Greetings North Dakota Nurses,

I want to thank you for taking the time to read the publication of the North Dakota Nurses Association. This issue brings you a summary of the NDNA Annual meeting and the combined Board meetings of NDNA and the Nursing Students Association of North Dakota. It was an honor to get to know them and observe their leadership. We are also including an update on the HERO organization and how nurses have helped across the globe for years. There are 2 updates from the Mid-West Multi-State Division (MWMSD) for your perusal. We are fortunate to offer CE services for our state through the MWMSD.

I hope you already have March 11th marked on your calendar for Nurses Day at the Legislature. You will be able to read a bit more about it in this edition. NDNA is proud to offer CE services for our state through the MWMSD.

I have recently experienced a major role change in my professional work. Working through the transition has heightened my realization of what parts of work are really of value and what is not. In a word, “relationships” provide the value. I have been so fortunate to work with great people who are also very fine health care leaders. They have taught me so much.

I have also had the privilege to work with a great group of nurses, nursing assistants, physicians, pharmacists, chaplains, who have a passion for expert palliative care. The root of the word palliative is to cloak, so the work is about cloaking or covering, managing symptoms so they are not annoying and getting in the way of life. Palliative care uses a multidisciplinary approach to manage not only physical symptoms of chronic and life limiting conditions but also mental, emotional, and spiritual wellbeing. This is a work that is the very foundation of nursing practice, because to be successful it has to be patient and family driven. That also makes it relationship driven.

Expert practitioners of palliative care live the value of honoring the patient clinician relationship, the true value of team relationships and relationship with self. Good palliative care is at its foundation, patient centered with intention. Meaning that it is not just cliché words of being “patient centered” but one where the question is asked out loud many times to help drill down to whose expectations is being met. The question is simple, “Is this the patient’s goal?” or “Is this what the patient has asked for.” The answer often or may make others uncomfortable.

For instance if a patient chooses to tolerate a higher level of pain to be more alert, it may make nurses or a family member uncomfortable. In relationship with the patient, the nurse needs to respect and support their choice. In relationship with self, the nurse needs to be wise enough to examine his or her own motives for wanting the patient to have more pain meds. Does the nurse want to provide more pain medication because it will make the nurse feel more comfortable and successful?

This is where good team relationships become valuable. In a strong team, they can honestly call out behavior that is detrimental to the patient centered goal, in a caring manner. In a team that lacks trust, that kind of open dialogue may cause defensiveness and it can very difficult to untangle those conversations. We have all been there.

As you read this, I challenge you to examine your practice to improve and foster relationships that will result in improved patient/client care. Is it with a co-worker, or is it with yourself to acknowledge the need to be more willing to learn from patients and families. You can hone the skill of being present with patients and clients. You can hone the skill of being present with patients and clients, so you are listening to the meaning of their words and questions not just the surface of the conversation.

Although I see the attention to relationship more visible in the work of palliative care, I know it is a good work for any practice including yours.

To read more check out: http://www.nationalconsensusproject.org/
Join NDNA now! Use form provided or go to www.NDNA.org

ANA Membership Application

For dues rates and other information, contact ANA Membership Billing Department at (800) 923-7799 or email us at membership@ana.org

Essential Information

First Name/Middle Name ___________________________ Last Name ___________________________

Date of Birth ____________ Gender: Male/Female ____________

Credit Card: ____________ Phone Number ________ Circle preference: Home/Work ________

Email Address ___________________________

How did you hear about ANA? □ Colleague □ Mail □ Magazine □ Online □ Other: ___________________________

Employer ___________________________

Type of Work Setting: ____________

Practice Area: (e.g. pediatric) ____________

RN License # ____________________________ State ____________________________

Full Time (1300-40 hours) $ ____________

Part Time (1200-1300 hours) $ ____________

Charge/Deductible: ____________

Co-Pay: ____________

Monthly Payment: ____________

Authorization Signature ____________________________

Card Expiration Date (MM/YY) ____________________________

Printed Name ____________________________

Applications for membership accepted from nurses and student nurses in North Dakota. Applicants must be members of the NDNA. Applicants who are not members of the NDNA are not eligible for membership. Applications are accepted for membership only in the month of submission. Applications that are incomplete or unsigned are returned and are not accepted for membership.

Go to joinnda.org to become a member and use the code: NWW/14

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Completed application with credit card payment to (301) 468-5555

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Join instantly online. Visit us at www.joindna.org

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ANA Customer & Member Billing PO Box 50433 Sioux Falls, SD 56130-5815

http://www.ndna.org

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Discover a richly satisfying and rewarding future where compassionate professionals like you make a positive difference in the lives of hospice patients and their families every day. Careers with Hospice of the Red River Valley are filled with satisfying challenges and countless rewards. Every day. Careers with Hospice of the Red River Valley are making a positive difference in the lives of hospice patients and their families.

We are accepting applications for the following positions:

RNs: Staff, On-Call and Concentrated Care—Full and part-time available

Printable application and position information at www.hrrv.org or call Human Resources at (701) 356-1601.

Offices in: Detroit Lakes, Fargo, Grand Forks, Lisbon, Mountrail County Medical Center, Thief River Falls and Valley City.

Pre-employment drug test and background check.

Full and part-time available

The Prairie Rose

Official Publication of: North Dakota Nurses Association

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The Prairie Rose accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and in APA format. The article should be submitted electronically in MS Word to info@ndna.org. Please write Prairie Rose article in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. Deadlines for submission of material for 2015 Prairie Rose are 3/19/15, 6/19/15, 9/18/15 and 12/18/15. Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don’t know how or where to start, contact one of the NDNA Board Members.

The Prairie Rose is one communication vehicle for nurses in North Dakota.

Raise your voice.

The Vision and Mission of the North Dakota Nurses Association

Vision: North Dakota Nurses Association, a professional organization for Nurses, is the voice of Nursing in North Dakota.

Mission: The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.
• Promote access to safe, competent and affordable care.
• Support new and evolving roles as long as there is role clarity, appropriate education and training, appropriate oversight and that nurses are recognized for their role as care coordinators, which may necessitate removal of the delegation rules in the Nurse Practice Act that limit nurses ability to exercise their judgment.1
• Collaborating in the study of the Community paramedic pilot to ensure safe, gap free care.
• Continue monitoring of pilot sites for measurable health outcomes.
• Through legislation during the 2015 session, develop a scope of practice to better define the community paramedic role and skill set and to include a provision for Advanced Practice Registered Nurses to also supervise community paramedics.2
• Require uniform education and training program including core components.2
• Through legislation during the 2015 session, provide clear definition and reporting lines for accountability and mechanism for documentation of care including provider orders.3
• Advocating for increased access to behavioral health care
• Will monitor bill development on funding for increased access of mental and behavioral health.
• Monitor for increased funding for APRN education to provide Behavioral Health Care.
• Advocating for increased access to School Nursing
• Students’ health and health needs must be addressed in schools to achieve optimum learning.3
• Supports the assignment and daily availability of a registered school nurse for the central management and implementation of school health services at the recommended ratio of one nurse for every 750 students, with an ultimate goal of at least one nurse in every school.5
• On any given weekday, as much as 20% of the combined US population of children and adults can be found in schools (AHA, 2004). To best serve the health needs of students and staff in educational settings, ANA supports a collaborative school health model which requires the cooperation and participation of the school nurse, students, families, teachers, school administrators and staff, other health care professionals, and the community.4
• Collaborating with agencies such as American Cancer Society for decreased tobacco use.
• Tobacco is a worldwide epidemic that requires the leadership and active involvement of nurses.? All nurses and nursing organizations are actively involved in developing and supporting local, state, and national legislative and regulatory efforts that:
  • Restrict the direct and indirect marketing of tobacco products, including those products that might be launched in the future, and those making unproven health claims.4
  • Increase the price of tobacco products through taxation and allocate part of the revenue to tobacco-control programs and tobacco-related research.4
• North Dakota has the 46th lowest cigarette tax of all 50 states and the District of Columbia.6

1 Janet Haehler, Associate Director, ANA State Government Affairs 10/30/14
2 North Dakota Center for Nursing Policy Brief, Community Paramedic Pilot Study Recommendations, September 3, 2014
3 Assuring Safe, High Quality Health Care in Pre-K Through 12 Educational Settings, American Nurses Association Position Statement, 03/2007
4 Nursing Leadership in Global and Domestic Tobacco Control, Oncology Nursing Society Position, 01/2013
5 Campaign for Tobacco-Free Kids, June 20, 2014
6 Looking for Solutions to Improving Health Care in Your State?, IOM Recommendations, America Nurses Association, 07/2012
Let me begin by giving a huge thank you to Tammy Buchholz for her excellent minutes of our recent meeting. I received heavily from them to write this report. Thanks Tammy!

The annual meeting was held November 15th at the Radisson Hotel in Bismarck. Other than the low turn-out it was a very good meeting. The NDNA Board had begun the day by having a joint meeting with the Board of Directors of the Nursing Students Association of North Dakota (NSAND). It is sad to report but NSAND continues to have more members than NDNA! We are hoping our collaboration with them as students will show them the benefits of belonging to and supporting their professional organization after they enter the workforce. NDNA board members will be joining the students at their annual convention in Minot this last weekend in January. We are also looking at partnering with them on local community activities and fund raisers in 2015.

After calling the meeting to order President Roberta Young announced some upcoming dates that everyone needs to add to their calendars. Nurses Day at the Legislature will be March 11, 2015. The event is being coordinated by the North Dakota Center for Nursing with NDNA as one of the sponsors. The second date is the 100 year celebration of the North Dakota Board of Nursing on May 21, 2015 at the Heritage Center in Bismarck. The NDNA website has links to both events for more information.

Wanda Rose and Ev Quigley shared some highlights of the legislative session. They mentioned the urging of NDNA that the BON be created as a regulatory agency to oversee practice and policy. The first Executive Director of the BON was a status member of the new NDNA. The creation of the BON in 1915 by the nurses of North Dakota, who are almost exclusively women, is an impressive achievement. It will be important for us to vote in 2018. Be sure to read the next edition of the Prairie Rose for more history on the founding of the BON. In addition, the NDNA Assembly Membership, shared their experience at this year's meeting in June. Both Jane and Roberta participated in Lobby Day, when all delegates visit Capitol Hill to meet with their respective Senators and Representatives to share concerns regarding health care policy. They were unable to meet personally with Senators Hoeven and Heitkamp or Representatives to discuss the integration of palliative care into more healthcare systems, and the development of high-performance inter-professional teams.

President Young then reported on our (NDNA's) continued partnership with the Midwest Multi-State Division (MSD) through ANA. We have been able to use this partnership to gain efficiencies in accounting, reports, phone systems, website and emails. That is one of the three goals of the MSD. The other two are increasing membership and nurse advocacy. Those two goals will be the focus of the coming year for both NDNA and the MSD.

Next up was installation of new officers. Roberta Young announced a new officer, Donelle Richmond, VP of Finance, who were both reinstated for their second terms. Jamie Hamner was installed as the VP of Membership and Government Relations. The board looks forward to getting to know and work with Jamie in the coming years.

Donelle Richmond reported on the financial status of NDNA. Thanks to the continued diligence of the board we are in a healthy situation. Our primary concern is that our main source of funding comes from the Board of Nursing. Our work with the additional component in developing a CE program is one option being developed. If anyone is interested in specific budget numbers please contact me directly.

Discussion centered on the upcoming legislative session in North Dakota. Kristin Roers, VP of Government Relations, and Tammy Scott, VP of Membership, shared their insights on the upcoming legislation. The Center for Nursing was discussing a proposal to raise the tobacco tax in North Dakota. Please see Kristin's article elsewhere in this edition for more information on our platform and issues we will be following.

Bylaws revisions were centered on shortening notification requirements for new board members. A short time frame was shortened since communication occurs much quicker in our current times. The awards were changed so that they "may" be conferred upon any individual, regardless of the requirements of them instead of requiring them to be.

Other discussions on a variety of topics were held throughout the meeting and all board members would like to know more please contact NDNA for a copy of the minutes. Action items for NDNA in the coming year are the development of organizational policies and procedures (we were left without any when we went to virtual office), hiring a Director of State Affairs and getting them up and running, collaborating with NSAND on various activities, increasing membership and participation, and promoting the CE program through the MSD. Please join us!!

NDNA has a proposed bill to raise the tobacco tax in North Dakota. This bill, sponsored by Republicans, was a significant victory for the Anti-Tobacco Advocates. The bill was passed by the Senate with a vote of 33-0. It is now under consideration in the House of Representatives. The NDNA is urging its members to contact their state legislators to support the bill.

The other two goals of the MSD are increasing membership and partnership. We are also looking at partnering with them on local community activities and fund raisers in 2015. We are also looking at partnering with them on local community activities and fund raisers in 2015.

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ANA Professional Issues Panels: An Opportunity for Nurses to Lead their Expertise and Knowledge to Address National Issues Related to Practice and Policy

Tammy Buchholz, MSN, RN, VP Membership Services for NDNA

As I began increasing my involvement in NDNA, an email arrived encouraging me to apply for a position as an ANA member. Let me explain the purpose of and qualifications for Committee membership on an ANA Professional Issues Panel.

The purpose of the ANA Professional Issues Panels is to meet the new dynamics of care needs in every setting as the world of professional nurses changes. ANA policy is ever evolving. In order to effectively address these changes, ANA uses Professional Issues Panels to drive toward solutions for nurses. Applications and qualifications were presented in the form of a Professional Issues Panel. This exciting and dynamic format seeks to draw on the knowledge and expertise of all ANA members. Let me explain the purpose of and qualifications for Committee membership on an ANA Professional Issues Panel.

The Steering Committee typically includes up to 15 ANA members who will do a deep dive into a topic. Members meet at least once a month for about 2 hours in addition to email dialogue for a 3 to 6 month period. The Advisory Committee, which makes recommendations to the Steering Committee, is selected for the Steering Committee and the Advisory Committee. Each Panel includes both a Steering Committee and an Advisory Committee to ensure sufficient rigor while also allowing for broad feedback from a full range of practice arenas and interests.

Allow me to share the differences between the Steering Committee and the Advisory Committee. The Steering Committee typically includes up to 15 ANA members who will do a deep dive into a topic. This committee will meet intensively via conference call for a three to six month period, depending on the topic. The Advisory Committee will provide additional information, feedback and advice to the Steering Committee. All positions on the Professional Issues Panels are on a volunteer basis. You must be a member of ANA and you must be an RN in order to apply for a Professional Issues Panel. The time commitment depends on the Committee. As a member of the Panel, you are a member of the Steering Committee and the Advisory Committee. The Steering Committee typically meets at least once a month for about 2 hours in addition to email dialogue for a 3 to 6 month period of time depending on the topic. The Advisory Committee requires about 1 hour per month and typically 2 conference calls during the duration of the panel. Applicant qualifications required for each panel are listed with the application information on the ANA website. The Advisory Committee for the Professional Issues Panels is that all applicants who are not selected for the Steering Committee are placed on the Advisory Committee for the panel that they applied for.

When I began my term as VP of Membership in October of 2013, I applied to serve on the Code of Ethics for Nurses Revision Professional Issues Panel. I was excited to be placed on the Advisory Committee, and was the only nurse representing North Dakota. I have followed and participated in the revision process throughout this past year. Final approval by the ANA Board of Directors for the revised Code of Ethics for Nurses was given on November 12th. Plans are for it to be available in print and e-publication by early 2015.

This month I applied to serve on the Workforce Violence and Incivility Professional Issues Panel, 2014-2015. I will be one of two nurses representing North Dakota as an Advisory Committee member, and one of 441 nurses on this committee. The goal of this Professional Issues Panel is to develop a position statement on workplace violence and incivility and detailed guidance for registered nurses and employers.

As a former faculty member at a college of nursing and as a staff nurse on an obstetrical unit, I have seen and experienced for myself many incidents in both settings of uncivil behavior from or between patients, colleagues and students. This work is necessary and timely given that statistics from surveys and research that have been conducted estimate as high as 89% of nurses, faculty and student nurses report having experienced incidents of uncivil behavior in the workplace.

This November a joint meeting of NSAND and NDNA was held prior to the NDNA Annual Meeting. This opportunity allowed the NDNA Board and the NSAND Board to discuss collaborative ideas and how best to foster interest and engagement by nurses in their professional organization. During the discussion, mention was made of my being an Advisory Committee member of the WPVI Professional Issues Panel.

One of the NSAND Board members, Andrea Boerger, shared that she and a group of student nurses colleagues at the University of Mary, where she has worked on a project together that centered on disruptive and aggressive behavior by patients and the effects of those types of behaviors on staff caring for them. Andrea shared her written work with me, which included a proposal to use student education as a means to provide nurses with the tools needed to effectively de-escalate those behaviors in patients. Andrea and her colleagues’ work demonstrates that student nurses are aware of the environment that they will be entering upon graduation and have a genuine concern for how best to navigate these situations.

I encourage you as a member of ANA and NDNA to follow the progress of the work of the WPVI Professional Issues Panel in the next few months. I also encourage you to take action and join me, in representing the nurses in our wonderful state of North Dakota on a Professional Issues Panel. We need your knowledge, expertise and guidance as we navigate the ever-changing health care environment and develop policy and practice guidance for registered nurses.

Acknowledgement: If you are interested in learning more about the project that Andrea Boerger and her colleagues completed, she can be reached at: jeanboergerll@umary.edu

References

http://www.nursingworld.org/MainMenuCategories/PolicyAdvance/Professional-Panels


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Visit our website at internationalmusiccamp.com

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32nd Ave., 51st & St. S.
Being a Super HERO
by: Anne Virginia Lindstrom, Communications Director, HERO.

Hero. A person who is admired for great or brave acts or fine qualities. Do you have what it takes to be a hero? Even a super hero? Here at HERO, Healthcare Equipment Recycling Organization, we work hard to live up to being real super HEROes. HERO’s mission is to collect and redistribute donated healthcare materials to benefit those in need. In other words, HERO is here to help.

HERO started in 1996 when a group of operating room nurses from the Fargo-Moorhead area saw all the usable medical supplies discarded as waste at the hospitals. These nurses joined together and began saving the supplies they could in an effort to distribute them to those in need on a global level.

Within four years, HERO became established as a registered 501(c)3 nonprofit organization and by 2003, the nurses added a local aspect to their mission. Supplies were now also redirected within the local community to help those in need right here in Fargo-Moorhead. HERO was operating out of a small warehouse in Moorhead for a seven year span.

In 2005, the first full-time executive director was hired to help direct the mission. Only 5 years later, HERO moved to an even larger warehouse space in south Fargo, complete with offices and a storefront.

Today, HERO serves over 3,000 local individuals and agencies locally and provides supplies for 50 global medical missions. Since the start of HERO, nearly $1,000,000 in economic impact has been felt in the local community due to HERO’s work. From a 400 square foot garage to a 7,000 square foot warehouse and office space, HERO is continually growing and ready to help those in need.

HERO accepts donations of a variety of healthcare supplies from individuals and local hospitals and clinics. These materials are then inventoried to the storefront where individuals and agencies can pick up supplies at no-cost. Supplies range from bandages all the way up to hospital beds.

No one is ever turned away at HERO if unable to cover a suggested handling fee. We are happy to work with everyone. If you have any items you’re interested in donating or are in need of a specific item, check us out online at herofargo.org or call us at 701-212-1921.

The Midwest Multi-State Division
Spring 2015
by: Jill Kliethermes,
Midwest Multistate Division Leader

It is a pleasure and an honor to be able to serve as the Midwest Multistate Division Leader of an amazing group of Midwest State Nurses Associations and to work with some of the most incredible, hardworking, distinguished, educated, and collaborative registered nurses. The second year of the Midwest Multistate Division (MSD) pilot is well underway. The MW MSD pilot has been both exciting and challenging as we try to come together to increase operating efficiencies in order to build membership and advocacy efforts in the state nurses associations. The following states are currently included in the Midwest MSD: Iowa, Kansas, Missouri, Nebraska, and North Dakota. There are two additional Multistate Divisions being piloted which includes the Northeast MSD (RI, NH, ME, CT and VT) and the West MSD (UT, CO, ID and AZ).

There have been many successes as a result of the pilot; however a notable success has been the Midwest Multistate Division Continuing Nursing Education Unit (MW MSD CNE Unit) being launched. To learn more about the MW MSD continuing education approval process, please contact the MW MSD Office at 573-636-4623 or email questions@midwestnurses.org.

Through our pilot, we found several opportunities to increase operating efficiencies within the participating state nurses associations (SNAs) which have included:

• Launching a call center within the MSD to enable all SNAs to have a phone number and have the phone answered by an attendant.

• Offering financial and accounting services within the MSD and reducing individual SNA expenditures for these services with other service providers.

• Providing common policies and procedure templates to support SNA operations.

• Identifying nurse planners to help plan events co-provided within the MSD.

• Instituted a weekly Professional RN Update publication “Lighting the Way.”

• Monthly leadership calls with the SNAs.

• Monthly membership/marketing taskforce calls with the SNAs.

• Obtained group purchasing/contracts for services discounts for the SNAs.

• MSD Lead participating in SNAs board meetings for consultation.

The Midwest MSD will continue to work on implementing a stream-lined business operations model that leverages common capabilities of the SNAs and ANA to enhance the multistate operations. Through this joint, collaborative effort the Midwest MSD will be more efficient and profitable, allow for more effective advocacy and membership recruitment, and retention efforts in the SNAs. The overarching goal is for the SNAs to grow and become more vital and visible in the future.

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Modern scientific capability has profoundly altered the course of human life. People live longer and better than at any other time in history. But scientific advances have turned the processes of aging and dying into medical matters, to be managed by health care professionals and family. As a result, the medical world has proved alarmingly unprepared for it.

(Atul Gawande, p.6, 2014)

**Abbreviations**
- ACP - Advance Care Planning
- AHA - American Heart Association
- CPR - Cardiopulmonary Resuscitation
- IOM - Institute of Medicine
- NDMA - North Dakota Medical Association
- NDOC - North Dakota Healthcare Decisions Day
- NDACP - North Dakota Advance Care Planning Initiative
- NDHCR - North Dakota Healthcare Review, Inc.
- NDMA - North Dakota Medical Association
- POLST - Physician's Orders for Life Sustaining Treatment

**Advance Care Planning Background (1900-1950)**

Over the past 50 years, North Americans have seen significant changes in how illness and death are experienced. These changes can be attributed to the advancement of healthcare and the national attention given to informing legal cases in recent decades. In the past, physicians made decisions regarding patient treatment and care based on what was medically advisable. With the primary focus on saving and extending a patient's life, there was a reluctance to fully disclose a person's health status, in part, due to the limited life-sustaining interventions available at that time. The change in the patient experience occurred as the practice of full disclosure evolved. (Wilkinson, Wang & Lehman, 2007, Office of Assistant Secretary, 2008).

Generally speaking, patients were not only uninformed of their medical status but also not included in medical decisions. The evolution of the patient experience is related to patients' ethical and legal entitlement to decision-making involvement. Through social change, legal cases, and a patient's right to choose health care and treatment options has been an accepted practice since 1967. In 1967, the modern era of surgically placed feeding tubes began in the late 19th century, in 1914 the courts, they found sufficient evidence to prove she would not have wanted her life sustained, and ordered the artificial hydration and nutrition tube removed due to the extensive brain damage she was in a persistent vegetative state. In this case, the Court held that an individual's right to privacy overrode the state's interest in preserving life. The concept of ‘being a vegetable’ emerged (Brown, 2003, Sabatino, 2007).

In 1990, Nancy Cruzan (1957-1990), age 25, was ventilator-dependent due to the extensive brain damage she experienced from a vehicle accident. She was unresponsive, in a persistent vegetative state, and was also kept alive via artificial nutrition and hydration. When the Cruzan case was presented to the courts, they found sufficient evidence to prove she would not have wanted her life sustained, and ordered the artificial hydration and nutrition tube removed due to the extensive brain damage she was suffering from (Brown, 2003, Sabatino, 2007).

Both of these cases involved young adults who were physically strong but who were in a persistent vegetative state. These cases brought about a stimulatory public debate, which resulted from the court's inability to confirm the patient's wishes for end-of-life care. They did not have the right to determine what shall be done with his own body” (Brown, 2003, Green & MacKenzie, 2007).

By 1992, all 50 states, as well as the District of Columbia, had passed legislation to legalize some form of advance directive. The important elements of informed consent have since been further clarified. (Sabatino, 2007, Wilkinson, Wenger & Shurgarman, 2007). The issue of dying and death had been openly discussed and was beginning to be scrutinized. In 1995, the Institute for Medicine published a 455-page Approaching Death report, which documented the state of end-of-life care. The report examined several dimensions of this the end-of-life care, an urgent need to translate those preferences into medical orders surfaced. In the late 1990s, the POLST (Physician Orders for Life Sustaining Treatment) approach came out. POLST an approach to end-of-life care planning that emphasized the importance of conversations between patients, loved ones, and health care professionals. POLST focuses on palliative care, patient values, and informed consent have since been further clarified.
on the right to die (Hampson & Emanuel, 2005). The Schiavo case highlighted the fact that most Americans believed that life-sustaining medical interventions, including artificial nutrition and hydration, should be determined by physicians, but rather by individuals and their families.

Soon after the Schiavo case, there was an increased interest in completing healthcare directives. The state requirement of medical care with its ever increasing complexity and ensuing legal and ethical dilemmas demonstrates the fact that advance directives and living wills, and healthcare agents, as important as they are, are only one aspect of the solution. The essential and often overlooked elements of advance care planning include the need for patients and families to have conversations regarding their wishes for end of life care and for healthcare providers to translate those wishes into medical orders (Hampson & Emanuel, 2005).

Having a conversation about end-of-life care preferences before the need arises enables easier decision-making when appropriate time for decisions arrives. Though most Americans say that having a discussion with their family about wishes for end-of-life care is important, very few have had that conversation. That suggests the need for conversations about end-of-life care preferences include the National Healthcare Decisions Day (NHDD) project. The NHDD project in 2009 and NHDD public campaign targets April 16th as the annual date for educating the public and providers about the importance of advance care planning. (NHDD website)

An additional organization that provides assistance to individuals and families having conversations about their preferences for end-of-life care is the national grassroots campaign, The Conversation Project, developed in 2010. The goal of The Conversation Project is to provide resources that help foster a conversation among family members of what they as individuals value (The Conversation Project website).

Because of the importance of conversations between healthcare providers and patients about end-of-life care preferences, when the Affordable Care Act was drafted in 2009, a version of the bill authorized Medicare to pay physicians who counseled patients about living wills, advance directives, and options for end-of-life care. Due to the change in the bill, many suggested that the legislation would lead to government-sponsored euthanasia and “death panels,” the proposal regarding end-of-life care could not be found within the Patient Protection and Affordable Care Act (ACA) passed in March 2010.

In September 2014, the Institute of Medicine released its second report regarding the status of end-of-life care in United States entitled, Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. The current state of end-of-life care examined was in regards to:

- Delivery of medical care and social supports
- Patient family provider communication of values and preferences
- Advance care planning
- Health care costs, financing and reimbursement
- Education of health professionals, patients, families, and the public at large.

The report identified persistent major gaps in these areas that require urgent action from numerous stakeholder groups. The consensus believes that compassionate, affordable and effective care is essential and they recommended that: “The provision of person-centered/family-oriented care, including patient-communication and advance care planning, professional education and development, policies and payment systems, public education and engagement (IOM, 2014)

Evolution: End-of-Life Care Planning in North Dakota

In 1991, the North Dakota Board of Medicine and the Patient Self-Determination Act was enacted nationally, the North Dakota legislative branch added chapter, 23-06.5 “Advance Care Planning “to the Century Code, which currently states:

“Every competent adult has the right and responsibility to make the decisions relating to the care, treatment and supportive aspects of their health care including the decision to have health care provided, withheld, or withdrawn. The purpose of this chapter is to enable adults to retain control over their own healthcare during periods of incapacity through health directives and the designation of an individual to make health care decisions on their behalf. This chapter does not condone, authorize, or approve mercy killing, or permit an affirmative or deliberate act or omission to end life, other than to allow the natural process of dying (ND Century Code, 2014).”

From 1999 to 2003, the North Dakota Medical Foundation Research Foundation (an affiliate of the North Dakota Medical Association) organized a broad grassroots constituency to improve end of life care in North Dakota. Due to the increased need andVolume: To create a culture across ND where continuous (on-going) advance care planning is the standard of care and every individual’s informed preferences for care are documented and upheld.

Mission: To assist statewide community partners with the development and implementation of a comprehensive advanced care planning program (NDACCP website).

The accomplishments of the Matters of Life and Death effort were numerous including end-of-life care education for providers and nurses using the Emergency and Crisis (ELNEC) and End-of-Life Nursing Education Consortium (ELNEC) curricula respectively. An additional end-of-life care educational outreach included emergency medicine residency training, medication management by community volunteers, and medical technicians. A community-level perspective was used when addressing the challenges of providing quality end-of-life care. The vision of the North Dakota Medical Association (NDMA) endorsed the voluntary use of POLST by North Dakota providers in 2010. It continues to be used in several North Dakota communities.

In 2013, the North Dakota Medical Association’s (NDMA) goal to improve end of life care for North Dakotans was re-energized when North Dakota Health Review, Inc. (NDHCR, since renamed Quality Health Associates of North Dakota) facilitated several conference calls with all stakeholders to continue the effort to improve advance care planning. NDHCR facilitated several conference calls with these individuals. The initial topics were on advance care planning and re-admissions, then specifically became the need for improved, quality end-of-life care. These activities led to the creation of an ongoing state-wide working group named the North Dakota Advance Care Planning Initiative (NDACP) by the end of year.

This advance care planning dialogue piqued the interest of numerous healthcare professionals and community members from across North Dakota. Face-to-face meetings and conference calls were held to determine the creation of the NDACP was to be housed, what advance care planning model would best meet the needs of North Dakotans, how an individual’s preferences for care could be communicated through the use of a standardized medical order, and what communication resources would be needed for effective education on clinical practice and standards. These activities led to the creation of the NDACP and include over 70 members representing 42 different organizations and agencies. NDACP Coalition has established two main goals to include:

Vision: To create a culture across ND where continuous (on-going) advance care planning is the standard of care and every individual’s informed preferences for care are documented and upheld.

Part II of this Advance Care Planning series will discuss where NDACP is in 2015 and its future goals. The continued use and dispersal of POLST in North Dakota to translate end-of-life goals, wishes and informed preferences into medical orders will be
addressed. Part III will address the specific role of the nurse, bedside to advance practice.

“Talking about death helps us live more fully today.”

(Marianne, The Conversation Project Blog, 2012)

Becoming an Approved Provider of Continuing Nursing Education

The Midwest Multistate Division is pleased to announce that organizations interested in becoming an ANCC/MW MSD Approved Provider Unit now have easy access to all of the materials they need to get started.

Who can become an Approved Provider Unit?
Any organization, facility or individual interested in providing ANCC continuing nursing education that is not considered a commercial interest in providing ANCC continuing nursing education is eligible. Any organization, facility or individual interested in becoming an ANCC/MW MSD Approved Provider must:

• Have the understanding and capacity requirements of eligibility, and demonstrated knowledge to the Midwest Multistate Division.
• Have an application (CNE) that is not considered a commercial interest in providing ANCC continuing nursing education.
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(Marianne, The Conversation Project Blog, 2012)
13th Annual Northwest Region North Dakota Collaborative Educational Conference

“The Brain Connection”

April 17, 2015
7:45am - 3:30pm
The GRAND Hotel
1565 North Broadway
Minot, ND

Provided by:
District 1, North Dakota Nurses Association and Omicron Tau Chapter,
STTI Honor Society of Nursing

Presenters
Lori Garnas, PhD, Associate Director of Development for the North Dakota Center For Persons with Disabilities (NDCPD) and Special Education Faculty Member, Minot State University
Barbara Johnson, Parent of two children with ASD
Gretchen Dobervich, LSW, BSW, North Dakota Field Director for the Minnesota-North Dakota Chapter of the Alzheimer’s Association
Nicola Roed, DNP, RN, CNE – Assistant Professor, Chairperson at the Dept. of Nursing, Minot State University
Teri Eckmann, PhD – Professor at Minot State University

Handouts will be available for download on your personal laptop, e-reader, or mobile device at https://sites.google.com/site/nwthebrainconnection/
There will be NO handouts available at the conference.

Upon completion of this program, the participants will be able to:
1. Identify “red flags” or indicators that a person may have Autism Spectrum Disorder (ASD).
2. Identify three or more strategies that may aid communication with a person who has ASD.
3. Describe how to alter common practices to accommodate a person with ASD.
4. Differentiate between the three most commonly occurring forms of dementia.
6. Identify common causes of traumatic brain injury (TBI) in the veteran population.
7. Identify common causes of post-traumatic stress disorder (PTSD) in the veteran population.
8. Compare and contrast symptoms of TBI and PTSD.
9. Express understanding of the impact and treatment options for veterans suffering from hidden wounds of TBI and PTSD.
10. Identify six critical domains of brain health.
11. Explain how current research of the brain on exercise.
12. Understand how twenty brain boosters affect the physiology of the brain.
13. Participate in twenty brain boosting activities.

Contact hours for this continuing nursing education activity have been submitted to the North Dakota Board of Nursing. Please contact Mary Smith for more information regarding contact hours.

Contact Ann Draper for more information 717-713-7892 or adraper@vibrathcalth.com

The purpose of this educational offering is to increase understanding of diseases and disorders of the brain and identify strategies to promote rehabilitation and brain health.

Agenda

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<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:15am</td>
<td>Registration</td>
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<td>7:45am</td>
<td>Welcome</td>
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<td>8:00am</td>
<td>Competence and Confidence:</td>
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<td>Strategies to Work with</td>
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<td>People on the Autism Spectrum</td>
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<td>9:20am</td>
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<td>The Face and Impact</td>
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<td>Brain Boosters</td>
<td>Teri Eckmann, PhD</td>
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<td>Evaluations</td>
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Conference Objectives

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The Use of Z-track Method for Intramuscular Injections

Appraised by: Alyssa Dahle, SN, Megan Humann, SN, Molly Kahl, SN, and Merry Kraft, SN (North Dakota State University, Sanford Health Bismarck, ND)

Clinical Question:
In the adult patient receiving a medication by intramuscular injection, is there a preferred method for administration that increase medication absorption and decrease patient complications?

Articles:

Synthesis of Evidence:
The systematic review of Yim, Ng, Tsang, and Leung (2009) reviewed six different studies; three randomized studies, two randomized control studies and one quasi-experimental design that was a clinical control trial that focused on using essential oils for patients with depression, or depressive symptoms and examined their clinical effects. The findings were consistent across the studies showing improved depression scores by utilizing multi-stage, and Hamilton Depression Rating Scale (HAMD), Profile of Mood States (POMS), Hospital Anxiety and Depression Scale (HADS), and visual analogue and Structure Clinical Interview (SCID).

Kara & Gunes (2014) found that technique B (internally rotated foot) measured the least amount of pain intensity. Limitations of the study included: postoperative pain obscuring the pain intensity from the intramuscular injection, the three techniques were administered by the same investigator, and the sample size was small and more studies on larger samples should be researched.

The Use of Z-track continued on page 12

Aromatherapy to Decrease Anxiety

Appraised by: Jerri Jo Sterna SN, Karli Olson SN, Rachelle Feigitsh SN, & Rachael Vallero SN, (NDSU Nursing at Sanford Health, Bismarck, ND)

Clinical Question:
In adult patients with anxiety and/or depressive symptoms, is there a preferred method that can reduce the pain and tissue trauma associated with intramuscular injections and better absorb medications? It is recommended that aromatherapy be used as an adjunct therapy for treatment of depressive and/or anxiety symptoms. Multiple studies that were reviewed had small sample sizes, which may have directly affected the quality of the results. However, other studies were of sufficient sample size. The collaborative findings from all studies is that aromatherapy is promising therapeutic effects when applied as a complementary and alternative intervention.

Articles:

Synthesis of Evidence:
The systematic review by Yim, Ng, Tsang, and Leung (2009) reviewed six different studies: three randomized controlled trials, two randomized control studies and one quasi-experimental design that was a clinical control trial that focused on using essential oils for patients with depression, or depressive symptoms and examined their clinical effects. The findings were consistent across the studies showing improved depression scores by utilizing multi-stage, and Hamilton Depression Rating Scale (HAMD), Profile of Mood States (POMS), Hospital Anxiety and Depression Scale (HADS), and visual analogue and Structure Clinical Interview (SCID).

Kara & Gunes (2014) conducted a level II randomized controlled trial utilizing Spiel Berger’s anxiety form. The finding of this study was that aromatherapy had a noticeable effect on decreasing the symptoms of anxiety among female students.

The study by Takeda, Tsujita, Kaya, Takemura, & Oku (2008) is a quasi-experimental study that examined the symptoms of anxiety at rest, during massage, and massage with essential oils. Findings were consistent throughout the trials. The State-Trait Anxiety Inventory, Visual analog scale, Faces scales and IgA and cortisol secretions were tools that observed for symptoms of anxiety. The findings of this study will be of value to practitioners in clinical settings and demonstrate the effects caused from aromatherapy and long lasting effects during stressful environments where anxiety issues were impro

Lee, Wu, Tsang, Leung, and Cheung (2011) conducted a systematic review that examined the clinical effects of aromatherapy in adults with anxiety or anxiety symptoms. The results were based on 16 randomized controlled trials (RCTs) that focused on the anxiolytic effects of aromatherapy. It is recommended that aromatherapy be used as a complementary therapy for people with anxiety symptoms. However, there is no evidence to show lasting effects of aromatherapy.

Overall, the studies were of good quality with a generally consistent that aromatherapy can be used as an adjunct therapy for treatment of depressive and/or anxiety symptoms. Multiple studies that were reviewed had small sample sizes, which may have directly affected the quality of the results. However, other studies were of sufficient sample size. The collaborative findings from all studies is that aromatherapy is promising therapeutic effects when applied as a complementary and alternative intervention.

Bottom Line (findings):
Aromatherapy may suppress symptoms of anxiety and depression. By using aromatherapy, patients’ clinical outcomes may be improved. It can be more cost effective and may improve patient satisfaction. There have not been any reported adverse effects associated with the use of aromatherapy.

Implications for Nursing Practice:
Nurses will be able to advocate for patients with depression and/or anxiety by suggesting aromatherapy as a complementary and alternative intervention when applicable. The studies were which were reviewed suggested that treating depression and/or anxiety with aromatherapy can increase quality of life. Aromatherapy is proven to be a safe and effective intervention.

The Use of Z-track continued on page 12

EVIDENCE BASED PRACTICE
The Use of Z-track continued from page 11
received the Z-track technique and treatment B received the standard technique. The researchers recorded the data using measurement tools such as, the four point Likert scale, discomfort questionnaire and site lesions were measured by the subcutaneous space. The study showed that the Z-track technique does not decrease the initial pain at the injection site but instead the Z-track method affects the discomfort secondary to leakage and injection of the injected tissue into the subcutaneous tissue.

The level V systematic literature review conducted by Nicoll & Hesby (2002) addressed the proper administration of IM injections in the clinical setting. The purpose of this review was to establish an evidenced based clinical guideline for safe administration of intramuscular injections that would improve patient outcomes and reduce errors. The study showed that use of the Z-track technique reduced leakage of medication into the subcutaneous space and resulted in less discomfort for the patient and decreased incidence of lesions at the injection site. The review consistently showed that in two out of three studies, the technique of leaving an air bubble in syringe when administering an IM injection, showed no benefit to the patient. The quality and strength of this study was considered moderate due to inclusion and exclusion data, research designs not clearly defined, and the number of participants in each group not stated. There was an increase in the quality of this systematic review was fair because it reported the findings of descriptive and qualitative studies, but did not integrate the information to conclusion. It could be explained by the fact that this was the first study of its kind and a guideline was developed based on the review, but the study identified that there are many areas that need further research in regards to intramuscular injections.

Clinical Bottom Line:
A strength of three studies reviewed was that they had large sample sizes, which provided sufficient power to detect statistically significant differences. The validity was high for each trial and Level VII opinion of the authorities. The levels are those modified by Melnyk & Fineout-Overholt (2009).

One study was a systematic review of randomized controlled studies, the other three studies were single blinded RCT. Copanitsanou & Valkeapää (2014) conducted a systematic review of randomized controlled studies. The systematic review included 16 studies, 2185 total participants, that included children aged 12-18 who were undergoing an elective surgery. The interventions included a variety of different teaching methods prior to surgery such as, the tour of the operation room, the tour of the induction room and operating room, and a review of randomized control trials contradicting each other. Keen (1985) stated that the Z-track method may not decrease the initial discomfort but may decrease to discomfort to medication leakage into the subcutaneous tissue. Kara (2014) stated that having the patient internally rotating their foot is more effective in pain reduction than using the Z-track method. Another study, Engstrom et al. (2000) was a descriptive study that showed children were not interested in using procedures that could reduce the pain and tissue trauma associated with intramuscular injections. The last study stated that the Z-track technique showed no significant if using techniques that could reduce the pain and tissue trauma associated with intramuscular injections. The last study stated that the Z-track technique showed no significant benefits if using techniques that could reduce the pain and tissue trauma associated with intramuscular injections.

Implications for Nursing Practice:
The evidence from three out of the four studies supports the use of the Z-track method when administering intramuscular injections in adult patients. The Z-track technique demonstrated decreased anxiety during intramuscular injections would provide consistency in medication delivery. The Z-track technique demonstrated decreased anxiety during intramuscular injections would provide consistency in medication delivery.

Pre-Op Education for Children

Appraised by: Chris Coombe, SN, Amy Meyer, SN, Lindsey Miles, SN, Jenn Rinas, SN (NDSU Nursing at Sanford Health Bismarck, ND)

Clinical Question:
Does preoperative education decrease anxiety in children who undergo elective surgeries?

Articles:


Synthesis of Evidence:
Four articles were reviewed as evidence in this study. Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a study with a level II randomized controlled trial, Level III with a level II randomized controlled trial, Level IV with a level III randomized controlled trial, Level V with a level IV randomized controlled trial, Level VI with a level V randomized controlled trial, and Level VII with opinions of the authorities. The levels are those modified by Melnyk & Fineout-Overholt (2009).

The evidence from three out of the four studies supported the use of the Z-track method when administering intramuscular injections in adult patients. The Z-track technique demonstrated decreased anxiety during intramuscular injections would provide consistency in medication delivery. The Z-track technique demonstrated decreased anxiety during intramuscular injections would provide consistency in medication delivery. The Z-track technique demonstrated decreased anxiety during intramuscular injections would provide consistency in medication delivery.

Bottom Line:
Of the four articles reviewed, all articles indicated a decrease in anxiety of the child in the experimental group. The Z-track method was more effective in pain reduction than using the Z-track method. Another study, Engstrom et al. (2000) was a descriptive study that showed children were not interested in using procedures that could reduce the pain and tissue trauma associated with intramuscular injections. The last study stated that the Z-track method showed no significant benefits if using techniques that could reduce the pain and tissue trauma associated with intramuscular injections. The last study stated that the Z-track method showed no significant benefits if using techniques that could reduce the pain and tissue trauma associated with intramuscular injections.

Implications for Nursing Practice:
Evidence suggests that implementing a preoperative educational program for children undergoing elective surgery can reduce anxiety preoperatively and postoperatively, which can improve postoperative outcomes and patient satisfaction. We recommend converting an unused operating room for pediatric education through preoperative tours and demonstration two days a week.
Nurse to Patient Ratio

Appraised by: Kaitlin Regan, SN and Sandra Hanly, SN (NDSU Sanford College of Nursing Bismarck)

Clinical Question:
Does increasing nurse to patient ratio decrease patient morbidity and mortality?

Articles:

Maffiuletti, N. A., Roig, M., Karatzonos, E., & Nanas, Gerovasili, V., Stefanidis, K., Vitzilaios, K, Karatzanos, the review. With 87 articles reviewed including reviews criteria (AMSTAR) were excluded from not meet the assessment of multiple systematic reviews. Articles published before 2009, those modified by Melnyk & Fineout-Overholt Level VII opinion of authorities. The levels are a systematic review of random control trials and evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melnyk & Fineout-Overholt (2005).

Shekelle (2013) conducted level V systematic review including studies published from September 2009-2012 and published in English. Eighty seven articles were reviewed along with the systematic reviews included in two cross-sectional studies, nine longitudinal and a systematic review. Articles published before 2009, articles not published in English and a study that did not meet the assessment of multiple systematic reviews criteria (AMSTAR) were excluded from the review. With 87 articles reviewed including one systematic review it covered a large number of articles that offered valid conclusion. This systematic review discussion concluded that the nurse staffing ratio is related to hospitalized patient morbidity and mortality. Limitations of the study is low response rates to surveys, potential poor matching on RN staffing to actual patients they were not satisfied with their work relative to Pennsylvania staff nurses from the National Sample Survey of Registered Nurses.

Synthesis of Conclusions:
Critique of two studies concluded that the evidence supports design criteria and has scientific merit. Both studies discussed the issue of nurse to patient ratios and their impact on patient morbidity and mortality. The studies helped answer the clinical question: Does nurse to patient ratios affect patient morbidity and mortality? Each study was rated on the strength of their evidence from Level I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melnyk & Fineout-Overholt (2005).

Overall both studies found that there is a consistent relationship between higher number of nurses per patient and the reduction of hospital related mortality and morbidity. There is significant evidence to make changes in practice because there is statistical significance in all studies reviewed and patient morbidity and mortality is decreased with more nurses to fewer patients. Based on the conclusions of these studies we recommend that facilities implement staffing policies that limit the number of patients to no more than 4 to 6 for every nurse.

Implications for Nursing Practice:
Evidence based practice shows that nurse to patient ratios do affect patient morbidity and mortality. Patient acuity is increasing along with a shortage of experienced nurses to take care of them. With the ever increasing cost of health care the issue of nurse to patient ratio is a concern across the country. Nurses are frustrated by increasing patients to care for as hospitals try to cut costs. It is in the best interest for hospitals to cut costs as well as financial security to take nurse to patient ratios seriously. Changes are not easy but evidence based research supports nurse to patient ratios which decrease patient morbidity and mortality. Nurses working on medical/ surgical units should be key players in support practice change and implementation of evidence based practice nurse to patient ratios which are proven to decrease patient morbidity and mortality.

Use of Neuro Electrical Stimulation to Decrease Muscle Wasting in ICU Patients

Appraised by: Taylor Winner, SN, Angela Walz, SN, Kaylee Greene, SN, & Corey Winge, SN (NDSU Nursing at Sanford Health, Bismarck, ND)

Clinical Question:
Does neuromuscular electrical stimulation of core muscle groups in critically ill patients reduce the percentage of muscle wasting?

Articles:


Meeen et al. (2010) conducted a level II randomized controlled trial. The aim of this study was to explore if neuromuscular electrical stimulation will help reduce muscle atrophy in critically ill patients. This study was not randomized but further research is needed to prove the significance.

Bottom Line: (findings)
The evidence suggests that the use of neuromuscular electrical stimulation will help reduce muscle atrophy in critically ill patients but further research is needed to prove the significance.

Implications for Nursing Practice:
A protocol to be developed to include the use of NMES therapy in critically ill patients. Caregivers of critically ill patients can recommend NMES as an option to decrease muscle wasting and promotes earlier rehabilitation in the recovery process.
Curcumin for Patients with Depression

Clinical Question: Does the use of curcumin decrease depressive symptoms in patients with depression?

Articles:
- Logresti et al (2014) conducted a level I randomized double-blind placebo controlled trial. The study showed that curcumin had significant antidepressant effects on patients with major depressive disorder. The authors concluded that curcumin is a safe and effective treatment for depression.
- Lopresti et al (2014) conducted a level III quasi-experimental study to investigate the effects of curcumin in patients in a randomized controlled trial. The study showed that curcumin is effective in reducing symptoms of depression, and with a wide variety of treatment styles and study designs. The study was published in the Journal of Clinical and Translational Medicine (2014, 343:1002-1005)
- Panahi et al (2014) conducted a level II randomized controlled trial over a 6 week period in which patients were assessed on the effects of curcumin on depression symptoms. The study concluded that curcumin is effective in reducing symptoms of depression.

Evidence for all three articles supported the use of curcumin to treat symptoms of depression were appraised. Each study showed positive evidence for the use of curcumin as a natural medication to decrease the symptoms of depression.

Bottom Line: Evidence based research shows that curcumin was found to be safe and effective in treating depressive symptoms. The natural supplement was studied by comparing it to placebos or current medications used to treat depression and/or in combination with these medications. The evidence found in the field of curcumin research showed that natural supplements produce fewer side effects, and the research showing that curcumin does decrease the signs and symptoms of depression and is as effective as the current medications used, there is sufficient evidence to suggest changing the current standards of treatment to improve clinical outcomes and patient satisfaction.

Implications for Nursing Practice: Practice recommendations include an in-service with medical providers who work in the psychiatric field. A staff meeting for nurses working alongside these providers would also receive an in-service or online education about the benefits and plan for use of curcumin in patients diagnosed with depression. With these education opportunities nurses would be able to properly educate patients on the benefits of a holistic approach to treating depression. Ideally medical providers would implement the recommendation of curcumin gradually, but nurses would like to give the patient the option of a natural supplement to treat symptoms of depression with fewer negative side effects than standard antidepressant medications.

Delayed Umbilical Cord Clamping in Full Term Infants

Clinical Question: In full term newborn babies, does delaying umbilical cord clamping for greater than 60 seconds contribute to increased blood volume and subsequent increases in hemoglobin, hematocrit, and iron stores?

Articles:

Evidence for all three articles supported the question of delayed umbilical cord clamping and its increase in benefits to infants. In the immediate postpartum period of less than 48 hours, both systematic reviews found increases in hemoglobin and hematocrit in newborns. All three studies found increases in iron stores that last up to 6 months in infants, and all agreed that the benefits to babies merit a more enthusiastic approach to delayed umbilical cord clamping.

Bottom Line: Delaying umbilical cord clamping takes less than five minutes. In full term, healthy infants, and without any emergent complications for mother or baby, it is a reasonable amount of time to offer the neonate in exchange for immediate increases in blood volume, hemoglobin and hematocrit, and for further benefit of an increase in iron stores lasting 6 months. The evidence in all included systematic reviews and studies shows a clear benefit for babies when umbilical cord clamping is delayed for 3 minutes.

Implications for Nursing Practice: Changing institutional policy is one way that the benefits of delayed umbilical cord clamping can become more consistent among health care providers. Nurses will be at the front lines in making this practice more widespread by encouraging patients to delay the clamping of the umbilical cord and educating them about the benefits of a delayed clamping. With these educational programs and plans, the topic of delayed cord clamping will fit seamlessly in with the education and birth planning process.
Synthesis of Conclusions:

Four articles discussing fat consumption in relation to cardiovascular events were carefully assessed. The evidence in each study reviewed was of high quality with sufficient sample sizes for the study design. The studies also had adequate control and definite conclusions. Each study was rated on the strength of their evidence from Levels I to VII, with Level I being a systematic review of random control trials and Level VII opinion of authorities. The levels are those modified by Melnyk & Fineout-Overholt (2005).

The first study, by Biong, Veierod, Ringstad, Thelle, & Pedersen (2005) is a case control study conducted in Norway. The purpose of the study was to relate dairy fat intake in relation to those at an increased risk of having a first myocardial infarction (MI). The study found that intake of dairy fat may in fact have protective properties against developing cardiac complications.

The second study, conducted by Howard, Van Horn, Haia, Manson, Stefanick, Wass whirlt-Smoller, &... Kotchen (2006) is a random control trial. This study, conducted in forty U.S. clinical centers, compared lowering fat consumption and increasing servings of fruits and vegetables to a regular diet. The study focused on the incidence of cardiovascular events in relation to the interventional diet. The results of the study found that there was no significant influence on cardiovascular events when fats were lowered.

The third study was a systematic review performed by Kratz, Baars, & Guyeten (2013). There were sixteen studies which were conducted in the U.S., Europe, and Australia. It compared the consumption of high fat dairy products and the incidence of cardiometabolic disease. The findings concluded that there was no significant association between the amount of dairy fat consumed and cardiovascular events.

The fourth study by Mead, Atkinson, Albin, Alphey, Baic, Boyd &... Hooper (2006) was a systematic review comprised of thirteen studies. The research was based on the consumption of omega-3 and substituting saturated fats with unsaturated fats. In this study, the intervention group was advised to increase omega 3 fats and decrease lipids. There were no significant findings between these diet changes and cardiovascular disease.

Bottom Line:

There is evidence to suggest that there is no correlation between fat intake and the occurrence of cardiovascular events. The research supports that since there is no significant relationship between decreasing the fat, patients should not be restricted to a lower fat diet. In fact, some fats, especially dairy, have cardio protective properties. The change from a restricted, low fat diet to an unrestricted, regular diet is cost-effective, improves patient satisfaction, and may lower the occurrence of cardiovascular events. Therefore, implementing this type of diet would be beneficial not only to patients, but also to the health care industry.

Implications for Nursing Practice:

Nurses, cardiologists, and diétitians who care for patients in the health care setting should be aware of this new research to support the implementation of a unrestricted, regular diet. Since this topic is new to research, there is limited information; however, the health care team should be more proactive in conducting further research, ultimately advocating for their patients.

Many hospitals in the region follow the American Heart Association guidelines which suggest a low fat diet. Therefore, the increased fat diet isn’t being implemented. Nurses working with cardiac patients should be team leaders in incorporating this practice change into the health care setting with additional research.
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