Exposure to bloodborne pathogens via needlesticks and blood and bodily fluid exposures continues to be a significant problem among nurses and other health care workers. The pathogens that are of serious concern are human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV). Though the risk of transmission is low, the fear and anxiety after an occupational exposure can be devastating.

Health care workers, among them mostly nurses, are exposed to dangerous and deadly bloodborne pathogens (BBPs) on a daily basis through contaminated needlesticks, other sharps, and splashes of blood and other potentially infected bodily fluids (Foley & Leyden, 2005; “Role of Preventable Infections,” 2008). The most common BBPs that are transmitted through occupational exposures are hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

The risk of acquiring a bloodborne pathogen from an occupational exposure depends upon several factors such as the type of exposure (mucocutaneous or percutaneous), depth of injury, visible blood on device, procedure involving needle placed directly in a vein or artery, terminal illness in source patient, or post-exposure use of prophylaxis. While the risk of transmission is low, the debilitating effect of these diseases makes each potential exposure a very frightening experience for the exposed employee (Association for Professionals in Infection Control and Epidemiology, Inc. [APIC], 2005; Centers for Disease Control and Prevention [CDC], 2005; Foley & Leyden, 2005; HIV Clinical Resource, 2008). The purpose of this article is to educate nurses about prevention and management of occupational exposure to BBPs with emphasis on post-exposure prophylaxis (PEP), follow-up, prevention of exposures and secondary transmissions, and bloodborne pathogens standards.

**Occupational Exposure**

Occupational exposure means contact with blood or other potentially infectious materials through needlesticks, splashes, human bites, cuts, and abrasions that may result from the performance of daily nursing duties.
President’s
MESSAGE

It’s About You: Opportunities, Options, and Optimism

Kathleen A. Singleton

Summertime gatherings include family reunions, workplace picnics, vacations, and just time away. It’s a chance to take time to rejuvenate, relax, reconnect, and be refreshed by sun, fun, and taking a break from your usual routine. I hope you are enjoying the summer. In the meantime, rest assured that AMSN is continuing to work on your behalf to advance the specialty of medical-surgical nursing.

The AMSN Board of Directors (BOD) recently met at the National Office in sunny Pitman, NJ. The BOD took time to connect with the staff that supports every operational aspect of your AMSN membership activities and services. We left our busy professional and personal lives behind, shared a few minutes catching up with each other, laughed and visited over dinner, and spent much time aligning our volunteer activities with the new strategic plan. Assembling the elements of the strategic plan brings much cause for optimism, volunteer opportunities, and options for ongoing professional development.

AMSN is able to lead the medical-surgical specialty and provide professional development opportunities to you because of the dedicated work of our members who volunteer their time, talent, energy, enthusiasm, and expertise. The AMSN volunteer is the lifeblood of our professional organization. Our volunteers work tirelessly, selflessly, and brilliantly, and make phenomenal strides to advancing the practice of medical-surgical nursing. AMSN recognizes the complex work demands of today’s health care environment, the fast pace of the information age, competing priorities at home and at the bedside, and the generational-based expectations of the volunteer experience. To capitalize on our volunteers’ time, we moved from a predominately standing committee structure that lasted for an indefinite period of time to task forces.

A task force is a group that is convened for the duration of a specific project. Under the direction of a charter or a tool that provides a clear description of the task at hand, the group accomplishes the goal. A charter includes background information, the purpose of the work, and outlines expectations, objectives, timeframes, resources, and the deliverable product or work. Building the task force includes putting out a call for volunteers with the requisite skill set to effectively accomplish the goal. The task force structure gives the volunteer flexibility, a prescribed timeframe of commitment, and the satisfaction of completing professional work with a team of dedicated medical-surgical nurse colleagues.

What's in it for You?

Volunteering for your professional specialty nursing organization brings you many intangible rewards and learning opportunities which can’t be found elsewhere. Making this type of contribution to AMSN also helps your colleagues — other medical-surgical nurses — and our specialty. AMSN offers many ways to engage your talent and skill and nurture your inner, untapped potential. Just as the current medical-surgical nursing workforce is comprised of four generations, AMSN offers a variety of ways to engage and promote the growth and development of the medical-surgical nursing specialty along your entire career path. The majority of volunteers participate because someone asked for help. I am asking you to consider contributing to our most important professional cause — the investment in nurturing each other through your professional nursing specialty organization, AMSN.

continued on page 17
Janet E. Burton

Is Your Work Environment Healthy?

The work environment of medical-surgical nurses and nurses of other specialties has been the subject of many studies in the last few years. Fortunately these studies have brought the idea that nurses cannot provide excellent care in an environment of disrespect and incivility to the forefront. I personally can join the ranks of other bedside medical-surgical nurses who can share stories about unhealthy work environments.

I remember once being summoned to the evening shift supervisor’s office, where she informed me that I had been chosen to be hypnotized by a physician. This physician claimed there was no staff member on duty that he could not hypnotize. The supervisor countered his claim by stating she was sure there was one person he would not be able to hypnotize, thus my summons to her office. Did I feel threatened? Yes. Did I feel I had no way out? Yes. I was much younger then and it was not accepted in those days to refute authority. Besides, the physician was between me and the door, so I could not simply walk out of the office. Was he successful? No. I mentally willed myself to not give him control of my mind.

The AMSN leadership has asked the MedSurg Matters! Editorial Committee to write a series of articles on the characteristics of an unhealthy work environment (UWE) and to identify strategies to change the workplace culture to a positive environment. Some of the topics to be discussed in this series are nurse-physician relationships, bullying, “eating our young,” generational differences, management support, and wellness of employees. This first article will set the stage by defining a healthy work environment (HWE) and identifying the American Association of Critical Care Nurses (AACN) Standards for Establishing and Sustaining Healthy Work Environments (AACN, 2005).

As previously mentioned, studies by the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing, National Quality Forum, Agency of Healthcare Quality and Research, and other nurse researchers provide evidence that an UWE leads to poor patient outcomes, increased mortality, nurse burnout, decreased nurse retention and recruitment, and medication errors. These studies will be referenced in future articles of this series. One most often thinks of an UWE as being characterized by negative behaviors, passive-aggressive behaviors, verbal abuse, hostile attitudes, undermining activities, and withholding information (Nickitas, 2008). An UWE is further characterized by a leadership style that does not create a healthy environment.

A HWE that encourages and empowers nurses and promotes respect and civil behaviors is the key to “unlocking excellence in clinical practice and patient safety” (Nickitas, 2008, p. 390). This environment will have a nursing leadership team that promotes a culture where negativism, demoralizing, and unsafe working conditions are no longer acceptable. AACN states that nursing’s work environment “must be safe, healing and humane, respectful of the rights, responsibilities, needs and contributions of patients, their families, nurses and all health professionals” (2005, p. 5). Research by Aiken, Clarke, Sloane, Lake, and Cheney (2008) supports the belief that hospitals that achieve the American Nurses Credentialing Center (ANCC) Magnet® status have the characteristics of a HWE for nurses. Although research supports this belief, it is also possible to have a HWE in an institution that has chosen not to pursue Magnet status.

AACN created a nine-member panel to develop standards that describe a HWE. Once the panel’s work was completed, the standards were validated by 50 expert reviewers (AACN, 2005). The standards are evidence-based and are in alignment with competencies for health care professionals which are recommended by the Institute of Medicine. The standards do not address patient safety, nursing education and credentialing, or clinical practice because these areas are addressed by other regulatory and professional groups.

The six AACN standards for establishing and sustaining HWEs are: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership.

Skilled communication is described by AACN as “a two-way dialogue in which people think and decide together” (2005, p. 16). This standard requires the nurse to be as skilled in written, verbal, and nonverbal communication as he or she is in clinical skills. Ineffective professional relationships lead to mistrust, disrespect, stress, and dissatisfaction. A HWE will have a zero tolerance policy for negative and disruptive behavior in the workplace (AACN, 2005).

AACN describes true collaboration as “a process, not an event” (2005, p. 20). This process centers on mutual respect for the knowledge and abilities of all professionals involved in a patient’s case. The result of this type of collaboration is safe and quality patient care. A nurse, as the single constant person present during a patient’s hospital stay, is responsible for the patient’s safety, is a patient advocate, and collects data that are used by other professionals in making patient care decisions. In spite of other professionals seeing the nurse as responsible for patient safety, few physicians actually regard nurses as effective members of the decision-making team. The nurse is a vital link in the decision-making process and must be a valued member of this process (AACN, 2005).

Appropriate staffing is one of the hot topics across the nation today. It is well-documented that adequate staffing with an appropriate number of registered nurses results in better patient outcomes and nurse satisfaction as well as less nurse turnover and burnout. Staffing models must be flexible and able to adjust to changing patient’s needs rather than focusing on a fixed nurse-

continued on page 7
The population of the United States is becoming increasingly more diverse racially and ethnically. It is predicted that by 2015, diverse populations will constitute over 30% of the population. Cultural competency is about developing the knowledge, skills, and resources to effectively care for patients of diverse cultures. Culturally competent nursing care requires the ability to provide respective and effective patient care.

There are 35.5 million minority individuals living in the United States. This number will continue to increase as more individuals seek refuge or a new beginning here. Culturally competent nursing care is a standard of practice in today's multicultural health care settings, and nurses must develop these skills in order to effectively meet the health care needs of patients from a variety of cultures (Coffman, 2004).

Schim, Doorenbos, and Borse (2005) stated in order for cultural competent nursing care to occur, nurses need a knowledge base, attitudinal framework, and skill set to appreciate, accommodate, and negotiate cultural and individual variations in beliefs, values, lifestyles, and other elements that encompass cultural differences. There is also evidence that nurses who receive prior education and/or experience in cultural diversity report significantly higher levels of cultural competency versus nurses with no prior education and/or experience in cultural diversity (Schim et al., 2005).

The challenge for nurses to become culturally competent is not new. For many years, nurse anthropologists, educators, and researchers have stressed the importance for nurses to gain cultural awareness and to demonstrate knowledge and understanding of each patient’s culture (Green-Hernandez, Quinn, Denman-Vitale, Falkenstern, & Judge-Ellis, 2004).

The Meaning of Culture

Culture is a dynamic and unique force that can be defined as the learned values, beliefs, and practices of individuals or groups (Leininger & McFarland, 2006). Cultural practices can be affected by the social environment in which a group lives and will evolve over time. Changes are usually gradual and constant. Culture can be instrumental in guiding individual actions and behaviors. Leininger and McFarland (2006) also pointed out that culture has many unspoken rules for life that can influence how individuals exist.

Personal Values

Defining one's own personal values, beliefs, and biases is the beginning stage of becoming a culturally competent nurse. Reflection on personal values can help provide clarification into what is important for oneself (Green-Hernandez et al., 2004). Camphina-Bacote’s cultural competency model emphasizes that cultural competency is an ongoing process and nurses must continue to develop knowledge and skills to effectively care for diverse patients (Camphina-Bacote, 2002).

There are five constructs to Camphina-Bacote’s cultural competency model. The first construct – having cultural awareness – requires examining one’s own culture and recognizing one’s own prejudices and biases about individuals who are culturally diverse. The second construct – cultural knowledge – involves a nurse’s willingness to understand and gain knowledge about another individual’s cultural values and beliefs, which is a key component to providing culturally competent nursing care. The third construct – cultural skill – is the ability to accurately conduct a culturally competent nursing assessment. The fourth construct – cultural encounters – involves nurse interactions with culturally diverse patients. Cultural interactions can help nurses decrease assumptions and stereotyping that existed about a cultural population. Finally, cultural desire is the nurse’s motivation and desire to become more culturally involved with his or her patients (Camphina-Bacote, 2002).

Cultural Responsiveness

Nurses who have the desire to become culturally responsive to the health care needs of diverse patients will begin to engage in the process of cultural competency in their nursing practice. The following scenario provides an example of a culturally responsive nurse versus a non-responsive nurse.

A nurse received a change of shift report on a 58-year-old African American male who had been admitted to the medical-surgical floor with a diagnosis of congestive heart failure. The off-going nurse reported this was the patient’s first admission into the hospital. Additional background information reflected that the patient has a close extended family and was a member of a local church community. The patient has several visitors and frequent phone calls throughout the day and night. Often times, family members have stayed overnight at the hospital.

A nurse who may not have the motivation or desire to provide culturally competent nursing care may find the frequent visits and phone calls disruptive, rude, or annoying. However, the culturally responsive nurse will recognize that the church members and extended family are typically the cornerstone of the African American family. Frequent visits and phone calls are a mechanism by
which concern and care are demonstrated among African Americans. The culturally responsive nurse will integrate these values into the plan of care for the patient.

A Cultural Awareness Assessment Tool, designed to assess caregiver cultural awareness, can assist nurses in examining their own cultural values, beliefs, and biases as they relate to providing culturally responsive nursing care. Nurses’ ability to reflect upon their own level of cultural awareness will help develop the knowledge and skills needed to provide culturally competent care. Figure 1 shows an example of a cultural awareness assessment tool. The questions should be answered honestly so the score can provide valuable insight into the individual nurse’s cultural awareness.

**Cultural Assessment**

Once a nurse has decided to become proactive in providing culturally competent nursing care, the next step is to begin developing a plan of care that includes conducting a culturally competent, focused patient care assessment. This assessment is a tool that is used to obtain cultural information (both objective and subjective) to assist the nurse in meeting all needs of the patient.

Objective data includes the physical examination. For example, an important assessment should include the ability to recognize differences in skin color of diverse patients. It is important to recognize and understand that variations in skin tone can affect the ability to recognize various pathological skin conditions such as petechiae, anemia, and jaundice, all of which may indicate an acute condition (Dennis & Small, 2003).

Collecting details pertaining to patient medications should be included in objective data. Nurses must be able to recognize that diverse patients metabolize medications differently, which may impact therapeutic ranges and thresholds. For example, African Americans may experience a reduction in efficacy of ACE inhibitors and may also experience a higher incidence of angioedema (Adams, Holland, & Bostwick, 2008). Nurses providing culturally competent nursing care will recognize these differences.

**Figure 1. Cultural Awareness Assessment Tool**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Directions: Please enter A, B, or C for each item listed below that best reflects your honest response to the statement. Instructions on interpreting your answers are provided at the end of the tool.</th>
</tr>
</thead>
<tbody>
<tr>
<td>___1. I use bilingual, bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation treatment, interventions, meetings, or other events for individuals and families who need or prefer this level of assistance.</td>
<td>A = Things I do frequently  B = Things I do occasionally  C = Things I do rarely or never</td>
</tr>
<tr>
<td>___2. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.</td>
<td>9. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.</td>
</tr>
<tr>
<td>___3. I intervene in an appropriate manner when I observe other nursing staff or clients within my health care organization engaging in behaviors that show cultural insensitivity, racial biases, or prejudice.</td>
<td>10. I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural or ethnic groups.</td>
</tr>
<tr>
<td>___4. I understand and accept that family is defined differently by various cultures (e.g., extended family members, fictive kin, and godparents).</td>
<td>11. I understand that grief and bereavement are influenced by culture.</td>
</tr>
<tr>
<td>___5. I accept and respect that male-female roles may vary among different cultures and ethnic groups (e.g., high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).</td>
<td>12. I seek information from individuals or families that will help in service adaptation to respond to the needs and preferences of the culturally and ethnically diverse served by my health care organization.</td>
</tr>
<tr>
<td>___6. I understand that age and life-cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decision of elders, the role of the eldest male or female in families, or roles and expectation of children within the family).</td>
<td>13. When assessing a client, I seek information on acceptable behaviors, courtesies, and customs that are unique to culturally and ethnically diverse groups of my health care organization.</td>
</tr>
<tr>
<td>___7. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision-makers for services and support that may impact their lives.</td>
<td>14. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my organization.</td>
</tr>
<tr>
<td>___8. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.</td>
<td>15. I am aware of the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically, and racially diverse populations served by my organization.</td>
</tr>
<tr>
<td>___9. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.</td>
<td>16. I am well versed in the most current and proven practices, treatments, and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.</td>
</tr>
<tr>
<td>___10. I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural or ethnic groups.</td>
<td>17. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and support to culturally, ethnically, racially, and linguistically diverse groups.</td>
</tr>
<tr>
<td>___11. I understand that grief and bereavement are influenced by culture.</td>
<td>18. I seek information from individuals or families that will help in service adaptation to respond to the needs and preferences of the culturally and ethnically diverse served by my health care organization.</td>
</tr>
<tr>
<td>___12. I seek information from individuals or families that will help in service adaptation to respond to the needs and preferences of the culturally and ethnically diverse served by my health care organization.</td>
<td>19. I am aware of the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically, and racially diverse populations served by my organization.</td>
</tr>
<tr>
<td>___13. When assessing a client, I seek information on acceptable behaviors, courtesies, and customs that are unique to culturally and ethnically diverse groups of my health care organization.</td>
<td>20. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my organization.</td>
</tr>
</tbody>
</table>

In reviewing your answers, please note there is no answer key with correct responses. However, if you frequently responded “C,” you may not necessarily demonstrate beliefs, attitudes, values, and practices that promote culturally competent nursing care.

Source: Goode, 2000. Adapted with permission from the National Center for Cultural Competence.
nences and respond by providing individualized patient education.

Subjective data obtained in a culturally competent assessment includes information regarding the patient’s response to pain, which can be culturally influenced. In addition, obtaining patient food preferences can give nurses insight to provide optimal nutrition that respects each patient’s cultural beliefs and values. This is particularly important when family members request to provide culturally familiar food from home.

Finally, obtaining information regarding family structure is important. Family structure can affect how a patient responds to health and illness. It is a component that provides a patient with social comfort, which can help aid in restoring and/or maintaining the patient’s overall health and well-being (Maier-Lorentz, 2008).

The Health Care Environment

Nurses do not care for patients alone. Providing culturally competent nursing care at the bedside will involve a multidisciplinary commitment which includes leadership and various members of the health care team. Leadership is clearly a critical element to the success of a diversity initiative. Health care administrators such as the chief nursing executive and the chief operating officer will need to support the importance of culture competency in the workplace. For example, health care administrators can provide culturally competent workshops for staff nurses. Money can be allocated for language assistive devices that will aid nursing staff to effectively communicate with patients when language is a barrier. Some workplace initiatives may include the development of policies regarding cultural competency and the development and implementation of a code of conduct to support cultural sensitivity.

Health care organizations can facilitate cultural competency in the workplace by valuing cultural diversity and seeking to improve the ability to care for patients of diverse cultures. According to Olavarria, Beaulac, Bélanger, Young, and Aubry (2009), organizations that are culturally competent seek to obtain knowledge that support the cultural values and beliefs of the patients they serve.

Nurse managers set the tone for the nursing staff and for a positive nurse-patient care environment. They have the responsibility to facilitate nursing staff involvement in organizational change, particularly as it relates to cultural diversity on nursing units.

Conclusion

Acquiring culturally competent capabilities requires the nurse to integrate cultural awareness, knowledge, and skills into nursing practice. Culturally competent care requires the ability to provide respectful and effective patient care. Research has shown that cultural competency education is the key element to providing culturally competent nursing care to all patients. Some of the suggested educational strategies include workshops and in-service programs to increase the level of nursing knowledge and skills in caring for patients of diverse backgrounds. As diverse populations continue to increase in the United States, nurses will be required to become culturally knowledgeable, sensitive, and competent.

References


Angela Groves, RN, MSN, BC, is Assistant Professor of Nursing, Notre Dame College, South Euclid, OH.

Corporate Spotlight

Linet Americas is an operating unit of Linet, an international leader in healthcare technology. Founded in 1990, Linet has beds installed in 93 countries and is now considered one of the most dynamic companies in the healthcare field. Based in Charlotte, North Carolina, Linet Americas opened its U.S. headquarters in 2010 by introducing its top-selling bed, the Eleganza, to the U.S. market. With over 120,000 installations around the world, the Eleganza family of products deliver functionality, simplicity, and reliability while providing effective management of a hospital’s capital budget and improving patient care. Backed by the industry’s best warranty, Linet beds are recognized for low cost of ownership, simple maintenance, and innovative design. Visit www.linetamericas.com for more information.
Healthy Work Environments continued from page 3

patient ratio. Appropriate staffing means there must be a match between patient needs and nurse competence (AACN, 2005).

Every nurse longs to be recognized by his or her peers and nursing leaders as being a valued member of the health care team. AACN (2005) proclaims that meaningful recognition is a central element of the HWE and is essential to the growth and development of nurses. Inadequate recognition is often cited as the primary reason nurses leave a place of employment or the nursing profession altogether.

AACN (2005) describes the nurse leader in a HWE as being a skilled communicator, a team builder, positive change agent, committed to service, results-oriented, and a role model for collaborative practice. Nurse leaders must embrace the concept of a HWE and be positioned to influence decisions that affect nursing practice and the work environment.

Is your workplace healthy? Has it been “diagnosed” as being unhealthy and on a “treatment plan” for changing the culture? AMSN is concerned about the environment that nurses work in and has established a task force on Nursing Work Environment. The purpose of this task force is to examine work environmental issues and develop a toolkit containing resources that are timely and helpful to the medical-surgical nurse in creating a healthy work environment. Along with this new column in MedSurg Matters!, AMSN plans to provide you with assistance in establishing, enhancing, and maintaining a healthy work environment.

References

Janet E. Burton, MSN, RN, CMSRN, is a Clinical Nurse Specialist/Clinical Nursing Instructor, Columbus Regional Hospital, and a Medical-Surgical Nursing Instructor, Ivy Tech Community College of Indiana-Columbus, Columbus, IN. She is the Editor of MedSurg Matters!

Write for us! Do you have something to say about healthy work environments? Send us an email at msmnews@ajj.com if you’d like to share your thoughts in an upcoming column.

Congratulations!

Honor a Newly Certified Nurse

Sitting for a medical-surgical certification exam like the CMSRN certification can be stressful. If you know someone who passed the exam, say “Congratulations” in a unique way. Make your wishes public when you donate to the AMSN Scholarship and Awards program. Your donation will go toward AMSN’s scholarships and grants, and your personalized message to your friend will be printed in a future edition of MedSurg Matters! You can make your donation online at www.amsn.org through the Scholarship and Awards section or by mailing your request with payment. Not only will you be recognizing your friend, you’ll be advancing med-surg nursing!
"My Deadline Is What?!"
Why Publishers Need Your Materials so Early

Carol M. Ford

For anyone who has ever written “on deadline,” you know how difficult it can be to meet on your target date of submission. Life often has this funny way of simply getting in the way. Whether it’s work, family, the laundry, the dishes, Emily’s piano recital, catching up with an old school pal, or that can’t-miss episode of Lost, “something” always manages to sneak in and steal away those precious moments of time you had set aside to write. By 11:00 p.m., you’re just barely awake enough to raid the half-empty container of chocolate chip cookie dough ice cream before crashing into bed, knowing you have to do it all over again tomorrow. The “Write Column for Newsletter” item on your to-do list gets moved from Tuesday to Wednesday, and you mumble half aloud, half to yourself as you drift off to sleep, “One more day won’t matter. The editor can just drop it and you mumble half aloud, half to yourself as you drift off to sleep. By the time next Monday rolls around, you have managed to write your column, and you send it proudly off to the editor, in. How much time does the publisher really need, anyway?”

By the time the episode of Lost, “something” always manages to sneak in and steal away those precious moments of time you had set aside to write. By 11:00 p.m., you’re just barely awake enough to raid the half-empty container of chocolate chip cookie dough ice cream before crashing into bed, knowing you have to do it all over again tomorrow. The “Write Column for Newsletter” item on your to-do list gets moved from Tuesday to Wednesday, and you mumble half aloud, half to yourself as you drift off to sleep. “One more day won’t matter. The editor can just drop it in. How much time does the publisher really need, anyway?”

Frustrated and angry, you resign yourself to the belief that the publisher’s deadlines are much too rigid for manuscript submission. After all, newspapers and other print items publish daily. Why does this publisher require such an early deadline?

The Publication Process: From Soup to Nuts

Publishing deadlines across the country and around the world vary depending on each individual publisher. Some publishers are in operation only during normal business hours, while others have shifts that work around the clock. Newspapers and weeklies, for example, usually have 24-hour staff; therefore, they are able to publish up-to-the minute news and items of current interest. They also have certain staff dedicated to working on one publication only; in other words, 100% of their time is devoted to one particular publication. This is the nature of those media, and it is quite different from scholarly journals, periodicals, magazines, and newsletters that are published monthly or bi-monthly. Often, editorial and art staff employed at such publishing firms must divide their time between several publications, and to meet every publication’s particular deadline, production schedules are created to allow plenty of lead time.

Regardless of the type of publication, deadlines set forth by the publisher must be respected. If an author does not adhere to the deadlines, it could mean a delay in publication or the publisher’s decision to pull the author’s manuscript from the lineup. This article provides a brief overview of the publication process for peer-reviewed journals and newsletters, giving a “behind the scenes” look at why those early deadlines are so important.

Blind Peer Review

The editor and editorial staff of scholarly publications typically request the first draft of a manuscript to be submitted at least six months prior to an intended issue. These manuscripts are sent out to colleagues considered to be experts in the field of the manuscript’s topic, and they review the manuscript content for accuracy. In addition, these reviewers can offer suggestions to strengthen the manuscript grammatically and structurally. This is a blind review, and the identities of reviewers and authors are kept confidential. Reviewers typically have three to four weeks to complete the review and return the manuscript to the editor with comments.

Comments from reviewers, as well as the editor’s own suggestions, are compiled by the editor and sent to the author. A revision of the manuscript will likely be requested. If you are an aspiring author, don’t panic! Nearly every manuscript submitted will have at least one revision request. Authors should keep in mind that these suggested changes are meant to enhance the published article. It is never fun to have your work critiqued; however, this revision stage is for the benefit of the author to help make the article as dynamic as possible. Pay attention to what the editor and reviewers have to say, and do your best to submit the revision by the date specified.

Layout and Design/Page Proofs

After the manuscript has been accepted for publication, it will be slated for a particular issue. The author may not hear from the publisher for several months. That does not mean the publisher has forgotten about the manuscript; rather, it means that no further work can be done on the manuscript until it gets closer to the issue’s deadline. It is acceptable to contact the publisher to check on your manuscript. It is also important to communicate any times of the year you may be away while your manuscript is active so the publisher knows where you can be reached.

The manuscript will generally be edited twice, once by the editor and once by the managing editor, prior to layout and design. There may or may not be author queries during this time. The manuscript will then be formatted, and the author will see a proof of his or her article to approve or make last-minute changes, which should be kept to a minimum. It is most impor-
tant for the author to review the page proofs carefully and in a timely manner.

Turn-around time for page proof corrections can vary depending on the publisher. The editor and managing editor will also proof and re-read the formatted article. Authors’ corrections are collected by the managing editor, reviewed by both the editor and managing editor, and incorporated into the formatted article. Authors should not resubmit a Word document of a revised manuscript in lieu of highlighted corrections on the proof; at this late stage in the process, the publisher is unable to return to the early stages of manuscript development and begin the process over again. Failure to respond to author queries and page proof requests in the timeframe given can result in delay of publication or having the article pulled.

**Imposition**

When a publication enters the imposition stage, all author queries and edits should be complete. At this stage, editorial content and advertisements are “married” into the final publication. If an article has been delayed, it can wreak havoc, causing the entire issue to sit in limbo for the duration. It may also result in late publication and distribution.

Working with both editorial and advertising staff, the art department will construct the issue, ensuring that everything fits together perfectly. A set of page proofs encompassing the entire publication is created, and the editor and advertising and editorial staff review the issue one last time before it is sent to the printer. The art department uploads the issue to the printer via a secure Web site, and the printer sends a blueline – the printer’s version of a final proof – to the publisher as one final check before printing begins.

**What Does this Mean for Me As an Author?**

Generally, the process from raw manuscript to published issue for a peer-reviewed, scholarly publication takes approximately six months or longer from start to finish. Many factors are involved, including the quantity and quality of manuscripts, as well as the cooperation from key players – the editor; reviewers; editorial, art, and advertising staff; and most importantly, the author. When all work in tandem, the final issue and the articles therein have the potential to make the author and publisher proud. It only takes one, however, to step out of sync with the others to bottleneck the process and cause disarray.

As the author, you are in control. While you will most likely be faced with revision requests and article queries, your quick and direct attention to your editor and publisher will get your article published. Remember, they are working for you, not against you. By complying with the tricks of the publishing trade, you can place yourself in the position to learn, become an established author, and continue your successful journey down the publishing road for years to come.

Carol M. Ford, BA, is Director of Editorial Services, Anthony J. Jannetti, Inc., Pitman, NJ.

© Jannetti Publications, Inc., 2010
www.ajj.com

---

Write for Us

If you would like to submit a manuscript on any of these or other topics, please email msnews@ajj.com.

We are more than happy to mentor novice writers!

**Manuscript Wish List**

- Image of nursing portrayed in media
- Process and effects of hospitals going green
- H1N1 influenza
- Health care reform
- Impact of economy on nursing shortage
- Nursing education
- Wellness programs for nursing staff
- Evidence-based care
- Stroke in young adults
- Genitourinary disorders
- Gastrointestinal diseases
- Congestive heart failure
- Pain management for addicted/detox patients
- Care of aggressive/psychiatric patients
- Transplants and transplant care
- HIV/AIDS and prevention
- Assertive behavior and unsafe practice
- Pancreatitis
- VA care/war trauma
- Infection control
- Renal disease and peritoneal dialysis
- Musculoskeletal health
- Clinical leadership

---

Clinical Nurse Specialists: Influencing the Medical-Surgical Arena

The Clinical Nurse Specialist (CNS) role was developed in the 1950s with a focus on advancing clinical practice. Today, CNSs function in all patient care arenas and advance nursing practice by providing inter-professional, system-wide leadership. CNSs create, monitor, and evaluate cost-effective, evidence-based policies, procedures, protocols, and best practice models.

The first week in September marks the second annual celebration of Clinical Nurse Specialist recognition week. It is an opportunity for CNSs to highlight their contributions in their organizations, and hopefully an occasion for staff to recognize them for the difference they make in nursing practice on the medical-surgical unit.

Considering a career as a CNS? Go to www.NACNS.org for a wealth of information regarding education requirements and practice tools.

Elizabeth Thomas, MSN, RN, APRN-BC, is a Medical-Surgical Clinical Nurse Specialist, Albert Einstein Healthcare Network, Philadelphia, PA, and a member of the MedSurg Matters! Editorial Committee.
The Case of the Wilted Plant

Remember the scientific method of grade school days? Ask a question, do background research, construct a hypothesis, test your hypothesis through an experiment, analyze data and draw conclusions, and communicate your results. These steps were drilled into us in each science course from grade school through high school. Eventually we found ourselves in nursing school and we learned about the nursing process. Is there any relationship between the scientific method and the nursing process? Many believe the two mirror each other (see Table 1).

The nursing process can be overwhelming to new nursing students. Here is an effective way I have introduced the nursing process concepts to my students. A few days before the lesson, I buy a small plant and let it wilt and be on its way to dying when I take it to class. Table 2 illustrates how I use what they are familiar with (the scientific method) and transfer that knowledge to a new way of thinking (the nursing process). After this exercise, I begin the formal presentation of the nursing process.

The nursing process becomes a way of thinking and a way of life for nurses. Do you assess veins of the person at the next table in a restaurant to determine if he or she would be a difficult stick? Are you always “ready to work?”

Suggested Readings

Table 1. Comparison of the Steps of the Scientific Method and the Nursing Process

<table>
<thead>
<tr>
<th>Scientific Method</th>
<th>Nursing Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask a question.</td>
<td>Assessment</td>
</tr>
<tr>
<td>Do background research.</td>
<td>Assessment</td>
</tr>
<tr>
<td>Construct a hypothesis.</td>
<td>Nursing Diagnosis</td>
</tr>
<tr>
<td>Test your hypothesis through an experiment.</td>
<td>Planning and Implementing</td>
</tr>
<tr>
<td>Analyze data and draw conclusions.</td>
<td>Evaluating</td>
</tr>
<tr>
<td>Communicate your results.</td>
<td>Documentation in the Medical Record</td>
</tr>
</tbody>
</table>

Table 2. Applying the Scientific Method to the Nursing Process

<table>
<thead>
<tr>
<th>Scientific Method</th>
<th>Nursing Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask a question. What does this plant look like? Usually students say the leaves are limp and discolored on the edges, leaves are missing, dirt is dry, etc.</td>
<td>Assessment. Pretend this plant is your new patient. Your question is: What is the condition of my patient? Answer: The plant looks like it is dying (inspection).</td>
</tr>
<tr>
<td>Do background research. Research what causes a plant to look like it was described above.</td>
<td>Assessment. Look at where the plant is sitting. Is it receiving too much sun? Not enough sun? When was it last watered?</td>
</tr>
<tr>
<td>Construct a hypothesis. If this plant does not get the care it needs, then it will surely die.</td>
<td>Nursing Diagnosis. This is a statement of what is wrong with the patient based on gathered data. It includes the problem and the cause of the problem. Example: The plant is in the proper location, but no one has watered it for a week (fluid volume deficit related to lack of water).</td>
</tr>
<tr>
<td>Test your hypothesis through an experiment. Plan to provide proper nutrients, water, and light.</td>
<td>Planning and Implementing. Continue to set the plant in the proper lighting, water the plant every day, and evaluate in one week (note the time frame). This is where you need to individualize your plan; some plants need watering every day and others every other day or only once a week.</td>
</tr>
<tr>
<td>Analyze data and draw conclusions. In two days, the plant leaves are not limp and discolored on the edges, it hasn’t lost any more leaves, the soil is moist, and it no longer looks like it is dying.</td>
<td>Evaluating. In two days, the plant leaves are not limp and discolored on the edges, it hasn’t lost any more leaves, the soil is moist, and it no longer looks like it is dying.</td>
</tr>
<tr>
<td>Communicate your results. The results can be communicated to the owner via verbal or written message.</td>
<td>Documentation in the Medical Record. Initially you record the assessment findings, your nursing diagnosis, plan, and implementation. A second entry would include the evaluation findings.</td>
</tr>
</tbody>
</table>

Janet E. Burton, MSN, RN, CMSRN, is a Clinical Nurse Specialist/Clinical Nursing Instructor, Columbus Regional Hospital, and a Medical-Surgical Nursing Instructor, Ivy Tech Community College of Indiana-Columbus, Columbus, IN. She is the Editor of MedSurg Matters!
Congratulations, Directors!

AMSN Election Results

The AMSN Nominating Committee is pleased to announce the results of the 2010 national elections. Members elected the following nurses to serve as Director on the AMSN Board of Directors. They will begin their terms on October 24, 2010, when they are inducted into office during the Membership Meeting at the AMSN 19th Annual Convention in Las Vegas, NV.

Denise Verosky, MSN, MS, RN, CMSRN

Denise Verosky has been elected for a second term in the role of Director, which she started in 2008. Goals for her term are to promote AMSN as an organization supporting the specialty of medical-surgical nursing and to expand the resources available to nurses. In 6 years of membership, she has served AMSN on the Foundation Committee, End-of-Life Special Interest Group, and as president of Western Pennsylvania Chapter #111. Denise was also faculty for the Certification Review Course On-the-Road program. She is part of several other organizations, including serving as director of a committee for Sigma Theta Tau International. Denise is currently working as Director of Palliative Care at the University of Pittsburgh Medical Center, Mercy, in Pittsburgh, PA.

Dee Eldardiri, MS, RN-BC, CMSRN

Dee Eldardiri of Herndon, VA has been elected to serve as Director of AMSN. She has been a med-surg nurse for over 20 years and an AMSN member for 6 years. As Director, she wants to share her passion and commitment to develop membership in AMSN. Dee has served as Chair of the Educational Assessment Task Force and on the Web Site Committee. She has presented on topics such as leadership, certification review, and pain management at her hospital and AMSN’s Annual Convention. Dee serves for American Society for Pain Management Nursing (ASPMN) as a founder and secretary for the local chapter, along with other memberships. Dee currently works at Inova Health Systems in Falls Church, VA, as the Inova Learning Network Lead Educator.

Welcome back, Denise, and welcome, Dee, to the AMSN Board of Directors!

Thanks to Pamela Gray for sharing how she uses the nursing process every morning before going to work in the following poem.

— Janet E. Burton

Ready to Work

It all started as an exercise
That my students were to do.
“NANDA yourselves,” I told them
And I decided to try it too.

Now each morning as I drink coffee
And grab the paper for a look,
I reach for something just as needed —
My Nursing Diagnosis Handbook.

Care plans seemed useless long ago
When I as a student viewed.
I never thought I’d utilize this book
In my morning solitude.

As I sip my steaming brew
I ramble through the pages
I assess my state of mind —
And my body as it ages.

What problems should I address
Before I leave my chair?
Pain? Anxiety? Fatigue?
How is my self care?

I then formulate a diagnosis
And ponder interventions
Does this nursing process really help
Or is it just good intentions?

I only know it works for me
To implement a plan
By using methods that I learned
To be the best nurse I can.

“What are my goals today?” I ask.
What outcomes do I see?
My own care plan will be revised
I am never done evaluating — me.

Pamela Gray, FNP, DNP
Assistant Professor
Augusta State University
Augusta, GA

Calling All Nurse Educators!

MedSurg Matters! is looking for authors to write for the "Strategies for Nurse Educators" column. If you have an educational story you’d like to share, send it to us at msmnews@ajn.com. Help your fellow AMSN members by exchanging teaching tips!

Check out the AMSN Web site!
With the Utmost Gratitude

2009-2010 AMSN Chapter Officers

The AMSN Board of Directors wishes to express its appreciation to all the AMSN Chapter Officers who generously volunteer their time and talents to serve AMSN members and medical-surgical nurses in their local area. We recognize them for their leadership and commitment to upholding AMSN at the local level. We are sincerely grateful for your effort.
from AMSN... Thank You!

2009-2010 AMSN National Volunteer Units

The AMSN Board of Directors wishes to express its appreciation to the committee chairs and members who generously donate their time and talents to AMSN by serving at the national level. We also recognize the Online Mentors for their gracious nurturing of new nurses. With the tireless efforts of volunteers, AMSN continues its mission of promoting excellence in medical-surgical nursing. We are truly grateful to every one of you for your leadership and commitment.

Committees

Chapter Development
Terry Ditton, Chair
Nancy Giarrocco
Mimi Haskins
Allison Perkins
Patricia Smart

Clinical Practice
Andie Melendez, Chair
Sharon Gothberg
Beth Norman
Jeffrey Woods

Legislative Policy
Robin Hertel, Chair
Richard Beard
Tanda Beck
Hilda Burnette
Michelle Close
Jackie Hansen
Donna Mangruen
Cheryl Mee
Donna Seaman

Medsurg Matters!
Janet Burton, Editor
Barbara Chamberlain

AMSN offers, from position statements to the membership directory. We also have pages dedicated to Care of Older Adults, End of Life, and even Netiquette Guidelines. Another noteworthy page is Questions for Clinical Practice, a section with clinical answers to real problems nurses face.

A hidden treasure for researchers is the Research and Evidence-Based Practice page. It provides links for research grants, reviews key terms, and has an online module on evidence-based practice. AMSN also wants to come alongside our nurses conducting research. You can have a personal consultation with our Research Coordinator by filling out a request form. A member of the Research Task Force will contact you to assist you in designing a project, data analysis, preparing a manuscript or proposal, or implementing a proposal.

AMSN has amazing resources for med-surg nurses, whether they are thinking through a clinical question, creating a poster presentation, or starting evidence-based practice. Think of AMSN first, and you will be off to the right start.

What Resources?

AMSN often talks about providing resources for med-surg nurses. The Resources section of our Web site (www.amsn.org) is a wealth of knowledge, and we want to prove it. The Resources main page is a quick navigation for anything that AMSN offers, from position statements to the membership directory. We also have pages dedicated to Care of Older Adults, End of Life, and even Netiquette Guidelines. Another noteworthy page is Questions for Clinical Practice, a section with clinical answers to real problems nurses face.

A hidden treasure for researchers is the Research and Evidence-Based Practice page. It provides links for research grants, reviews key terms, and has an online module on evidence-based practice. AMSN also wants to come alongside our nurses conducting research. You can have a personal consultation with our Research Coordinator by filling out a request form. A member of the Research Task Force will contact you to assist you in designing a project, data analysis, preparing a manuscript or proposal, or implementing a proposal.

AMSN has amazing resources for med-surg nurses, whether they are thinking through a clinical question, creating a poster presentation, or starting evidence-based practice. Think of AMSN first, and you will be off to the right start.

A Celebration for You:

Med-Surg Nurses Week

Start your planning soon for the ways your chapter or facility will recognize medical-surgical nurses during Med-Surg Nurses Week, November 1 - 7, 2010. AMSN encourages its members to lead the way in Making a World of Difference in the lives of their nurse colleagues.

Medical-surgical nurses focus on compassionate, effective care for patients every day. Since 1999, AMSN has designated this special time to shift that focus back to the nurses. Plan celebrations to honor nurses’ dedication and skill in an increasingly challenging work environment. Be an advocate for yourself and your colleagues. Ask your chapter/facility to hold educational activities during Med-Surg Nurses Week to teach nurses how they can make a difference and improve their work environment.

For products and other celebration ideas, go to www.amsn.org and click on Medical-Surgical Nurses Week under About AMSN.
**Occupational Exposure**

continued from page 1

ance of an employee’s duties. See Table 1 for the list of potentially infected materials and bodily fluids (APIC, 2005; CDC, 2005; HIV Clinical Resource, 2008).

**Risk of Transmission**

The mean risk of acquiring HIV following occupational percutaneous exposure is approximately 0.3%. After a mucous membrane exposure, it is approximately 0.09%. However, the mean risk may be significantly increased in cases in which more than one risk factor (deep injury, hollow gauge needle, needle placed directly in a vein or artery, high viral load in the source patient, etc.) is involved.

**Table 1. Potentially Infected Materials and Bodily Fluids**

| Any unfixed tissue or organ from a human – living or dead |
| HIV-containing cell/ tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or solutions; blood, organs, or other tissues from experimental animals infected with HIV or HBV |
| Any unfixed tissue or organ from a human – living or dead |
| HIV-containing cell/ tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or solutions; blood, organs, or other tissues from experimental animals infected with HIV or HBV |

The risk of transmission of HBV and HCV from an occupational exposure is significantly higher. The risk for HCV infection following a needlestick is 1.8% whereas the risk for HBV infection ranges from 6%-30% depending on the presence of hepatitis B e antigen (HIV Clinical Resource, 2008).

**Immediate Steps after Exposure**

Cleanse the wound and skin sites with soap and water and flush mucous membranes with water immediately. It is imperative that the exposed employee report the incident to the supervisor immediately, delegate patients’ care to the responsible staff, and seek medical care right away. The Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard requires health care facilities to provide each injured employee immediate access to post-exposure follow-up, testing, and prophylaxis (APIC, 2005; Foley & Leyden, 2005; National Institute for Occupational Safety and Health [NIOSH], 2009).

**Medical Care at Occupational Health Service or Emergency Department**

Evaluating the employee’s status and the type of injury are essential in order to assess the risk for transmission of the BBP and to initiate appropriate prophylaxis. It is important to provide emotional support to the employee as well as appropriate testing, counseling, and education on post-exposure protocol. Baseline testing includes (but is not limited to) HIV antibody, hepatitis B surface antigen and antibody, hepatitis C antibody, and evaluate for post-exposure prophylaxis (PEP) for HIV and hepatitis B. The exposed employee must be educated on follow-up protocol, workers’ compensation coverage, and prevention of secondary transmission and future injuries (APIC, 2005; Foley & Leyden, 2005; HIV Clinical Resource, 2008).

**Post-Exposure Prophylaxis (PEP)**

Centers for Disease Control and Prevention (CDC) and the Department of Health (DOH) have established well-defined protocols to assess and manage health care workers potentially exposed to bloodborne pathogens. Indications for PEP include percutaneous exposure with contaminated sharps, mucus membrane and non-intact skin exposure to blood and potentially infected fluid, and human bite involving blood contact to non-intact skin or mucus membranes (CDC, 2005; HIV Clinical Resource, 2008; Weber, Rutala, & Eron, 2008). HIV post-exposure prophylaxis should be initiated as soon as possible, ideally within 2 hours and no later than 36 hours after exposure (HIV Clinical Resource, 2008). The preferred PEP regimen is Combivir® (AZT 300 mg + 3TC 150 mg) one tab twice a day, plus Tenofovir (Viread® 300 mg) daily for four weeks. Alternative agents may be used in the setting of drug intolerance or toxicity. Any change from the recommended regimen should be made in consultation with an HIV specialist or an experienced occupational health clinician (CDC, 2005; HIV Clinical Resource, 2008; Weber, Rutala, & Eron, 2008).

Hepatitis B PEP includes hepatitis B Immunoglobulin (HBIG) and/or vaccine when indicated. Initiate hepatitis B vaccine series if the employee has not been previously vaccinated. HBIG is indicated if the source patient is HBsAg positive and the employee is unvaccinated or non-immune. Currently there is no proven effective prophylaxis for persons exposed to HCV blood or contaminated bodily fluids (CDC, 2005; HIV Clinical Resource, 2008; Weber et al., 2008).

**Blood and Bodily Fluid Exposures: Monitoring Recommendations**

Health care workers with occupational exposure to bloodborne pathogens should receive follow-up counseling, post-exposure testing, and medical evaluation regardless of whether or not they receive PEP (CDC, 2005; HIV Clinical Resource, 2008; Weber et al., 2008). Table 2 shows the monitoring recommendations in the post-exposure period.

**Prevention of Secondary Transmission to Bloodborne Pathogens**

Health care workers should be educated on prevention of HIV transmission during the post-exposure period. Exposed workers should be advised to use precautions such as covering all wounds, having protected sex or practicing sexual abstinence, avoiding pregnancy (or if pregnant, consulting with personal provider), avoiding breast feeding until HIV infection in the source is ruled out, and abstaining from donation of blood, blood products, semen, tissues, and organs for one year. Those exposed to HBV or HCV-infected blood do not need to take any special precautions to prevent secondary transmission during
needlesticks and other blood and bodily fluid exposures is the responsibility of employers as well as employees. Needlesticks and other blood and bodily fluid exposures need to be managed as an emergency and the protocol and procedures for handling and disposing of needles (unless no alternative is feasible), use of sharp containers appropriately, and procedures for handling and disposing of sharps during and after procedures. Use of personal protective equipment such as gloves, gowns, masks, goggles, and face shields is imperative to prevent sharps injuries and other blood and bodily fluid exposures (APIC, 2005; Foley & Lenyden, 2005; NIOSH, 2009; The Joint Commission, 2009). It is essential that both the employer and health care workers have a commitment to health care safety.

**Employee Rights**


**Bloodborne Pathogens Standard**

The OSHA Bloodborne Pathogens Standard provides directives for employers to develop an exposure control plan and to review and update these plans at least annually or as necessary (APIC, 2005; NIOSH, 2009). The Bloodborne Pathogen Standard includes exposure determinations by defining which job classifications have occupational exposure and providing the hepatitis B vaccine to the employees at risk within 10 days of employment. The Bloodborne Pathogen Standard also requires employers to provide education on potential hazards, personal protective equipment, and engineering and work practice controls before employees’ initial assignment. Post-exposure evaluation, follow-up, and recordkeeping are also a requirement found in this standard (APIC, 2005; NIOSH, 2009; The Joint Commission, 2009; U.S. Department of Labor, 2009).

**Prevention of Occupational Exposures to Blood and Bodily Fluids**

While occupational exposures to blood and bodily fluids continue to be a dangerous matter that health care workers face on a daily basis, it is also one of the most preventable. As technology and engineering controls develop rapidly, prevention has become even easier. Identifying high-risk procedures and devices, eliminating sharps, and using safer devices are found in this standard (APIC, 2005; NIOSH, 2009). The Bloodborne Pathogen Standard includes exposure determinations by defining which job classifications have occupational exposure and providing the hepatitis B vaccine to the employees at risk within 10 days of employment. The Bloodborne Pathogen Standard also requires employers to provide education on potential hazards, personal protective equipment, and engineering and work practice controls before employees’ initial assignment. Post-exposure evaluation, follow-up, and recordkeeping are also a requirement found in this standard (APIC, 2005; NIOSH, 2009; The Joint Commission, 2009; U.S. Department of Labor, 2009).

**Conclusion**

Health care organizations are required by regulatory agencies (OSHA, DOH, CDC, etc.) to provide a safe environment for their employees, and the employees in turn need to follow the recommended practices to protect themselves from potential exposures. In the event of a potential exposure, well-defined protocols have been established to evaluate and manage the health care worker in order to prevent transmission of these BBPs from patients to health care workers. Occupational exposures need to be managed as an emergency and the prophylaxis is given based on risk assessment. Prevention of needlesticks and other blood and bodily fluid exposures is the responsibility of employers as well as employees.

**Table 2. Needlesticks/Sharps Injuries/Bloodborne Fluid Exposures Monitoring Recommendations**

<table>
<thead>
<tr>
<th>Visit</th>
<th>CBC</th>
<th>LFTs/ Amylase</th>
<th>HIV Ab</th>
<th>HCV Ab</th>
<th>HCV PCR RNA (Qualitative)</th>
<th>HBsAg/ Ab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Week 1</td>
<td>X^a</td>
<td>X</td>
<td>X^a</td>
<td>X^0</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Week 2</td>
<td>X^a</td>
<td>X^a</td>
<td>X^0</td>
<td>X^a</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Week 3</td>
<td>X^a</td>
<td>X^a</td>
<td>X^0</td>
<td>X^a</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Month 1</td>
<td>X</td>
<td>X^a</td>
<td>X^0</td>
<td>X</td>
<td>X^e</td>
<td>X</td>
</tr>
<tr>
<td>Month 3</td>
<td>X</td>
<td>X^a</td>
<td>X^0</td>
<td>X</td>
<td>X^e</td>
<td>X</td>
</tr>
<tr>
<td>Month 6</td>
<td>X</td>
<td>X^0</td>
<td>X</td>
<td>X^e</td>
<td>X^e</td>
<td>X</td>
</tr>
</tbody>
</table>

LFTs – Liver Function Tests
X^a – If the health care worker is on HIV post-exposure prophylaxis (PEP)
X^0 – If the source patient is known to be HCV-antibody seropositive or if the serostatus is unknown
X^e – Post vaccination – if needed/as appropriate


the follow-up period; however, they should refrain from donating blood, plasma, organs, tissues, or semen (CDC, 2005; HIV Clinical Resource, 2008).

**Table 3. Employee Rights**

| Safe work environment and availability of safety devices |
| Training on occupational exposure prevention and management |
| Timely access to medical care and availability of drugs for prophylaxis |
| Filing an injury or illness claim and workers’ compensation programs |
| Confidentiality of medical information |
| Filing an OSHA complaint |

continued on page 16
Needlesticks and blood and bodily fluid exposures continue to be serious hazards among nurses and other health care workers, exposing them to a number of bloodborne pathogens despite significant progress in products, policy, and practice. Undoubtedly, there is room for improvement! Nurses, being the largest group of health care workers, spend the most direct time with patients, often working under suboptimal conditions. They need to be educated on analyzing risk factors, implementing effective preventive measures, and taking the necessary steps in the event of an exposure to ensure the safety of health care workers as well as the patients they care for.

Knowledge has a significant positive impact on behavioral change, though knowledge alone is not enough. Nurses need to be educated on prevention and management of occupational exposure to bloodborne pathogens. Nurse educators play a significant role in achieving this goal. Understanding the importance of appropriate and continuous use of various safety devices and personal protective equipment is imperative. The protocols, policies, and guidelines must be easily accessible to the nurses for reference. Nurse educators need to understand and educate staff on the importance of following current evidence-based practice protocols and written guidelines and policies. A well-structured educational program must be in place to teach staff at the beginning of employment and for periodic in-service, continuous enough to effect behavioral change. Nurses should be able to analyze risk factors, implement effective preventive measures, and take the necessary steps in the event of an exposure.

References


Solymole Kuruvilla, PhD, ACNP-BC, SAFE, is an Associate Nurse Practitioner II of Occupational Health Service Department, North Central Bronx Hospital/North Bronx Healthcare Network, Bronx, and Adjunct Faculty, Department of Nursing, College of Mount Saint Vincent, Riverdale, NY.
As an AMSN volunteer, you will have the ability to participate and benefit from activities such as:

- Being a member of the Workplace Advocacy Task Force
- Gathering information about a healthy work environment for a column in upcoming issues of MedSurg Matters!
- Participating in the Scholarship and Awards Committee
- Leading a task force to review research and evidence-based practice (EBP) and grant applications (this activity requires a PhD)
- Collaborating with other task force members to evaluate ways to facilitate AMSN Chapters
- Joining the Legislative Policy and Issues Committee
- Being an Ambassador to represent AMSN at other association meetings or conventions
- Learning about the evaluation of the Nurses Nurturing Nurses (N3) program
- Attending the annual convention
- Reading about AMSN’s current affiliations and the Strategic Affiliations Task Force
- Becoming a member of the Convention Program Planning Committee
- Checking out online educational, career resources, and leadership development activities on the AMSN Web site
- Writing an article for the MedSurg Matters! newsletter or MedSurg Nursing: The Journal of Adult Health
- Attaining certification in medical-surgical nursing

As you can see, the opportunities for you to get involved in AMSN are plentiful; the options for matching your time, talent, and passion abound; and it is with much optimism that AMSN takes the next step in becoming the influential, respected leader for the medical-surgical specialty. For more information about becoming an AMSN volunteer, visit www.amsn.org and click on Committees.

If you did not get a chance to get away this summer or if you are ready for time away for yourself, online registration is now available for AMSN’s 19th Annual Convention October 20-25, 2010, in Las Vegas, NV, at the Riviera Hotel. Don’t miss this great opportunity!

Kathleen A. Singleton, MSN, RN, CNS, CMSRN
AMSN President

As an AMSN volunteer, you will have the ability to participate and benefit from activities such as:

- Being a member of the Workplace Advocacy Task Force
- Gathering information about a healthy work environment for a column in upcoming issues of MedSurg Matters!
- Participating in the Scholarship and Awards Committee
- Leading a task force to review research and evidence-based practice (EBP) and grant applications (this activity requires a PhD)
- Collaborating with other task force members to evaluate ways to facilitate AMSN Chapters
- Joining the Legislative Policy and Issues Committee
- Being an Ambassador to represent AMSN at other association meetings or conventions
- Learning about the evaluation of the Nurses Nurturing Nurses (N3) program
- Attending the annual convention
- Reading about AMSN’s current affiliations and the Strategic Affiliations Task Force
- Becoming a member of the Convention Program Planning Committee
- Checking out online educational, career resources, and leadership development activities on the AMSN Web site
- Writing an article for the MedSurg Matters! newsletter or MedSurg Nursing: The Journal of Adult Health
- Attaining certification in medical-surgical nursing

As you can see, the opportunities for you to get involved in AMSN are plentiful; the options for matching your time, talent, and passion abound; and it is with much optimism that AMSN takes the next step in becoming the influential, respected leader for the medical-surgical specialty. For more information about becoming an AMSN volunteer, visit www.amsn.org and click on Committees.

If you did not get a chance to get away this summer or if you are ready for time away for yourself, online registration is now available for AMSN’s 19th Annual Convention October 20-25, 2010, in Las Vegas, NV, at the Riviera Hotel. Don’t miss this great opportunity!

Kathleen A. Singleton, MSN, RN, CNS, CMSRN
AMSN President

As an AMSN volunteer, you will have the ability to participate and benefit from activities such as:

- Being a member of the Workplace Advocacy Task Force
- Gathering information about a healthy work environment for a column in upcoming issues of MedSurg Matters!
- Participating in the Scholarship and Awards Committee
- Leading a task force to review research and evidence-based practice (EBP) and grant applications (this activity requires a PhD)
- Collaborating with other task force members to evaluate ways to facilitate AMSN Chapters
- Joining the Legislative Policy and Issues Committee
- Being an Ambassador to represent AMSN at other association meetings or conventions
- Learning about the evaluation of the Nurses Nurturing Nurses (N3) program
- Attending the annual convention
- Reading about AMSN’s current affiliations and the Strategic Affiliations Task Force
- Becoming a member of the Convention Program Planning Committee
- Checking out online educational, career resources, and leadership development activities on the AMSN Web site
- Writing an article for the MedSurg Matters! newsletter or MedSurg Nursing: The Journal of Adult Health
- Attaining certification in medical-surgical nursing

As you can see, the opportunities for you to get involved in AMSN are plentiful; the options for matching your time, talent, and passion abound; and it is with much optimism that AMSN takes the next step in becoming the influential, respected leader for the medical-surgical specialty. For more information about becoming an AMSN volunteer, visit www.amsn.org and click on Committees.

If you did not get a chance to get away this summer or if you are ready for time away for yourself, online registration is now available for AMSN’s 19th Annual Convention October 20-25, 2010, in Las Vegas, NV, at the Riviera Hotel. Don’t miss this great opportunity!

Kathleen A. Singleton, MSN, RN, CNS, CMSRN
AMSN President

AMSN Bylaws Amendment

The membership approved a change to the bylaws concerning the amount of time a member may serve on the AMSN Board of Directors. The approved amendment to the bylaws is:

- No individual may serve more than two consecutive terms on the Board of Directors except for an individual pursuing election to the position of President-Elect.

MedSurg Matters! welcomes news from AMSN members. If you have a news item, photo, or success story that you would like published, send it along with your name, email address, phone number, and other comments/suggestions to: Katie Brownlow, MedSurg Matters!, Managing Editor; East Holly Avenue, Box 56; Pitman, NJ 08071-0056; Email: msmnews@ajj.com

<table>
<thead>
<tr>
<th>Issue</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>November/December 2010</td>
<td>October 15, 2010</td>
</tr>
<tr>
<td>January/February 2011</td>
<td>December 15, 2010</td>
</tr>
<tr>
<td>March/April 2011</td>
<td>February 15, 2011</td>
</tr>
</tbody>
</table>

MedSurg Matters! welcomes news from AMSN members. If you have a news item, photo, or success story that you would like published, send it along with your name, email address, phone number, and other comments/suggestions to: Katie Brownlow, MedSurg Matters!, Managing Editor; East Holly Avenue, Box 56; Pitman, NJ 08071-0056; Email: msmnews@ajj.com

<table>
<thead>
<tr>
<th>Issue</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>November/December 2010</td>
<td>October 15, 2010</td>
</tr>
<tr>
<td>January/February 2011</td>
<td>December 15, 2010</td>
</tr>
<tr>
<td>March/April 2011</td>
<td>February 15, 2011</td>
</tr>
</tbody>
</table>

Amendments to the bylaws concerning the amount of time a member may serve on the AMSN Board of Directors. The approved amendment to the bylaws is:

- No individual may serve more than two consecutive terms on the Board of Directors except for an individual pursuing election to the position of President-Elect.

MedSurg Matters! welcomes news from AMSN members. If you have a news item, photo, or success story that you would like published, send it along with your name, email address, phone number, and other comments/suggestions to: Katie Brownlow, MedSurg Matters!, Managing Editor; East Holly Avenue, Box 56; Pitman, NJ 08071-0056; Email: msmnews@ajj.com

<table>
<thead>
<tr>
<th>Issue</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>November/December 2010</td>
<td>October 15, 2010</td>
</tr>
<tr>
<td>January/February 2011</td>
<td>December 15, 2010</td>
</tr>
<tr>
<td>March/April 2011</td>
<td>February 15, 2011</td>
</tr>
</tbody>
</table>

Amendments to the bylaws concerning the amount of time a member may serve on the AMSN Board of Directors. The approved amendment to the bylaws is:

- No individual may serve more than two consecutive terms on the Board of Directors except for an individual pursuing election to the position of President-Elect.
Welcome, New Chapter!

South Shore Massachusetts Chapter #121

Congratulations to the South Shore Massachusetts Chapter #121, which earned its charter in May 2010. Serving the South Weymouth surrounding area, the chapter has appointed the following officers:

- President: Kelly Fitzpatrick
- President-Elect: Kelly Cederlund
- Secretary: Ellen Wenners
- Treasurer: Cindy Fiocchi

The chapter planned the following goals:
- Enhance and highlight the image of medical-surgical nursing.
- Increase Massachusetts medical-surgical nurses’ contributions to AMSN.
- Provide educational opportunities specific to the medical-surgical nurse.

Welcome Back!

First Coast NE Florida Chapter #226

After a period of inactivity, a committed group of nurses in the St. Augustine, FL area has rechartered as the AMSN First Coast NE Florida Chapter #226. The chapter will carry on serving the St. Augustine, Palm Coast, and St. Johns/Flagler areas. The chapter has appointed the following officers:

- President: Misti Craig
- President-Elect: Kellie Colvin
- Secretary: Margaret Walter
- Treasurer: Andrea Sheldon

Other committees include Education and Membership. Chapter meetings will be held the first Tuesday of each month and dues are $20. Goals of the chapter are:
- The promotion of medical-surgical nursing as an integral part of professional nursing.
- Encouraging the application of evidence-based practice to the art of medical-surgical nursing.
- Acting as an advocate for medical-surgical nurses in the hospital environment and within the communities served.
- Encouraging continuing professional development of medical-surgical nurses.

Chapter Event

Chicago Chapter #317

For the Chicago chapter’s second anniversary, we met on June 9, 2010 to celebrate with cake, punch, networking, and laughter. Nurse Nancy and Dr. Dave visited us and sang and danced, and the group talked about teamwork. We then held our meeting and educational in-service entitled “All about IV Access Devices,” which was presented by Nora Polk Green, RN, MSN.

The members of AMSN’s Chicago chapter gathered in June to celebrate their second anniversary. Guests shared cake, conversation, and a meet-and-greet with “The Little People.”

What followed was a big treat for our nurses. In walked our surprise guests, “The Little People!” Our 19 attendees greatly enjoyed the presentation, and we were successfully able to integrate education with humor. Thank you to all who joined us!

Cora J. Palmer, BSN, RN-BC
Chapter #317 President

Member Benefit Highlighted: Chapter Involvement

AMSN local chapters bring the national organization right to you. Chapters provide local educational events, networking functions, and volunteer leadership opportunities. As a member, you are automatically assigned a local chapter. If you are not sure what your chapter is, check your membership card; it provides your chapter number. Then look for your chapter and contact person in the online chapter listing at www.amsn.org (under Chapters).

No chapter near you? Start a new one! Look online for how to get started.
Got Something to Say?
Say It at AMSN’s Convention

Share your valuable knowledge with other med-surg nurses at AMSN’s 2011 Convention. This is a chance to tell others about clinical trends, research methods, new technology, or leadership skills. If you have something you can’t wait to talk about, let us provide the platform. Submit an abstract to the national office by October 30, 2010. Abstract guidelines are available online at www.amsn.org under Events.

How to Get to Convention
Tip: Write a Proposal

AMSN’s 19th Annual Convention is heating up in the lights of Las Vegas! From October 20-25, more than 30 speakers will gather to produce the premiere event for improving your practice. If you’re hoping to get your hospital to approve funds for you and your colleagues to attend, let AMSN help you prepare a proposal. Present to your hospital administration a concise proposal using convention facts and benefits to your employer. We already brewed up some ideas that are listed online. If you are feeling squeamish about starting a proposal from scratch, you can use our letter template to help guide you. Find more tips and the template online at www.amsn.org/convention. Click How to Get to Convention. We want to see you there!

Certification for Educators And Managers Too

MSNCB wants to set the record straight. If you’re a medical-surgical nursing manager or educator, you are eligible to apply for the CMSRN exam, recertify your existing CMSRN credential, or apply via the exam exemption route. The MSNCB Board of Directors has clarified the criteria for the CMSRN exam and recertification requirements (see the bolded sentences below):

Certification Requirement #3
Have accrued a minimum of 2,000 hours of nursing practice within the past three (3) years of practice in a medical-surgical setting. Practice may include clinical, management, or education.

Recertification and Exam Exemption Certification Requirement #3
Have accrued a minimum of 1,000 hours of nursing practice within the past five (5) years of practice in a medical-surgical setting. Practice may include clinical, management, or education.

The MSNCB directors regularly review the criteria for both certification and recertification to ensure that the criteria are clear and easy to understand. If you have any questions, please contact the National Office at 866-877-2676 or email cmsrn@ajj.com.
The Nightingale Pledge

In light of 2010 being the International Year of the Nurse, commemorating the death of Florence Nightingale, it is good to meditate on the Florence Nightingale Pledge. Below is an updated pledge that many nurses use today.

In the full knowledge of the obligations I am undertaking, I promise to care for individuals with all of the skill and understanding I possess without regard to race, creed, color, politics, or social status.

I will respect at all times the dignity and religious beliefs of the individuals under my care, holding in confidence all personal information entrusted to me and refraining from any action that might endanger life or health.

I will endeavor to keep my professional knowledge and skill at the highest level and to give loyal support and cooperation to all members of the health team.

I will do my best to honor the code of ethics of the nursing profession and to uphold the integrity of the profession.

AMSN is a proud sponsor of the 2010 International Year of the Nurse initiative. Find out more at www.2010ynurse.net.