. They appear well grounded and wise for their young age. They aren't as radical as the Baby Boomers or as materialistic as the Busters. But they are goal oriented and highly motivated toward their perceptions of success. They were taught to question parents/teachers and the status quo. Each seems to have established specific objectives with a clear path toward achievement.

With the different generations come different challenges in providing healthcare. A new demanding, outspoken healthcare consumer is replacing the more obliging patient of past.

Healthcare and the Generations

Experts suggest this attitude shift can be partly explained by the distinct personalities of different generations of Americans. Baby boomers—who are the largest group of healthcare consumers—tend to be more informed, opinionated, and difficult to please than their seniors, for example. Overall, research shows that a patient's age—from senior on down to twenty-something—explains a lot about his or her attitude toward health care.

The Mature Attitude

Older Americans grew up when healthcare information wasn't easily accessible. So to many of them, medicine was mysterious and what their physician said was final.

Even now it would not occur to many seniors to challenge their physicians the way many younger patients do. For many seniors—including her own parents—"whatever the physician says to do they do." Despite the trust they place in their physician, they are skeptical of the technology that has sent medicine far into the future. A quick trip to the hospital for a same-day surgical procedure may cause high anxiety for the senior who prefers a cautious approach to their health care.

Older Americans are generally more satisfied with their health care overall than baby boomers and young adults, although they are the most demanding in terms of the complexity of their illnesses and medications.

Older people are the most likely of any adults to have built long-term relationships with their health providers, a good indicator of satisfied patients. A 1998 report by the Center for Studying Health System Change in Washington, D.C., shows that 90 percent of people over 55 have a usual source of care, the highest percentage among all adults. People over 55 are also most likely to have health insurance, which means they have better access to care in the first place. Only 15 percent of those over 55 reported having difficulty getting health care in the past year, the lowest percentage among adults.

Boomer Consumers

Baby boomers—now 40 to 59 years old—crave convenience and control, two standards that are difficult to achieve in healthcare. Boomers won't stay with health providers who make them wait.

In addition to valuing convenience, boomers expect providers to listen to them completely, answer their questions fully, and be receptive to their ideas. They expect them to be willing to discuss health information they pulled off the information highway or to give them details about the drug they just saw on television or read about in a magazine.

Boomers have seen amazing progress in medicine; they've witnessed the near eradication of polio and childhood diseases. They remember a time when all surgeries were major events, rather than outpatient procedures. But while they appreciate these advances, they are still critical of their own experiences receiving care. The healthcare industry has emphasized high-tech over high touch. Boomers are now clamoring for both.

Generations X, Y, Z

Young adults won't reach their peak consumption of health care for many years, so researchers haven't studied their attitudes in-depth. One thing is clear: They have the highest rate of being uninsured of any generation. They are no longer eligible for their parents' insurance and may take jobs that don't offer insurance. And some young adults choose not to be insured even if they have the option. Young adults are generally healthy, so they think they're going to live forever.

If they do have insurance, they may face inconsistency in their care providers because they tend to switch jobs a lot and may be forced to switch health plans with every new company. Of course, many young adults do have insurance. A subgroup of this young adult population is highly educated and internet-savvy, and has precise ideas about what they want for health care.

Building Bridges Across the Generations

Age is important in predicting a patient's attitudes, but prior experience with the healthcare system carries more weight. Age—along with other demographic variables like sex and income—aren't always the best predictors of attitude. Past behavior is the best indicator of future behavior. To ensure the best response, get acquainted with each generation's values and respect differences of individuals. All generations value honesty and open lines of communication.

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