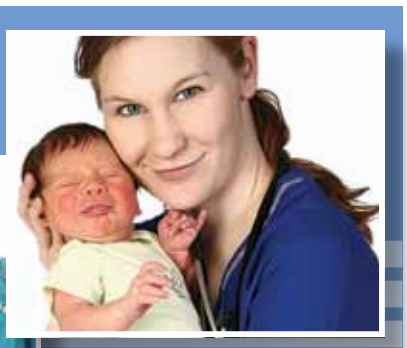
RN IDAHO



ANA IDAHO AMERICAN NURSES ASSOCIATION IDAHO

Official publication of the Idaho Nurses Association
Quarterly circulation approximately 21,000 to all RNs, LPNs, and Student Nurses in Idaho.

Volume 37, • No. 3 November, December 2014, January 2015

from the President...

by Holly Decker-Carlson, MS, CCRN
Email: president@idahonurses.org

Holly Carlson

What a privilege and an honor to be a constituent state nursing association (CSNA) president. I am grateful for this opportunity and excited about the upcoming two years to serve the nurses of Idaho. I have been on the Idaho Nurses Association (INA) board since 2012. My tenure has included the Conference Planning Committee for the last two years, attending the latest American Nurses Association (ANA) House of Delegates session in Washington, D.C., and participating in the last two Membership Assemblies. For the last two years, I have been "living INA" and I love it!

The experiences I have had working with INA/ANA have humbled me as a nurse; I have personally witnessed the advocacy, education, and support the ANA provides to nurses across the nation and throughout the world. ANA strives every day to build professionalism in each nurse through the programs and resources they offer to individual nurses and to other organizations. ANA is very active in policy advocacy on a federal level and subsequently empowers and provides the CSNAs with the resources to advocate within their own states. As a matter of fact, Idaho was able to successfully pass legislation this year that provides recourse for patient abuse. This was accomplished through the collaboration of Idaho nurses across the state, including INA members and nurses from other specialty associations. We were activists and we made a lasting difference.

Together, We Can Make a Difference

As nurses, we can only make a difference if we continue to grow professionally and get involved. Professional growth needs to be channeled by the drive to want to know more. Nurses are innately this way but may lack comprehensive, easy access to resources. I think we have an opportunity to build upon this. I think each of you deserves professional growth opportunities "on the ready," whether it is a webinar, written materials, conferences, online modules, or current resources. **One of my goals as INA president is to tie together education "on the ready" and continuing education credits that support our professional certifications and our organizational professional ladders.**

Membership growth for sustainability is also imperative. INA membership must grow. It has been stagnant for the last two years. We average 300 members in a state that has 14,381 nurses. How can our voices be heard when we marginalize INA membership? It concerns me deeply when I hear nurses say, "No one is listening." As nurses, our voice is not heard as individuals but as nurses collectively. We are responsible for making sure our voice is heard and believe me "they" do listen. How many of you participated in the National Lobby Day with ANA, either in person or virtually? If you are not sure what I am referring to, then you have an opportunity to have your voice heard, and you have an opportunity to participate. How many of you are aware of the Board of Nursing's licensure proposal – proof of competency IDAPA 23-0101-1402? If approved, this proposed rule change will have a huge impact on your 2015 licensure renewal. Again, if you are not familiar with this current legislative issue, we need you to become a member of the Idaho Nurses Association so that we can keep you informed and help your voice to be heard where it counts.

While ANA has a healthy advocacy program, Idaho does not. Idaho's nurses need to come together to decide what our concerns are, healthcare related or not; to access our personal contacts and resources; and to make sure our unified voice is heard in our state. We as nurses need to learn how to contact our policy makers and how to make sure our voice is heard and acted upon. Don't mistake this for organized labor initiatives or collective bargaining, because it is not. Healthcare is changing and we are key players in the change. I challenge each of you to get involved!

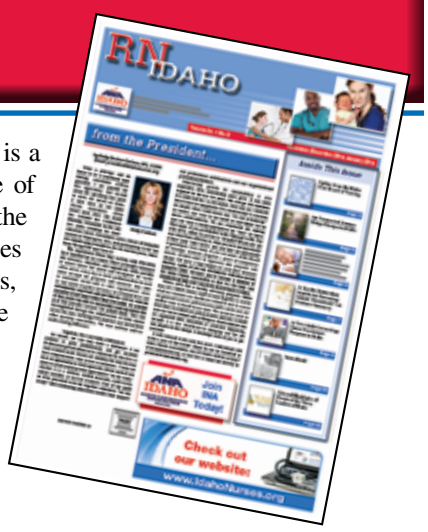
I look forward to the next two years. I encourage you to be a part of the whole! Check us out on Facebook at Idaho Nurses Association, our *RN Idaho* website at http://www.idahonurses.org, or feel free to email me directly at president@idahonurses.org.

Inside This Issue

current resident or

Presort Standard
US Postage
PAID
Permit #14
Princeton, MN
55371

Guidelines for Submissions to RN Idaho



RN Idaho (RNI), the official publication of the Idaho Nurses Association (INA), is a peer-reviewed journal that is published quarterly. Views expressed are solely those of the authors or persons quoted and do not necessarily reflect INA's views or those of the publisher, Arthur L. Davis Publishing Agency, Inc. The *RNI* Editorial Board oversees this publication and welcomes nursing and health-related news items, original articles, research abstracts and other pertinent contributions. Authors are not required to be INA members.

For information about manuscript format, submission of photographs, publication selection and rights, and advertising in RNI, please visit the INA website at http://www.idahonurses.org under "News/Links." You may also contact the INA at rnidaho@idahonurses.org or by phone 1-888-721-8904.

www.idahonurses.org

Published by:
Arthur L. Davis Publishing Agency, Inc.

RN IDAHO

ANA IDAHO AMERICAN NURSES ASSOCIATION IDAHO

RN Idaho is published by the
Idaho Nurses Association
3525 Piedmont Road
Building 5, Suite 300
Atlanta, GA 30305

Toll-free Phone: 888-721-8904
Direct Dial: 404-760-2803 Extension: 2803
Email: rnidaho@idahonurses.org
FAX: 404-240-0998
Website: **www.idahonurses.org**

RN Idaho welcomes comments, suggestions and contributions. Articles, editorials and other submissions may be sent directly to the INA office via mail, fax or e-mail. Please call the INA office if you have any questions.

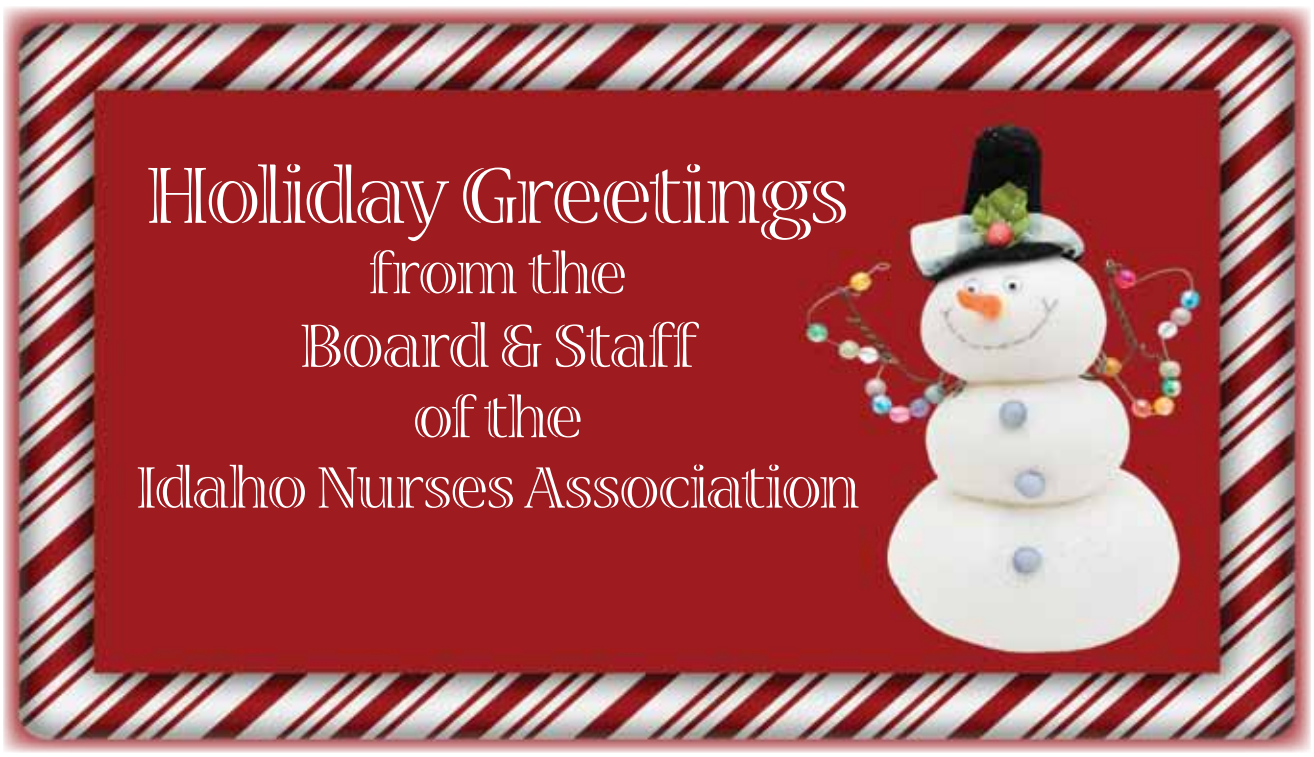
Join INA Today

We need you!
Membership application
http://nursingworld.org/joinana.aspx

For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@aldpub.com. INA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Acceptance of advertising does not imply endorsement or approval by the Idaho Nurses Association of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. INA and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser's product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the staff, board, or membership of INA or those of the national or local associations.

RN Idaho is published quarterly every February, May, August and November for the Idaho Nurses Association, a constituent member of the American Nurses Association.



Update from the IDAHO State of Idaho Board of Nursing

Continued Nurse Competency

by Sandra Evans, Executive Director
Email: Sandra.Evans@ibn.idaho.gov

Competence in nursing is the ability of the licensed nurse to perform skillfully and proficiently the functions within the role of the licensee. The role encompasses the possession and interrelation of essential knowledge, judgment, attitudes, values, skills and abilities which are varied and range in complexity. Competency is a dynamic concept, changing as the licensed nurse achieves a higher stage of development within the role, and as knowledge expands.[1]

[1] From: "Report of the Ad Hoc Committee on Continuing Competency" submitted and accepted by the Idaho Board of Nursing May 30, 1980

In 2011, the members of the Board of Nursing engaged in dialogue on the issue of nurse continued competence, a topic not new to the Board. Since 1977, the Idaho Nursing Practice Act has authorized the Board of Nursing to evaluate the continuing competence of licensed nurses and to "…develop standards which will advance the competency of licensees in accordance with developing scientific understanding and methods related to the practice of nursing" (Idaho Code §54-1404(7)). Since that time, the Board has considered how it might approach this authority, especially as it relates to licensure renewal. In fact, a review of past Board meeting minutes provides evidence of the many times the Board has considered whether or not nurses should be required to participate in continuing education activities as a prerequisite to licensure renewal.

In an effort to establish the foundation for the discussion, the Board charged a Board-appointed committee to clarify the Board's current belief related to continued competence. After two years of work by the committee and on-going Board discourse and deliberation, at their meeting in May 2013, the Board adopted their "Belief Statement on Continued Competence and Continuous Professional Development" as the first step in moving forward with strategies to assure that nurses remain accountable for their own professional competence. Using the adopted belief statement as the foundation, the Board drafted rules to **require engagement in activities of lifelong learning as a condition of continued active licensure for LPNs and RNs with a target implementation date of 2018.**

Proposed Rule Docket 23-0101-1402

The members of the Board met by teleconference on July 2, 2014, and approved the draft proposed rules to be presented for public comment. **The proposed rules require RNs and LPNs to demonstrate their continued competence to practice nursing in Idaho at the time of each licensure renewal and establishes methods by which nurses will comply with this obligation.**

Proposed Rule Docket 23-0101-1402 was presented during a public meeting on July 17-18, 2014. All comments received were reviewed by the Board. Several changes were made to the proposed rules which were then approved and set for rulemaking. A summary of comments received and resulting revisions with rationale, as well as Docket 23-0101-1402, are available on the Board's website at www.ibn.idaho.gov or by requesting a copy from the Board of Nursing.

Following the July public meeting, numerous requests for an additional public hearing on Docket 23-0101-1402 were received, prompting the Board to extend the comment period and schedule a second hearing on October 10, 2014. The public was again invited to provide oral and written comments for consideration by the Board prior to proceeding with the rulemaking process. The results of the October hearing are also posted to the Website to inform the public of the Board's decision related to the proposed rules.

As indicated in the Board's belief statement:

"There is no empirical evidence that licensed nurses, as a group, lack competence. However, the Board believes that, in order to maintain active licensure once it is granted, nurses should periodically be required to demonstrate substantive steps to maintain professional competence. The Board is aware that nurses' careers take widely divergent paths, varying by professional role, practice setting, therapeutic modalities, levels of health care delivery and, of course, the clients being served."

It is this awareness that prompted the Board to conclude that nurses who take personal responsibility to engage in purposeful activities to advance their professional development will likely maintain acceptable levels of professional competence.

Other Board Business

In addition to receiving comments on proposed rules, during their July 17-18, 2014 meeting, Board members Susan

Update continued on page 4

June, July and August, 2014

Boise, Idaho
Kacie Anderson
Nicole Benskin
David Cantrell
Dawn Dykstra
Maureen Karr
Rene Pallotti
Teresa Stanfill
Kelly Ann Stock
Lindsay Underwood

Burley, ID
Terry Richman

Eagle, ID
Dena Robinson

Hayden, ID
Debbie Callins

Kimberly, ID
Tanis Maxwell

Lewiston, ID
Karen Banks
Kristal Coghill
Janet Fonnesbeck
Lynna Johns
Brandi Langager
Malinda Massey
Linda Sienkiewicz

Moscow, ID
Bukola Arogundade

Mountain Home, ID
Stephanie Doane
Brianna Muth

Pocatello, ID
Cara-Lee Esplin

Shelley, ID
Kara Boll

Clarkston, WA
Gordon Glasby

Update continued from page 3

Odom, RN, Moscow, Chair; Vicki Allen, RN, Pocatello, Vice Chair; Jill Howell, RN, Jerome; Whitney Hunter, consumer member, Boise; Christopher Jenkins, RN, Homedale; Jan Moseley, RN, Coeur d'Alene; Carrie Nutsch, LPN, Jerome; Rebecca Reese, LPN, Post Falls; and Clay Sanders, APRN, CRNA, Boise, considered business consistent with their strategic goals related to licensure, practice, discipline and alternatives to discipline, education, governance, communication and organization. Specifically, the Board:

- Granted one LPN license by endorsement based on substantial equivalence;
- Appointed Chad Bailey, APRN-CNP, Coeur d'Alene and Cathy Arvidson, APRN-CNP, Idaho Falls to 3 year terms on the Advanced Practice Registered Nurse (APRN) Advisory Committee;
- Approved Proposed Rule Dockets 23-0101-1401 and 23-0101-1402 for rulemaking;
- Engaged in discussion about the current statutory qualifications for individuals appointed to the Board in comparison to qualifications of other boards of nursing as well as boards of other professional disciplines;
- Reviewed Board accomplishments for FY2014, the fiscal year just ended, and discussed anticipated activities for the coming fiscal year, including strategic benchmarks, pending legislative activities and national initiatives impacting nursing and nursing regulation in Idaho;
- Determined funded workforce initiatives for FY2015 will support work of the Idaho Nursing Action Coalition, charged to implement recommendations resulting from the Institute of Medicine report on the "Future of Nursing;"
- Elected Susan Odom, Chair, Vicki Allen, Vice Chair, Carrie Nutsch, Governance Committee Member-at-Large, and Jan Moseley, Chair of the Program for Recovering Nurses Advisory Committee for the 2014-15 year;
- Adopted Findings of Fact and Conclusions of Law and revoked the licenses of one RN and one LPN for violations of the Nursing Practice Act and Rules of the Board; and
- Set tentative Board meeting dates for the coming year for January 8-9, April 9-10, July 16-17 and October 1-2, 2015.

Next Meeting

As always, the Board welcomes your input and invites the public to attend scheduled Board meetings and participate in the Open Forum held on the second day of each meeting. The next meeting of the Board is tentatively scheduled for January 8-9, 2015, at a location to be determined.

An Unexpected Journey Brings Unexpected Gifts

by Alex Jaeger, age 26
Email: alex.jaeger14@gmail.com

Karen Jaeger, M.S., CCC-SLP
Licensed Speech Language Pathologist
Past President and Board Member of the
Brain Injury Alliance of Idaho
Email: jaeger4@cableone.net

Alex's Unexpected Event

Like the words to an Eagles' song, "in a New York Minute, everything can change," my life changed on June 4, 2005, when I was in a single car accident sustaining a severe brain injury and collapsed lungs. That Idaho minute took me on an unexpected journey that changed the course of my future. Around dawn, I fell asleep at the wheel of my Nissan Maxima, rolled in the freeway median, and remained in a coma for over five months. On this day, I began a 228-day journey through health care facilities in Boise.

About a month after my accident, the brain MRI showed diffuse axonal injury. The Neurosurgeon told my parents I would probably not wake up and would remain in a vegetative state the rest of my life. He also said that my young age and excellent physical condition at the time of the accident could aid in my recovery. Just weeks before the accident, I had turned 17, and as a starting goalie, helped my Timberline High School lacrosse team win the state championship. I have always been confident, opinionated, and strong-willed; so my parents persevered on the hope that if anyone could prove the doctors wrong, it was me.

Setting higher expectations for myself than anyone else dares set for me had shaped my foundation before the accident, and keeps me determined on my long road to recovery. The brain is an astonishing but puzzling organ. Its capacity to heal and recover is miraculous, even with the worst brain injury. The long months after my car accident brought many new changes and challenges for me with small steps towards recovery.

Alex's Recovery

I spent 19 days in the ICU at Saint Alphonsus Regional Medical Center, 34 days on their Neurological Unit, and three months on the sub-acute rehabilitation floor. I had a ventilator, chest tubes, tracheotomy, J tube, Peg tube, Foley catheter, and wheelchair. My treatments included splints and a joint active system (JAS) device for my right arm; Botox injections to my right arm/hand; and physical, speech, and occupational therapies. I have been told it literally took a village to care for me while at Saint Alphonsus: 15 different doctors, 30 Registered Nurses (RNs), countless Certified Nursing Assistants (CNAs), 15 physical therapists, eight occupational therapists, four speech pathologists, two dieticians, one neuropsychologist, eight respiratory therapists, six housekeepers, and six therapy dogs.

While still in a minimally conscious state, I was transferred from the hospital to across the street to Life Care Center of Boise. While there I continued to receive vital stimulation, physical, speech, and occupational therapies. November 13, 2005, was the dawn of a new day, a new life. The nurses at Life Care woke me that morning and I said, "Good Morning," proving that I had regained full consciousness. That year we had a very special Thanksgiving! My awakening allowed me to encounter different challenges as I experienced learning of many things, including swallowing, eating, speaking, standing, and walking.

After spending 37 days at Life Care Center of Boise, I was moved to The Idaho Elks Rehabilitation Hospital. It had been a very long road just to get across town. I spent six weeks as an inpatient at The Elks where I continued to receive vital stimulation and intense physical, speech, occupational, and recreation therapies. I was discharged to home on January 17, 2006. It had been over seven months since my car accident and I was finally returning home.

Recovery from a brain injury such as mine involved extensive rehabilitation. My days became weeks and weeks became months. I participated in an intensive eight-week outpatient program at The Elks. I also participated in a homebound high school program, vision therapy, private physical therapy, acupuncture, dental care, Interactive Metronome, summer school, and sessions with a personal trainer.

In the fall of 2006, I returned to high school as a senior and graduated from Riverstone International School in Boise on May 24, 2007. I was accepted at The College of Idaho (C of I) and received a generous four year scholarship. In May of 2011, I left The C of I with 94 credits, having majored in psychology.

Alex's Unexpected Gifts and New Discoveries

Failure has never been an option for me as I am determined to do my best and give my all in everything I do. It is amazing what a person can accomplish when he/she never settles for good enough. These beliefs drove me as I continued to progress. A quote by Winston Churchill reigns true for me: "Never, never, never give up."

My car wreck took worlds from me but I have been increasingly finding new life in every day. I have been forced to re-interpret the adage, "life is what you make it." I can now more openly and unreservedly recognize my own appreciation for living. I may have scored some tough points from my wreck but I can't think of a better lesson learned than the value of life.

My traumatic experience afforded me with a plethora of unexpected and non-refundable gifts. First and foremost, surviving my car accident was a gift. I must admit there's nothing that gives a person such an outlet by which to enjoy this life as almost losing it. I now consider myself to be "the extra-fortunate-recipient-of-a-very-lousy hand" and I am more than proud to play it. The gift of survival has helped to shape my outlook on life now.

The opportunity to view life from a new perspective is a gift I now choose to acknowledge and appreciate. This new perspective gives me a better recognition of the elements which make up the magnificence of life. For me, life is magnificent because of the spiritual presence which guides my future. I would like to think my accident happened for a reason. What has resulted from my experience is the motivation to share my story with people and make an inspirational impact about faith, hope, and perseverance. God's miracles happen every day. That I lived to tell my tale is a miracle. Now I live my life as if everything is a miracle.

Another gift bestowed on me is the feeling of anticipation I never had before my accident of looking forward to each new day. Striving to face daily challenges and the determination to never give up have shaped my attitude throughout my recovery. Now this attitude prevails in my day-to-day life.

The realization and willingness to let be what I cannot change is an additional gift. I believe in not looking back but instead, keeping my eyes toward the future. My memory loss is a gift as it helps keep me in the present. I can only really see what is in front of me now and live in the moment, with no regret or remorse about my life. The only limits I have now are the ones I make for myself. Before my accident I thought limits were what others set for me. I now realize that it has always been up to me. Through all of this, I acknowledge the fact that each person has the ability to change the circumstances which make up his/her situation. It is important to acknowledge that the only one with the power to make a difference is oneself.

Nursing Implications: Suggestions from Alex's Mom

The best thing about our experience with all the different nursing staffs was having caring, dedicated, and skilled health care professionals who recognized our need for support, encouragement, and moments of hope. It is important to the patient and family that nurses stay optimistic and encouraging in the process of recovery from a traumatic brain injury (TBI). We appreciated being able to be present almost 24/7 with Alex through his whole ordeal. Our presence seemed essential for his healing and his progress; we needed to advocate for him when he could not advocate for himself. We recommend the following for nurses caring for people with TBI.

- When a TBI patient requires extensive care, we suggest having *the same nursing staff assigned to the patient* so there is not a constant change of nurses and nursing care can remain consistent.
- We also think it is imperative if a TBI patient is on a feeding tube to make sure the *calorie intake is better than adequate*. In Alex's case, he lost 60 pounds on a feeding tube!
- It is important for nurses to keep communication open and answer questions from the patient and family members. Family members should be informed of medical and rehabilitation goals. Information about medication and associated changes should be communicated to the family.
- A printed and posted daily schedule of what the patient would be doing, including therapy services, would be helpful to the patient, family, and all medical staff.
- Nursing staff should provide important and helpful patient education information for TBI patients and their families. Topics include:
  - What to expect during brain injury recovery.
  - How to contact state and local advocacy agencies for people with brain injuries.
  - Where to apply for Medicaid, Social Security Income/Disability Income, and Vocational Rehabilitation Services.
  - Where to obtain community TBI resources for home health care, housing, transportation, and recreation.
  - How to contact the local TBI Support Group.

A major resource for our family in providing information and updates on Alex's progress was through a free on-line Website called "Caring Bridge" (www.caringbridge.org). We were able to post journal entries about Alex, upload pictures, and receive messages from family and friends. It was a great source for connecting with caring people and it provided us the link to the world outside of the hospital walls. We highly recommend this Website be passed on to patients and their families when they are facing prolonged hospitalization for any reason.

Alex Looks to the Future

While I don't remember the car accident or my prolonged period of limited consciousness, there are many important things that I have learned from my life-changing experience. Overall, don't take a minute of your life for granted, fear less, hope more, prayers do matter, and appreciate the love of your family and friends. Make today the best day you have ever seen and tomorrow will be even better.

A quote from Ida Scott Taylor explains how I now live my life:

"One day at a time, this is enough.
Do not look back and grieve over the past for it is gone and do not be troubled about the future for it has not yet come.
Live in the present, and make it so beautiful it will be worth remembering."

Evidence Summary: How Does Dexmedetomidine Compared to Other Sedating Agents Impact the Incidence of Delirium in Intubated Intensive Care Unit Patients?

by Gabriel Norton, R.N., Family Nurse Practitioner track MSN student
Gonzaga University, Spokane, Washington
Email: gnorton@zagmail.gonzaga.edu

The author has disclosed he has no potential conflicts of interest, financial or otherwise. Delirium is defined by Girard, Pandharipande and Ely (2008) as a "disturbance of consciousness and cognition that develops over a short period of time (hours to days) and fluctuates over time" (p. 1). Symptoms of delirium include acute onset, usually two to three days; difficulty concentrating; restlessness; irritability; insomnia; and poor appetite. As delirium progresses, the individual is increasingly inattentive and perceptions are grossly altered. The patient may also hallucinate or become violent (Huether & McCance, 2002, p. 459).

Delirium is a significant negative sequela of intensive care unit (ICU) admission and can result in an increased number of hospital days and a decrease in six month survivability (Girard et.al, 2008). A Confusion Assessment Method (CAM)-ICU assessment tool may be useful to detect the presence of delirium in these patients (Ely et al., 2001). The purpose of this evidence summary was to determine whether dexmedetomidine decreased the incidence of delirium in intubated ICU patients.

The Search for Evidence

To answer this clinical question and before conducting a search for relevant studies, the eligibility criteria (see Table 1) based on the PICOT framework (population, intervention, comparison, outcome and timeframe) were established. The detailed inclusion and exclusion parameters and search strategy are available from the author upon request.

Table 1. Eligibility Criteria for Selection of Studies

Population of Interest (P)	Intervention of Interest (I)	Comparison Interventions (C)	Outcome (O)	Timeframe (T)
Adult ICU patients who require sedation due to intubation for mechanical ventilation	Continuous IV drip of: Dexmedetomidine at 0.5-2 mcg/kg/ minute	Continuous IV drips of: • Midazolam at 0.02-0.1 mg/ kg/hr. • Propofol at 5 mcg/kg/ minute over 5 minutes; increase by 5-10 mcg/kg/ min to reach effect. • Fentanyl at 1-5 mcg/kg/hr.	Incidence of delirium as measured by the CAM-ICU tool	During time intubated.

A comprehensive systematic review of the following databases was then performed: the Agency for Healthcare Research and Quality (AHRQ), the National Guideline Clearinghouse, the Cochrane Library, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and PubMed. A total of eight studies were selected based upon eligibility criteria and further analysis. The following is a summary of the findings and practice recommendations developed from the review of these eight studies.

Evidence Findings

Major sedating agents considered in this summary were dexmedetomidine, benzodiazepine-based agents, opioid-based agents and propofol. Overall, there is a clear benefit to using dexmedetomidine versus benzodiazepine-based sedating agents; lower incidences of delirium were found with dexmedetomidine (Barr et al., 2013; Riker et al., 2009). When compared to the use of propofol for sedation, the superiority of dexmedetomidine was less obvious for delirium; however, there was a benefit for dexmedetomidine over propofol when all neurocognitive disorders, referred to in DSM-IV as "Dementia, Delirium, Amnestic, and Other Cognitive Disorders," are measured (Jakob et al., 2012; Neurocognitive disorders).

The data comparing patients sedated with morphine versus dexmedetomidine are inconclusive. Mo and Zimmerman (2013) reported no significant difference in delirium between dexmedetomidine and morphine while Reardon, Anger, Adams, & Szumita (2009) reported reduced incidence and length of delirium in patients receiving dexmedetomidine for sedation following cardiac surgery.

Limitations of Evidence

Evidence presented in this summary is graded B according to the U.S. Preventive Services Task Force (USPSTF) Grades of Evidence (2012) scale. Based on the findings in these eight studies, there is a significant positive benefit likely to occur from the administration of dexmedetomidine, especially in contrast to benzodiazepine-based medications (Riker et al., 2009; Reardon et al., 2009). This finding is evident especially in patients with sepsis (Pandharipande et al., 2010).

Certainty of the overall true benefit of dexmedetomidine is limited by the nature of the studies investigating dexmedetomidine's effect on delirium. In the majority of the studies, delirium is either not a primary outcome or the studies possessed a significant amount of heterogeneity (Fraser et al., 2013) or the studies measured delirium inappropriately (Jakob et al., 2013; Ji, Li et al., 2013; Mo & Zimmerman, 2013).

Practice Recommendations

Based upon a review of these studies, there are two main recommendations for clinical practice. First, in adult ICU patients requiring intubation and mechanical ventilation, the use of dexmedetomidine is preferred to benzodiazepines for sedation due to the decreased risk of delirium (Barr et al., 2013; Riker et al., 2009). Secondly, dexmedetomidine is an effective intervention in the management and treatment of patients experiencing delirium (Barr et al., 2013; Riker et al., 2009).

For nurses who regularly provide care to patients who are intubated and who require mechanical ventilation, the available data are a good place to start. Overall, the evidence indicates real benefits to patients receiving dexmedetomidine compared to other forms of sedation. Dexmedetomidine is one of several sedating agents ordered by physicians and nurse practitioners for management of patients while intubated. With increased knowledge and understanding of this medication, the bedside nurse can be a stronger advocate for his/her patients. The bedside nurse can communicate the data on the impact of different sedative agents on a patient's cognitive function and long-term outcomes. This information will aid the physician or nurse practitioner in selecting the sedating agent which will provide the patient with the greatest benefit while avoiding the potential harm associated with delirium.

The other apparent finding based on this review of the evidence is the lack of specific, rigorous research concerning the effects of sedating medications on delirium and other neurocognitive dysfunctions. This research gap provides an opportunity for nursing research. From this research, nurses will be positioned to help shape the policies which will affect the treatment of their patients.

References

Barr, J., Fraser, G., Puntillo, K., Ely, E. W., Gélinas, C., Dasta, J., … Jaeschke, R. (2013). Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the Intensive Care Unit. *Critical Care Medicine, 41*(1), 263-306.

Ely, E. W., Margolin, R., Francis, J., May, L., Truman, B., Dittus, R., . . . Inouye, S. K. (2001). Evaluation of delirium in critically ill patients: Validation of the confusion assessment method for the intensive care unit (CAM-ICU). *Critical Care Medicine, 29*(7), 1370-1379.

Fraser, G., L., Devlin, J., W., Worby, C., P., Alhazzani, W., Barr, J., Dasta, J., F., . . . Spencer, F., A. (2013). Benzodiazepine versus non-benzodiazepine-based sedation for mechanically ventilated, critically ill adults: A systematic review and meta-analysis of randomized trials. *Critical Care Medicine, 41*(9), S30-8. doi:10.1097/CCM.0b013e3182a1689.

Girard, T. D., Pandharipande, P. P., & Ely, E. W. (2008). Delirium in the intensive care unit. *Critical Care (London, England), 12 Suppl 3,* S3. doi:10.1186/cc6149 [doi].

Huether, S., & McCance, K. (2002). Pathophysiology: The biologic basis for disease in adults and children. St. Louis: Mosby.

Jakob, S. M., Ruokonen, E., Grounds, R. M., Sarapohja, T., Garratt, C., Pocock, S. J., . . . Takala, J. (2012). Dexmedetomidine vs midazolam or propofol for sedation during prolonged mechanical ventilation: Two randomized controlled trials. *JAMA: Journal of the American Medical Association, 307*(11), 1151-1160. doi:10.1001/jama.2012.304.

Ji, F., Li, Z., Nguyen, H., Young, N., Shi, P., Fleming, N., & Liu, H. (2013). Perioperative dexmedetomidine improves outcomes of cardiac surgery. *Circulation, 127*(15), 1576-1584. doi:10.1161/CIRCULATIONAHA.112.000936.

Mo, Y., & Zimmermann, A., E. (2013). Role of dexmedetomidine for the prevention and treatment of delirium in intensive care unit patients. *Annals of Pharmacotherapy, 47*(6), 869-876. doi:10.1345/aph.1AR708.

Neurocognitive disorders. Retrieved from http://dsm.psychiatryonline.org/content.aspx?bookid=556&sectionid=41101783.

Pandharipande, P. P., Sanders, R. D., Girard, T. D., McGrane, S., Thompson, J. L., Shintani, A. K., . . . Ely, E. W. (2010). Effect of dexmedetomidine versus lorazepam on outcome in patients with sepsis: An a priori-designed analysis of the MENDS randomized controlled trial. *Critical Care (London, England), 14*(2), R38. doi:10.1186/cc8916.

Reardon, D., Anger, K., E., Adams, C., D., & Szumita, P. (2013). Role of dexmedetomidine in adults in the intensive care unit: An update. *American Journal of Health-System Pharmacy, 70*(9), 767-777. doi:10.2146/ajhp120211.

Riker, R. R., Shehabi, Y., Bokesch, P. M., Ceraso, D., Wisemandle, W., Koura, F., . . . Rocha, M. G. (2009). Dexmedetomidine vs midazolam for sedation of critically ill patients: A randomized trial. JAMA: *Journal of the American Medical Association, 301*(5), 489-499. doi:10.1001/jama.2009.56.

Skidmore-Roth, L. (2011). Fentanyl. In N. O'Brien, A. Perdue (Eds.), Mosby's nursing drug reference (pp. 494-496). St. Louis: Elsevier.

Skidmore-Roth, L. (2011). Midazolam. In N. O'Brien, A. Perdue (Eds.), Mosby's nursing drug reference (pp. 754-756). St. Louis: Elsevier.

Skidmore-Roth, L. (2011). Propofol. In N. O'Brien, A. Perdue (Eds.), Mosby's nursing drug reference (pp. 946-948). St. Louis: Elsevier.

U.S. Preventive Services Task Force (USPSTF). (2012). Grade definitions. Retrieved from http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm

Is Xarelto Better than Aspirin for Preventing Venous Thrombosis? An Evidence Summary

by Haley Scellick, MSN-FNP Student, Gonzaga University, Spokane, WA
Email: hscellick@zagmail.gonzaga.edu

Clinical Question

In patients who undergo a major orthopedic surgery **(Population)** how does the medication Xarelto® (rivaroxaban) **(Intervention)** versus regular strength aspirin **(Comparison)** compare in preventing venous thromboembolism **(Outcome)** postoperatively and up to thirty-five days **(Timeframe)**?

Patients undergoing orthopedic procedures, and specifically, total hip arthroplasty (THA), total knee arthroplasty (TKA), and hip fracture repair surgery (HFS), are at a significantly increased risk of venous thromboembolic events (VTE), with rates historically estimated as high as 60% when without appropriate prophylaxis (Stewart & Freshour, 2013). Rivaroxaban is a target-specific oral anticoagulant and was recently approved by the FDA in July, 2011. Full strength aspirin is being used alone as an anticoagulant and questions arise about its effectiveness against other anticoagulants.

The objectives of this paper include: 1) to update evidence-based recommendations for the use of anticoagulant therapy for the management of thromboembolic conditions with a focus on rivaroxaban and full strength aspirin, and 2) to report the findings from an evidence-based search and its comparison with the findings from the National Guideline Clearinghouse in order to further optimize patient education for thrombotic events.

A Search for Evidence

A systematic literature search of the following electronic databases was conducted: the Cochrane Database of Systematic Reviews, the National Guideline Clearinghouse (NGC), Medline, and the Cumulative Index of Nursing and Allied Health Literature (CINAHL). The inclusion criteria and exclusion criteria were determined a priori. The inclusion criteria are available upon request. The search excluded studies of patients who were already chronic users of anticoagulants prior to surgery and patients 18 years of age or younger. The initial search terms were: "venous thromboembolism," "pulmonary embolism," "deep vein thrombosis," "aspirin," "Xarelto," "orthopedic surgery," "total knee replacement," "total hip replacement," and "anticoagulants."

Evidence Findings

A total of nine studies were selected as meeting inclusion criteria. Of these, eight were considered as level I evidence; they were systematic reviews or clinical practice guidelines. The elements of my PICOT question were all addressed in these studies; however, there were no head-to-head studies comparing Xarelto® to aspirin. As a result, I broadened the initial inclusion criteria to include the effects of Warfarin as a second comparison intervention.

National Clinical Practice Guidelines and Best Practices

There were no head-to-head studies where aspirin was compared to other anticoagulants. This was surprising since there are clinical practice guidelines in the National Guideline Clearinghouse (2014) that recommend using aspirin as a multimodal approach. According to the NGC (2014), the potential benefit of proper use of optimal prophylaxis reduces postoperative pulmonary embolism and deep vein thrombosis in orthopedic surgery patients. There are associated risks however with anticoagulant prophylaxis such as an increase in bleeding and major bleeding complications. The use of compression stockings can be associated with skin complications. These potential complications need to be weighed with a thorough health history including whether a patient has a history of a previous deep vein thrombosis or pulmonary embolism.

Although no head-to-head comparison studies regarding my PICOT clinical question were found, the National Guideline Clearinghouse provides current detailed guidelines regarding this patient population and the use of anticoagulants. As best practice, the NGC recommends, in patients undergoing THA or TKA, the use of one of the following for a minimum of 10 to 14 days rather than no antithrombotic prophylaxis: low weight molecular heparin (LMWH), fondaparinux, apixaban, dabigatran, rivaroxaban, low-dose unfractionated heparin (LDUH), adjusted-dose LDUH, vitamin K antagonists (VKA), aspirin, or an intermittent pneumatic compression device (IPCD). One guideline panel member believed strongly that aspirin alone should not be included as an option, but no further elaboration of this statement was reported (NGC, 2014). As for application of IPCDs, the evidence supports eighteen hours of daily compliance with intermittent pneumatic compression devices (Loke & Kwok, 2011).

Xarelto®

The newness of Xarelto made it difficult to find studies without the potential for sponsorship bias from pharmaceutical companies. In a study by Soheir, Mcduffie, Lachiewicz, Ortel, and Williams (2013), Xarelto® (rivaroxaban) was found to be superior in preventing pulmonary embolism and deep vein thrombosis with minimal increased risks of bleeding. However, a common theme found throughout the body of evidence is that additional clinical research must be

Venous Thrombosis continued on page 8

Venous Thrombosis continued from page 7

conducted in order to identify longer-term adverse events that may emerge with more widespread use of this new anticoagulant (Soheir et al., 2013).

Conclusions

According to the NGC (2014), the use of aspirin is not indicated as monotherapy for prevention of venous thromboembolism; instead, aspirin should be used with other VTE interventions, including pneumatic compression devices and etc. Recommendations for initiating the anticoagulants in patients undergoing a total knee or hip arthroplasty and receiving LMWH as thromboprophylaxis are either 12 hours or more pre-operatively or 12 hours or more post-operatively (NGC, 2014). For patients undergoing major orthopedic surgery, prolonged prophylaxis of 21 or more days is recommended and decreases the risk for VTE, PE and DVT while increasing the risk of minor bleeding in patients (Sobieraj et al., 2012). All patients should be assessed for their individual risk of thrombosis and their increased risk of bleeding with pharmacological prophylaxis (NGC, 2014).

References

Brown, G.A. (2009). Venous thromboembolism prophylaxis after major orthopedic surgery: A pooled analysis of randomized controlled trials. *The Journal of Arthroplasty, 24*(6), 77-83. doi:10.1016/j.arth.2009.06.002.

Loke, Y., & Kwok, C. (2011). Dabigatran and rivaroxaban for prevention of venous thromboembolism: Systematic review and adjusted indirect comparison. *Journal of Clinical Pharmacy and Therapeutics, 36*(1), 111-124. doi:10.1111 /j.1365-2710.2010.01162.

Merli, G. (2010). New oral antithrombotic agents for the prevention of deep venous thrombosis and pulmonary embolism in orthopedic surgery. *Orthopedics, 27-32*. doi:10.3928/01477447-20100722-64.

National Guideline Clearinghouse (NGC). Guideline synthesis: [Venous thromboembolism (VTE) following total hip and knee arthroplasty: Risk assessment and prevention]. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [cited 2014 February 24]. Retrieved from http://www.guideline.gov.

Sobieraj, D., Lee, S., Coleman, C., Tongbram, V., Chen, W., Colby, J., & ... White, C. (2012). Prolonged versus standard-duration venous thromboprophylaxis in major orthopedic surgery: A systematic review. *Annals of Internal Medicine, 156*(10), 720-727. Retrieved from http://www.annals.org

Soheir, A., McDuffie, J., Lachiewicz, P., Ortel, T., & Williams, J. (2013). Comparative effectiveness of new oral anticoagulants and standard thromboprophylaxis in patients having total hip or knee replacement: A systematic review. *Annals of Internal Medicine, 159*(4), 275-284. doi:10.7326/0003-4819-159-4-201308200-00008.

Stewart,D.W., & Freshour, J.E. (2013). Aspirin for the prophylaxis of venous thromboembolic events in orthopedic surgery patients: A comparison of the AAOS and ACCP guidelines with review of the evidence. *The Annals of Pharmacotherapy, 47*, 63-74. Retrieved from http://www.theannals.com

Tahir, F., Riaz, H., Riaz, T., Badshah, M., Riaz, I., Hamza, A., & Mohiuddin, H. (2013). The new oral anti-coagulants and the phase 3 clinical trials: A systematic review of the literature. *Thrombosis Journal, 11*(1), 18. doi:10.1186/1477-9560-11-18.

Yoshida, R., Yoshida, W., Maffei, F., El Dib, R., Nunes, R., & Rollo, H. (2013). Systematic review of randomized controlled trials of new anticoagulants for venous thromboembolism prophylaxis in major orthopedic surgeries, compared with enoxaparin. *Annals of Vascular Surgery, 27*(3), 355-369. doi:10.1016/j.avsg.2012.06.010.

A New Adult Gerontology Nurse Practitioner Program in Idaho

by Shirley Van Zandt, MS, MPH, CRNP
Clinical Assistant Professor,
Boise State University
Email: shirleyvanzandt@boisestate.edu

With the implementation of the Affordable Care Act, the need for primary care providers has rapidly increased. Nurse practitioners have been seen as a solution for the shortage of primary care providers in this country. The Institute of Medicine's report *The Future of Nursing* (2010) and the Affordable Care Act (U.S. Department of Health and Human Services [DHHS], 2010) provide strong support for the role of advanced practice nurses, specifically for nurse practitioners.

The Idaho State Board of Education has approved a new advanced practice program at Boise State University (BSU) in response to the growing need for more primary care and acute care advanced practice nurses. As a result, Idaho nurses now have another option for continuing their education and preparing for advanced practice nursing care. In January, 2014, the Boise State University (BSU) School of Nursing began its first clinical graduate program, preparing nurses in the advanced practice role as adult gerontology nurse practitioners (AGNP). The first cohort of 28 students started the three-year, part-time on-line program, which will lead to a Master's degree. Most of the students in the first cohort live in Idaho; many live in the Boise area. Several students reside in Washington, Nevada and New Jersey. This cohort includes nurses of varied nursing experiences, with a range of one and a half to 17 years of RN experience in a variety of settings from home hospice to operating room to critical care to generalist care in critical access hospitals in rural Idaho.

This first class will be educated as primary care providers. The second cohort will begin in January, 2015, and will include students pursuing AGNP roles as acute and primary care NPs. Applications are now being accepted. Students in the program will complete their clinical experiences one-to-one with preceptors in the communities where they live. Nurse practitioners and physicians vetted by the School of Nursing will provide this clinical education in their practices.

On-line didactic course work has been designed to provide students with the flexibility of learning and developing their knowledge without coming to a brick-and-mortar campus. Students are required to come to the Boise campus for a 7-10 day intensive experience each summer for the three years. This gives students the opportunity to learn and demonstrate their knowledge and skills in person and will have face-to-face time with faculty for mentoring and professional development.

As with any on-line program, most of which are asynchronous, there are challenges and limitations. Most students in the program are balancing full-time work, family commitments and education. The flexibility for completing course work online is attractive to students who are balancing these commitments, but it also challenges students to be well-organized and self motivated.

Opportunities to develop in-person relationships with faculty as mentors are different in this setting. Students need to reach out to build these relationships, and stronger relationships may develop with preceptors in their communities than with their university faculty. Having university and community-based mentors provides students with a rich opportunity to build their professional network while in school.

The Boise State AGNP program is funded completely by student tuition. This is called a self-supported program which does not receive any funding from the State of Idaho. It is regulated by the State Board of Nursing and did receive initial accreditation by the ACEN (the Accreditation Commission for Education in Nursing) in August 2014. Other NP program options for nurses in Idaho include the Family Nurse Practitioner (FNP) and Psychiatric Mental Health Nurse Practitioner (PMHNP) programs at Idaho State University in Pocatello. These programs lead to a DNP degree and are also accessed on-line. This new program and other options in Idaho provide yet another opportunity for nurses who are eager to serve their communities and develop their nursing skills and knowledge.

References

Institute of Medicine (2010). *The future of nursing: Leading change, advancing health.* Retrieved from http://books.nap.edu/openbook.php?record_id=12956&page=R1

U.S. Department of Health & Human Services (2010). *The Affordable Care Act, Section by section: Title V. Heath Care Workforce.* Retrieved from http://www.hhs.gov/healthcare/rights/law/index.html.hhs.gov/healthcare/rights/law/index.html.

NEWS FLASH!

ANA Needs YOUR Help!

Cheryl A. Peterson, MSN, RN
Senior Director, Nursing Programs
American Nurses Association
8515 Georgia Avenue
Silver Spring, MD 20910
301-628-5089

As you have heard in the news, there is a major Ebola outbreak occurring in several West African countries. The health care systems in the affected countries have been overwhelmed and the nurses, in particular, are bearing the brunt of the care giving with many becoming infected and dying. ANA has been actively monitoring the situation and communicating with ICN to more fully understand the needs in country.

One of the most important strategies for providing assistance in this type of crises is to partner with someone who is already well-established in the area. To that end, ANA is again partnering with the International Medical Corps, a non-governmental organization that has established clinics and relations in Sierra Leon and Liberia. They have reached out to ANA for assistance in recruiting nurses who would be willing to volunteer and provide nursing care in these two countries. International Medical Corps will provide training, personal protective equipment and logistical support. President Cipriano will be sending an email letter via ANA's email list to all ANA members that we have an email for to invite them to consider volunteering. In addition, we are recommending that financial donations be made to either International Medical Corps or ICN's Florence Nightingale International Foundation. Finally, ANA has created an informational Webpage dedicated to Ebola – http://nursingworld.org//Ebola-Information.

ANA appreciates your support for this effort. If you have any questions, please contact either myself (Cheryl.peterson@ana.org) or Mary Jo Assi (Mary.jo@ana.org).

Thank you!

Cheryl

NURSE LEADERS OF IDAHO

Selected Highlights of Events of the Nurse Leaders of Idaho

by Susie Casebolt, R.N., Director of Operations

Idaho Alliance of Leaders in Nursing &
Nurse Leaders of Idaho
Boise, ID 83702
Email: scasebolt@nurseleaders.org
Web: www.nurseleaders.org

Annual Summit

June was a busy month at NLI! On June 5th the Idaho Nursing Action Coalition held its fourth annual summit. During the summit, attendees heard progress reports from IALN's 4 grant funded projects (see INAC update below). Later that evening NLI sponsored its annual "Celebrate Nursing Dinner" where we acknowledged 22 nurses from across Idaho who had been honored by their employers or colleagues. Here they are:

- **Barbara Allerton**: Boise State University
- **Jordie Booth**: West Valley Medical Center
- **Mary DeTienne**: Panhandle Health District
- **Marty Downey**: Boise State University
- **Allie Gooding**, St Luke's Health System
- **Iris Hawley**, Idaho Hospital Association
- **Andrea Fitzgerald**, West Valley Medical Center
- **Jane Grassley**, Boise State University
- **Traci Gluch**, NLI Aspiring Nurse Leader
- **Mary Hereford**, Boise State University
- **Julie Hoerner**, NLI Outstanding Nurse Leader
- **Elizabeth Jorgensen**, St. Luke's Health System
- **Coral Lee**, Clearwater Valley Hospital
- **Ginna Maggard**, West Valley Medical Center
- **Megan Marriot**, St. Luke's Magic Valley
- **Glenda Nelson**, West Valley Medical Center
- **Jai Nelson**, Panhandle Health District
- **Tracy Phillips**, West Valley Medical Center
- **Cheri Samuels**, West Valley Medical Center
- **Courtney Shanahan**, St. Luke's Wood River
- **Pam Springer**, the Council of Nurse Education Leaders
- **Mary Anne Towle**, Boise State University.

The following day, June 6th, NLI held its annual leadership conference, which this year featured two nationally known speakers and authors, **Catherine Robinson-Walker** and **Jennifer Mensik**, as well as four local speakers: **Gina Prindle, Sandra Evans, Janet Willis** and **Tammy Sanchez**. Attendees came away with new insights about their leadership styles, staffing strategies, nursing education and regulation, patient centered medical homes and alarm fatigue.

As part of our Robert Wood Johnson Foundation State Implentation Project (SIP) grant, NLI began offering a week long course **"Building a Foundation of Leadership Excellence"** annually across Idaho. The pilot course was held in Coeur d' Alene in May and received very positive evaluations. In November of 2014, the first regular course will be offered in Boise, and the following year, the course will be offered in eastern Idaho. The course is targeted to nurses in leadership roles and nurses who aspire to be leaders across all healthcare settings. **Deena Rauch** is the project manager for this project. The course has been acquired from the Association of California Nurse Leaders and features Idaho nurse leader faculty.

Aspiring and Outstanding Nurse Leader Awards

Congratulations to **Traci Gluch** as recipient of the Aspiring Nurse Leader Award and **Julie Hoerner** recipient of the Outstanding Nurse Leader Award

Membership

Get ready to renew your membership! As a reminder, annual membership renewals were sent out in June to expiring members. We currently have 128 individual members, 10 organizational members, 1 supporter member and 2 nursing affiliate members. NLI relies on membership dues to sustain the organization financially. NLI thanks to our renewing members for their continued involvement and welcomes our new members.

Nursing Workforce Data

Thanks to the leadership of **Sandy Evans** and the **Idaho Board of Nursing**, Idaho has the resources available to fund key nursing workforce research. Currently the board has approved two grants. The updated **Idaho Nursing Overview** will be published soon through the Idaho Department of Labor. The **APRN Practice and Employer** surveys are being gathered as a SIP project and will be reported in the winter. A **New Graduate Survey** is in the process of being developed.

Committee Reports

The **Education Committee** has provided guidance in the development of NLI's annual June Leadership conference and the October IHA affiliated conference. It is currently reviewing content and speaker suggestions for June 2015. Watch for a **Leadership Conference Survey** which will be launched in the next few weeks. Your responses provide valuable information that help shape our conference content. The Education Committee also reviews the **Nurse Refresher Program**, sponsored by NLI, which facilitates nurses re-entering into practice. The program is currently being reviewed by the Education Committee and the NLI Board for content relevance.

The **Academic and Practice Committee** was created by the Board and approved by membership in 2013. The goal of the committee is to create an opportunity to bring Idaho nursing education and practice closer together in a strategic and thoughtful manner. **Gina Prindle** is the education co-chair of the committee. NLI is recruiting a practice co-chair. If you are interested please contact Margaret Henbest.

The **Partnership Committee** reviews legislation of interest, advises the Executive Director about membership, oversees the annual Celebrate Nursing Dinner, and processes nominations for NLI's annual **Outstanding and Aspiring Nurse Leader Awards**. See names of award recipients above.

Get Involved!

NLI has three active committees and we are also seeking volunteers to work on the *Celebrate Nursing Dinner and our November Foundations of Leadership Excellence* course.

Contact Susie Casebolt or Margaret Henbest if you are interested in becoming involved.

In Memoriam

INA is pleased to honor deceased registered nurses who graduated from Idaho nursing programs and/or served in Idaho during their nursing careers. Included, when known or when space allows, will be the date when deceased and the Idaho nursing program. The names will be submitted to the American Nurses Association for inclusion in a memoriam held in conjunction with the ANA House of Delegates. Please enable the list's inclusiveness by submitting information to rnidaho@idahonurses.org.

Bowen, Kathryn (Kathy), 08/23/2014. As a dedicated nurse and leader, Kathy spent 20 years caring for patients in labor & delivery, in critical care, and in the Emergency Room. As a Family Nurse Practitioner, she was one of the first nurses to earn certification in functional medicine. She established Boise's Intermountain Functional Medicine Clinic that combined traditional and alternative care practices.

Chamberlain, Pamela "Pam" A., 08/02/2014. Pam earned her BSN Magnum Cum Laude and practiced nursing in Colorado and Boise, working in administrative, clinical and long-term care positions. She was dedicated to helping the disadvantaged. She was a nursing supervisor at the Terry Reilly Boise Clinic, caring for the homeless and indigent. She managed the employee clinic at Federal Occupational Health in Boise.

Christensen, Sharon (Gill), 04/24/2014. Sharon completed her nursing education through the Saint Alphonsus Nursing School. She had a long and rewarding career path.

Dinwiddie, Patricia D., 08/24/2014. Pat dedicated 30 years to the profession of nursing. Her contributions to her community will be remembered.

Edwards, Kim J., 07/03/2014. Kim graduated from Boise State University's School of Nursing in 1979 and greeted others with a radiant smile. She is remembered for her love of nursing and full life.

Grossklaus, Theresa B., 07/18/2014. Terri's nursing career included working for the North Central Idaho Health Department as a school nurse. She was a lifetime student, always taking classes to satisfy her thirst for knowledge. She was a compassionate wife and mother and a friend to all.

Julian, Anne C., 09/16/2014. Anne completed her LPN education at Boise State College in 1971 and provided over 20 years of dedicated service. She worked at St. Luke's Hospital in Boise on the medical-surgical floor and in the postpartum unit.

Lamet, Carole A. (Bortak), 01/11/2014. Carole graduated from Boise State University and was known to be a gifted, compassionate, and truly competent nurse. During her career, she worked at the Idaho State Veterans Home.

Matheny, Rosemary J. (McCann), 07/03/2014. Rosemary worked in the emergency room, ICU, and recovery room during her 38-year career at St. Joseph Regional Medical Center in Lewiston. She will be remembered for her nursing skills, her great faith, her humor, and her friendship.

Moody, Frances A. (Garrett), 03/03/2014. Frances held a variety of nursing roles and provided private, personal care to terminally ill patients.

Nolan, Gloria (Johnson), 05/06/2014. Her career path ranged from an LPN who received a Nurse of the Year award in Los Angeles to an RN who worked in California, Arkansas and Idaho.

O'Hara, Jean M., 09/2014. Jean worked as an RN at Bellevue and New York Hospital. During WWII, she served in the 15th Army Air Corps. She was an active volunteer in her church's food pantry.

Sellers, Donna Jeannette, 09/06/2014. Donna served as a flight paramedic in Idaho and was passionate for providing care to her patients. She earned her BSN from Boise State University in 2014 and anticipated an exciting career in nursing. She could light up a room with her presence and love of life.

Stiller, Noreen Margaret (Dvorak), 08/19/2014. Noreen served as a surgical assistant and joined the U.S. Army Nurse Cadet Corps during WWII. She worked at St. Luke's Hospital, Saint Alphonsus Hospital and at several local clinics with physicians who served as her mentors and friends. She later became an RN claims processor for Medicare. Noreen was an accomplished artist and led a full life while traveling and with her family.

Stuart, Dolores, (Hanson), 05/11/2014. Dolores graduated from the University of Minnesota and practiced in the Army Nurse Corps and Boise. She said, "I had a wonderful career as a nurse. After Army service, and when my children were old enough, I worked for years in a Boise nursing home, retiring at the age of 63 to travel with my husband and other family members."

The following are RNs whose final resting place is Idaho:

Bartley, Nora C. Cunningham, 06/17/2014. She had a long career in the Veteran's Administration in Pittsburgh.

Faylor, Carole Ann, 06/23/2014. She had an active career in three Seattle world-class medical institutions.

Lineberger, Wilma (McNabb), 06/16/2014. She graduated from the Michael Reese School of Nursing in Chicago and was a surgical nurse and caretaker of her spouse. She volunteered for children's activities and the arts in her community.

Harrigfeld, Jacqueline "Jackie" (Thorson), 08/112/2014. She had an active career as a nurse in Illinois.

Martin, Bobby A. (Erlich), 05/24/2014. Her career spanned nursing in the Army, Air Force and civilian sector.

Virtue, Joyce A. (Stovall), 05/19/2014. She trained at Cook County Hospital in Chicago.

Warner, Clair M. (McGuire), 05/14/2014. She graduated from the Mary Immaculate School of Nursing in 1938 in New York and practiced nursing in several states.