The Prairie Rose

NDNA
North Dakota Nurses Association

THE OFFICIAL PUBLICATION OF THE NORTH DAKOTA NURSES ASSOCIATION
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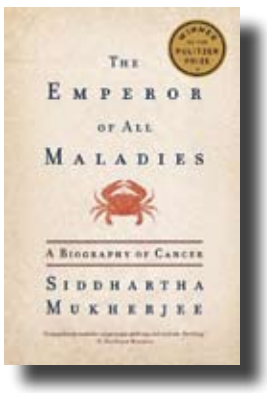

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Come One Come All to the 100 Year Celebration

2012 marks the 100th anniversary of the North Dakota Nurses Association. For 100 years NDNA has promoted high standards of nursing practice, fostered positive workplaces for nurses, fostered professional and educational advancement of nurses and lobbied on healthcare issues affecting nurses and the public. Over the years nursing has been recognized as one of the most valued professions due in part to the social responsibility nursing has to society. We have much to celebrate. A 100 year celebration will take place September 21, 2012.

To commemorate the 100 year anniversary of NDNA, we look forward to:

- Celebrating the accomplishments and professionalism of its members.
- Reviewing our history
- Looking into the future

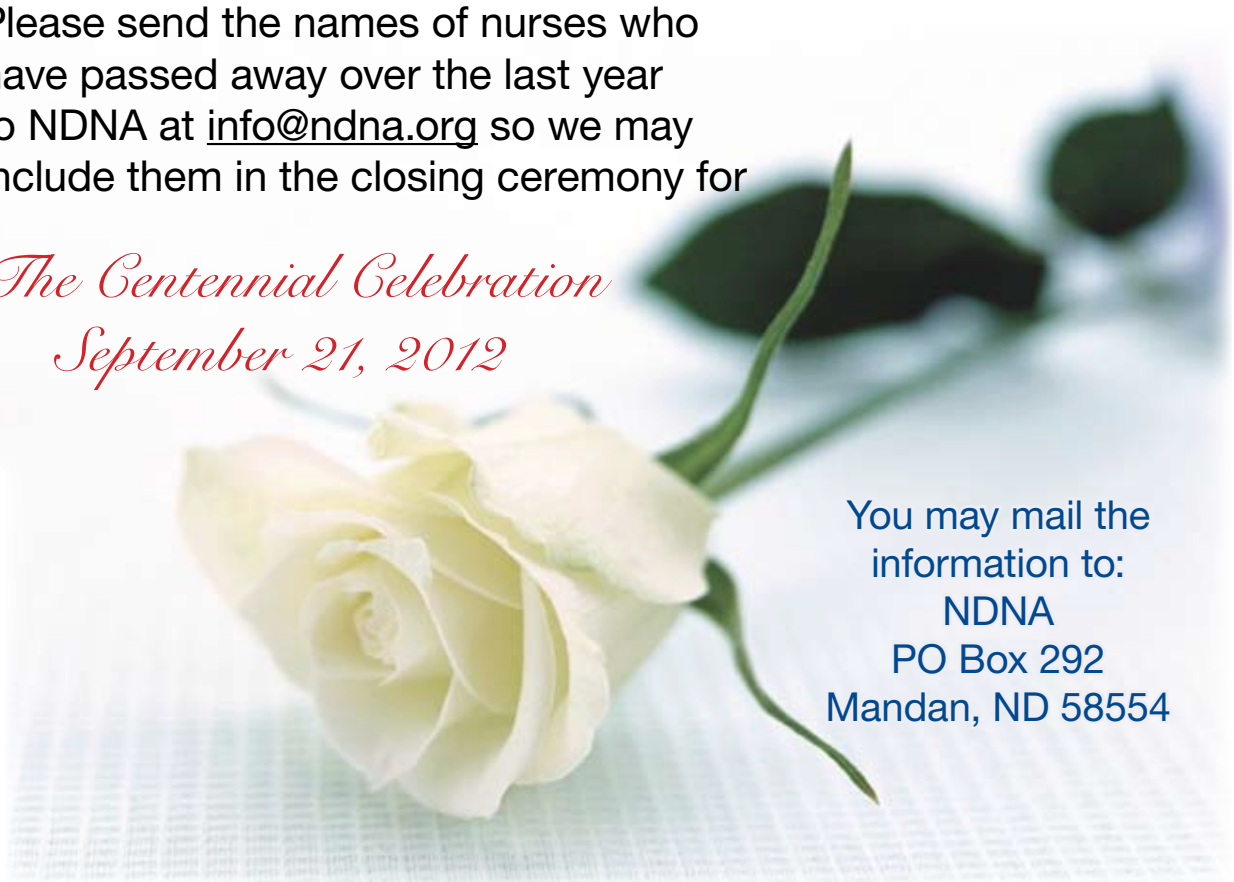
All nurses are invited to come and celebrate as we look back over our past, and refresh our vision for the future. Details of the celebration are described in this issue of the *Prairie Rose*.

I invite all nurses to come and share in the celebration.

Nightingale Tribute

Please send the names of nurses who have passed away over the last year to NDNA at info@ndna.org so we may include them in the closing ceremony for

The Centennial Celebration
September 21, 2012



You may mail the information to:
NDNA
PO Box 292
Mandan, ND 58554

You are cordially invited to join the North Dakota Nurses Association

See the NDNA Website at www.ndna.org
Click on Membership

Under how to join
Click on Membership Application (ANA website)

Click on Full Membership
(Be ready to provide your email address)

Full membership is just $20.50/ month! Less than 70¢ a day!

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.

http://www.ndna.org

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Prevent Child Abuse
North Dakota

Join the Campaign to End Shaken Baby Syndrome and Abusive Head Trauma!

Prevent Child Abuse North Dakota and Stop the Shake, in partnership with the North Dakota Department of Human Services and the North Dakota Department of Health, are working to ensure that every North Dakota family gets the message about shaken baby syndrome and abusive head trauma.

Working together we have set a goal this year to provide every parent with a newborn a Period of Purple Crying (PPC) prevention packet. PPC is a Center for Disease Control supported, evidence based project that has been shown to increase parents' ability to apply stress reduction strategies for themselves and articulate their child's needs to other caretakers. These two skills directly translate into reduced risk for young children. More information about PPC is available at http://www.purplecrying.info/.

Our plan is to supply every birthing facility in ND with PPC packets for each of the families they serve during the year. The packet consists of a DVD and printed booklet that demonstrate stress reduction approaches, provides information about child development and sends the clear message to never shake a baby. In addition, Prevent Child Abuse ND will make its staff available to facilitate on site in-service training to staff participating in the project. Both the parent packets and the in-service training are free of charge.

PPC packets will be ready for distribution beginning in December 2011. For more information and to join the campaign against Shaken Baby Syndrome, contact Prevent Child Abuse North Dakota at 701.223.9052 or at info@pcand.org.

For additional information:
pcand.org
stoptheshake.org
http://www.ndhealth.gov/injuryprevention/shaken/

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Writing for Publication in the Prairie Rose

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 becky@ndna.org. Please write ***Prairie Rose article*** in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA.

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 the office at NDNA: 701- 223-1385.

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.

Will the Real Nurse Leader Please Stand Up?

He profits most who serves best. – Arthur Fredrick Sheldon

Priscilla Smith-Trudeau, RN, MSM, CRRN, CCM

Reprinted with permission from the Vermont State Nurses Association, October 2011, Vermont Nurse Connection

Priscilla Smith-Trudeau

Will the real nurse leader please stand up? Not the chief nursing officer, nurse manager, or charge nurse, but the role model. Not the highest-paid nurse leader, but the one who inspires others to serve a higher purpose, something beyond themselves. Not the nurse leader who promotes herself or himself, but the promoter of others. Not the nurse leader who says, "Follow me!" The one who says "Let me help you!"

We all know and are experiencing the uncertainty of healthcare. To say that today's nurse leader must learn to initiate rapid and continuous change during these turbulent times is to state the obvious. As workplaces undergo these changes, the management-employee relationship is becoming more challenging. Nurse leaders are questioning what they can fairly expect from employees. Many organizations are facing a leadership crisis, which will only deepen unless some fundamental transformation takes place. There is an urgent need to do some soul searching regarding how to best address this need. The more traditional autocratic and hierarchical models of leadership have lost its effectiveness and many organizations are moving toward servant leadership as a way of being in relationship with others and still effectively navigate change. The servant leadership approach seeks to get people enthused, excited and energized to be able to withstand and effectively serve others during times of change. Leaders need to understand that the employees they serve need a hope beyond the change. No other leadership approach can accomplish this better than servant leadership.

Robert Greenleaf founder of the modern Servant leadership movement researched for forty years management, development, and education. All along, he felt a growing suspicion that the power-centered authoritarian leadership style so prominent in U.S. institutions was not working, and in 1964 he took an early retirement to found the Center for Applied Ethics. He developed a conceptual framework and philosophy that the servant-leader is servant first.

> It begins with the natural feeling that one wants to serve. Then conscious choice brings one to aspire to lead. The best test is: do those served grow as persons: do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society; will they benefit, or, at least, not be further deprived.[i]

In the twenty-first century the concept of servant leadership is increasingly viewed as an ideal leadership form to which countless numbers of people and organizations aspire. In fact, during these turbulent economic times we are witnessing an unparalleled sudden increase of interest in, and practice of, servant leadership.

For most of my career, I viewed myself and my colleagues as professionals providing a service, but never really as servants, until I met a young Tibetan woman, named Namgal. She was one of my nursing students who graduated as a nursing assistant and went to work in long term care to serve the elderly. Later on, I found out that she had left nursing and gone to work in retail. One day I walked into a store and there she was serving customers. I asked her why she had left the nursing center and the work she loved. In the most loving and thoughtful way, she shared the following account of her departure. Namgal said that one evening she had been preparing the patients for dinner by washing their hands and placing a bib around their necks to protect their clothing. All of a sudden another employee dashed into the dining room and ripped off the bibs and said, "We are short staffed and we don't have time for this." Namgal turned to one of the patients and saw that he had a tear running down his face. She gently brushed the tear away and asked him why he was crying. The patient responded, "That girl was so mean to you and I feel so sad." Namgal shared that in her culture she was taught to do no harm which sometimes means just being present when wrong is being perpetrated. In that moment listening to her, I realized servant leadership is not about a position of leadership, but that servant leaders are at all levels of the organization modeling the way.

Seven years later, I must have needed a reminder of servant leadership. I was working the night shift at the hospital where I met a housekeeper, who was in her late sixties named Alice. No matter how treacherous the weather and road conditions, Alice would arrive faithfully at five o'clock in the morning. Having marveled at her dedication for several months, I decided to inquire of her motivation and commitment. Her response to me was, "I need to get here so that the patients will have clean rooms and the nurses will have a clean workplace to begin their day. I thought to myself, another servant leader without a position on high, no degree, not the highest paid, but the lowest paid, leading by example demonstrating servant leadership, "Let me help you!"

> *My research debunks the myth that many people seem to have . . . that you become a leader by fighting your way to the top. Rather, you become a leader by helping others to the top. Helping your employees is as important, and many times more so, than trying to get the most work out of them.*
>
> **~William Cohen, The Stuff of Heroes: The Eight Universal Laws of Leadership**

Servant leadership is leadership turned upside down.[ii] Most of us in the nursing culture have been educated to view nurses in positions of leadership as authority figures, who direct others and expect to be obeyed and served. Self-interest dominates. The servant leader goes beyond self-interest to develop others by giving encouragement, to impart empathy, to show interest, to banish fear, to build self-confidence and awaken hope in the heart of others.[iii] In Greenleaf's view, servant leaders display some of the following characteristics:

- *They are servants first.* The desire to serve others takes precedence over the desire to be in a formal leadership position. They move into leadership through service rather than from the need to exercise power and control. Servant leaders make a conscious choice to use their gifts in the cause of change and growth for individuals and the organization.

- *Servant leaders rely on insight and vision.* They have an instinctive sense of the big picture, of where they and their team are headed, and they can articulate a vision to others that gives inspiration and meaning to work.

- *Servant leaders inspire trust.* Their spirit of giving is so unselfish that people trust them unconditionally. The followers know that the servant leader has their best interests at heart. Servant leadership can inspire followers in ways that traditional approaches cannot due to the leader's focus on the individual instead of the bottom line.

Real Nurse Leader continued on page 5

Nursing Honor Society Awards Scholarship

Danielle Ebnet, a nursing student at North Dakota State University, has been selected by the Xi-Kappa-At-Large Chapter of Sigma Theta Tau International Nursing Honor Society as the first recipient of the annual Martha Vorvick Berge Memorial Scholarship. The mission of the honor society is to support the learning, knowledge and professional development of nurses committed to making a difference in healthcare worldwide.

Ms. Ebnet is a resident of Holdingford, Minnesota and selected nursing because of the influence nurses have on each patient. In addition to her studies, she volunteers in a local Emergency Room/Urgent Care Setting and is involved in various community activities with the Student Nurses Association at NDSU.

For further information please contact Karen Robinson at 701-239-9558.

NDNA

1912-2012
September 21, 2012
Ramkota Hotel
800 South 3rd St. ✧ Bismarck, ND ✧ 701-258-7700
info@ndna.org

Schedule & EARLY Registration

Centennial Celebration Conference	***History Walk***	***Celebration Dinner, Nightingale Tribute***
8:00–8:30 AM Registration		Separate fee schedule for celebration dinner.
8:30–8:45 AM Welcome by NDNA President Wanda Rose PhD, RN, BC		See below ↓
8:45–10:00 AM Nursing Leaders Reflect on the Past and Vision for the Future (Panel Discussion)		
10:00–10:30 AM	**History Walk Opens**	
10:30 AM–12:00 PM "Genetics/Genomics–Nursing Practice enters a New Era" Mary Riske MS, RN, CNS	↓	
12:00–1:30 PM Lunch	↓	
1:30–2:30PM ***ANA President Address***	↓	
2:30–3:00 PM Break/ Networking	↓	
3:00–4:00 PM Nursing in the New Social Network	**History Walk Closes 4:00 PM**	
4:00–4:15 PM Evaluation & Wrap-Up		Partial refunds–$25 administrative fee up to August 17, 2012
$55 NDNA Members $65 Non-member		No refunds after August 17, 2012
5:30–6:30 PM	➢	Social Hour
6:30–7:30 PM	➢	Dinner
7:30–8:00 PM	➢	Awards & Recognition
8:00 PM	➢	Nightingale Tribute
[Schedule may be subject to change]	Cash bar available during social hour/ dinner.	$30/plate or **$300 to reserve table for 8**

✂- -

Name	
Address/City/State	
Email	
Phone	
Registration fee	☐ Conference ($55 member) ☐ Conference ($65 nonmember) ☐ Awards Dinner ($30/plate) # ___ of guests? = total ________ ☐ Reserved table for 8 ($300) (ER)

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Real Nurse Leader continued from page 3

- *Servant leaders listen first to affirm others.* One of their greatest gifts to others is seeking to understand first and listening fully to the problems that are presented, removing their own agenda and needs from the listening process. The leader affirms their confidence in others. Unqualified acceptance enables others to experiment, grow, and be creative without fear.[iv]

Servant-leadership is more than a concept, it is a fact. Any great leader, by which I also mean an ethical leader of any group, will see herself or himself as a servant of that group and will act accordingly." ~ **M. Scott Peck**

Much has been written about nursing leadership and management. Nursing programs continue to improve their curriculum. But are the graduates from these programs adequately prepared for today's turbulent and volatile world of healthcare where delivering value to employees and consumers is essential? The increasing diversity of the nursing workforce and the quickening pace of social networking and technological change require a fundamental rethinking in leadership and management education. The focus needs to be shifted from process and outcome to people and the future to develop nurse leaders who know how to unleash the creative potential of staff; create a positive workplace that will attract and retain talented nurses; and reinforce innovations and risk-taking. Servant leadership is an excellent place to start.

As leaders, we recognize that we are all prisoners of our hope. Our hope sustains us. Our vision of what could be inspires us and those we lead. In implementing our vision, we accept the reality that we don't have all the answers. A servant leader's results will be measure beyond the workplace, and the story will be told in the changed lives of others. There is no scarcity of feet to wash. The towels and the water are available. The limitations if there is one is our ability to get on our hands and knees and be prepared to do what we ask others to do.[v]

Will the Real Servant Nurse Leader Please Stand Up?

Priscilla Smith-Trudeau, RN, MSM, CRRN, CCM, is a healthcare management consultant specializing in workforce development. She is the President of Wealth in Diversity Consulting. The web is www.wealthindiversity.com

i Greenleaf, R., (2002), *Servant Leadership, A Journey into Power and Greatness*, Paulist Press, Mahwah, NJ

ii Daft, R., Lengel, R., (2000), *Fusion Leadership,* Berrett-Koehler Publ., San Francisco, CA

iii Cashman, K., (1998) *Leadership from the Inside Out,* Leader Source Limited, Minneapolis, MN

iv Daft, R., Lengel, R., (2000), *Fusion Leadership*, (p 176), A personal communication from George Starcher and Dorothy Marcic, 1994., Berrett-Koehler Publ., San Francisco, CA

v Pollard, C, (1996), The leader who serves, *The Leader of the Future,* The Drucker Foundation, Jossey-Bass Publ., San Francisco, CA

ANA Supports Adequate RN Staffing, APRN Recognition In Comments to CMS on Hospital Conditions of Participation

SILVER SPRING, MD–The American Nurses Association (ANA) supports proposed changes in Medicare and Medicaid rules for hospitals that would support the work of millions of registered nurses (RNs) and advanced practice registered nurses (APRNs), allowing them to provide more efficient and higher quality care to patients.

In comments submitted Dec. 16 to the Centers for Medicare and Medicaid Services (CMS), ANA encourages CMS to work together to improve guidelines to ensure nurse staffing is adequate to provide high-quality care for Medicare and Medicaid patients. Recommendations include implementation of hospital-wide staffing plans that identify an appropriate number of RNs on each unit to meet patients' needs; annual evaluation of staffing plans that analyze patient outcomes attributable to nursing care; and public posting of staffing plans.

ANA also advocates revisions that would enhance the ability of APRNs, such as nurse practitioners and certified nurse-midwives, to secure hospital clinical and admitting privileges and membership on medical staff. Such status would allow APRNs to work to the full extent of their education, skills and licensure, and provide more comprehensive care to patients. In the comments, ANA urges consistent recognition of the increasing role of APRNs.

ANA's comments on CMS' proposed changes to the Medicare/Medicaid "Conditions of Participation"—the guidelines hospitals must follow to qualify for involvement and reimbursement under the health programs—reflect changing trends in health care and aim to take full advantage of nurses' capabilities. The conditions also serve as guidelines for the Joint Commission and other private accrediting bodies that evaluate hospitals. CMS proposed modifications to the rules in October to reflect changes in current practice, and took into account the Obama Administration initiative to reduce regulatory burdens.

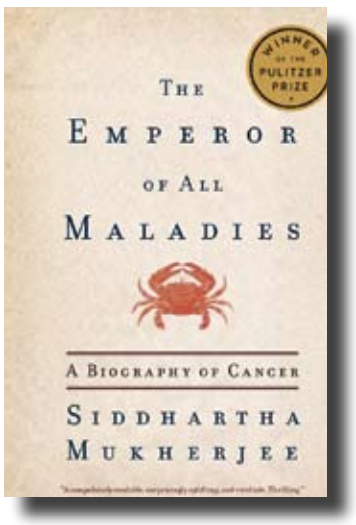
In its comments, ANA urges CMS to retain consistent reporting requirements for all deaths related to the use of patient restraints, including soft wrist restraints, to assure that patients' safety and rights are protected. Longstanding ANA policy states that "only when there is no other viable option should restraints be employed."

ANA also backs these CMS proposals that directly affect nursing practice and patient care for the roughly 60 percent of all U.S. RNs who work in hospitals:

- Allowing the nursing care plan to be part of the interdiscliplinary care plan;
- Expanding the use of standing orders and protocols for nurses to give medications;
- Permitting patients to take their own medications under certain circumstances;
- Deleting the requirement for verbal orders to be signed within 48 hours; and
- Allowing flexibility for infection control programs, which nurses often lead.

Recommend to Read

The Emperor of all Maladies: A biography of Cancer by Siddhartha Mukherjee (2010) And the Winner of the Pulitzer Prize.



Given the sobering numbers 1:3 women and 1:2 men in the United States will develop cancer in their lifetime, there is not a more relevant book to read about cancer than this quarter's recommend to read choice. First, the author's eloquent writing style which earned him the Pulitzer Prize is an absolute gift to read. Every story is richly written and helps the reader gain insight into the journey of the diagnosis of cancer. Threaded throughout the book are the multiple views of this complex disease, which in reality is more accurately described as many different diseases all lumped under the term: cancer. This book covers the politics, funding, women's rights, intrigue, manipulation, lies, investigations, research, cover-ups, commercial enterprise protectionism, and our collective coming to know the antecedents and consequences of this mysterious illness.

The author, Dr. Mukherjee, is an oncologist and this book chronicles his learning about cancer and its impact on his patients. Along with those stories, this book is about the history of cancer, treatments, researchers, advocates for and against public health initiatives, and our collective knowledge of what and how we have come to understand the disease. The history of cancer spans some four THOUSAND years, our capacity to unlock its secrets remains tested. It ends with the hope that we are closer to finding the key that will tame its unruly nature.

The book is richly complete with thousands of references.

For nurses, this is a must read!

History Walk

The North Dakota Nurses Association is soon to be 100 years old and is planning a Centennial Celebration to be held at the Ramkota Hotel in Bismarck on **September 21, 2012**.

Part of our day includes a **"History Walk"** where NDNA will display memorabilla from the last 100 years. We cordially invite you to participate in our History Walk by purchasing a booth to display your institution's history of nursing in North Dakota. We expect the audience to include student nurses, practicing nurses, past NDNA members, present NDNA members, and the public.

The History Walk will be assembled in the Court Yard at the Ramkota and open to the public from 10:00 AM to 4:00 PM. Our day has been crafted to allow plenty of time to meander through the displays and to visit with old acquaintances and colleagues. Set up begins at 8:00 AM on September 21 and take down should be complete by 8:00 PM.

The fee for the booth includes the 8 foot table, standard table cover, and a back drop cloth on a metal frame. We ask displays be historical in nature, meaning promotional and recruitment activity should not take up any more than 20% of the display. If you require electricity the cost is an additional $5.00/ booth. You must supply your own power cord and be prepared to secure the cord with duct tape. We recommend you bring your own power strip as well.

For further information contact Becky Graner becky@ndna.org or call 701-223-1385.

Please fill out the booth registration below and return with the fee. Please make check payable to NDNA and mail to PO Box 292, Mandan, ND 58554.

✂----------

Name of facility	
Address/City/State/ Zip	
Email (Must provide)	
Phone number	
Name of contact person at display	
Booth fee $60/ 8 ft. table	☐ Booth + ☐ _____ persons for lunch @ $15/ person. ☐ Electricity $ 5.00/ booth TOTAL _____

Booth space is limited so register soon!

NDNA Closes Refresher Course Program

After extensive review the North Dakota Nurses Association has determined it is time to close the Refresher Programs. The Refresher Programs came about back in the early 1980's. In 1977 the ND Nurse Practices Act was revised to include a continuing practice requirement for RNs and LPNs. NDNA developed the home study version of the Refresher Course after it was recognized that nurses needed an alternate way to refresh along with the standard method (which was to attend a centralized face to face event that typically took time away from home to complete both the theory and the clinical components). The face to face method was held on an occasional basis usually by the larger teaching institutions as they had the necessary resources and faculty.

NDNA's program evolved to include nurses seeking to re-instate their licenses from many other states as well as nurses seeking re-licensure in North Dakota. The program grew from the required 40 hours theory /80 hours practice to 100 hours theory /160 hours practice. (The Board of Nursing requires at least 120 clock hours for the practice component). NDNA stopped taking out of state refreshers several years ago. With changing and diverse criteria at the various boards of nursing and the extreme difficulty there was in placement of participants in clinical situations (especially as the program relied on volunteer preceptors from the various facilities to serve as the main source of clinical instruction), the program became overburdened with legal contracts, liabilities, and reluctant clinical sites to provide services for free. The original program grew from a paper based program to an internet/ electronic format where course participants accessed the course online. Communication moved from mailing paper and correspondence to exclusive use of email.

Nurses today are challenged to "refresh" on an ongoing basis. Nursing knowledge explodes on a monthly basis with the addition of new evidence that constantly changes our practice. The practice settings are many, and as nursing occurs every where, the need to individualize each refresher course participants' experience becomes more challenging. The newest ND Board of Nursing criteria for the theory portion of the refresher courses include: NDAC Chapter 54-05-01 Standards of Practice for Licensed Practical Nurses, NDAC Chapter 54-05-02 Standards of Practice for Registered Nurse, NDAC Chapter 54-05-04 Standards for Delegation, NDAC Article 54-07 Unlicensed Assistive Person, Pharmacotherapy, Leadership, Professional Values, Critical Thinking, Communication, Evidence Based Practice, Information Management, and Genetics/Genomics.

Refresher course participants are reminded these courses are considered refreshing or renewing and are not eligible for contact hour approval any longer from ANCC. As a newly licensed or re-licensed nurse there are abundant opportunities for contact hour accrual through a variety of sources for either a nominal fee or for free.

The remaining ND Board of Nursing approved "distant" program is hosted by the Minnesota State Community and Technical College. Karen Schumacher, is the Director for this program and can reached at 1-800-426-5603 at ext. 6586. The website is http://www.minnesota.edu/?id=953.

Blood Pressure Measurement:
A Commonly Delegated Task that Requires Quality Attention

by Becky Graner MS, RN

The ACCF/AHA 2011 Expert Consensus Document on Hypertension in the Elderly states "Reliable, calibrated BP measurement equipment is critical for hypertension management in any age group" (Section 4.1.1). Over 15 years ago I attended a full week seminar that culminated in the credential of Critical Care OB certified. During the course of the weeklong conference, the sponsors took an HOUR to demonstrate proper blood pressure measurement, given the need to accurately evaluate the critically ill pregnant patient; the presenters emphasized the need for attention to the details of proper technique. Included during this presentation were not only the manual assessment perils but the pitfalls of relying only on the automated technology. In April of 2002 the National Health, Lung and Blood Institute and the American Heart Association held a working meeting regarding the National High Blood Pressure Education Program on Blood Pressure Measurement. This meeting resulted in a fifty (50) page document that described the need for accurate blood pressure measurements and the consequences of poor measurement technique. Common mistakes are using the wrong size cuff, improperly calibrated equipment, and improper patient position.

In a brief survey some common errors I have recently witnessed are: improper size of blood pressure cuff used on patients (most often the cuff was too big), equipment improperly calibrated, with the "at rest" gauge measurement either above or below the "0" even before the cuff was applied. Other errors include the application of the right size cuff however, the cuff being applied too loosely, resulted in a downward drift ending up with most of the cuff over the patient's elbow. In one case the cuff's Velcro no longer adhered and the measurer needed to "hold" the cuff together while the blood pressure was assessed, and in several instances the health care provider pumped up the cuff, missed the reading, and then quickly re-inflated the cuff again. The most egregious error I noted was the patient pointed out the mistake in technique and her concern was dismissed.

Some of the consequences of inaccurate blood pressure measurement include misdiagnosis of hypertension, or the opposite, a lost opportunity to make a diagnosis for hypertension, and incorrect medication adjustments for those already diagnosed with hypertension.

In many settings the measurement of blood pressures is a delegated task to non-licensed persons. The Joint Statement on Delegation by the American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) states: The RN delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence, experience and facility/agency policies and procedures.

The RN uses critical thinking and professional judgment when following the Five Rights of Delegation, to be sure that the delegation or assignment is:

1. The right task
2. Under the right circumstances
3. To the right person
4. With the right directions and communication; and
5. Under the right supervision and evaluation.

The delegation process includes: Assess and plan the delegation, based on the patient needs and available resources; Communicate directions to the delegate including any unique patient requirements and characteristics as well as clear expectations regarding what to do, what to report, and when to ask for assistance; Surveillance and supervision of the delegation, including the level of supervision needed for the particular situation and the implementation of that supervision, including follow-up to problems or a changing situation; Evaluation and feedback to consider the effectiveness of the delegation, including any need to adjust the plan of care (See the Joint Statement in its entirety at https://www.ncsbn.org/Joint_statement.pdf).

As the RN, who now knows (because you are reading this article) there are persistent problems in obtaining accurate blood pressure measurements, it is your responsibility to improve the quality of this skill. It becomes your responsibility to first shore up your own blood pressure measurement skills, then provide the proper supervision and evaluation to those persons the task has been delegated. Do not take for granted that the person has the knowledge and skill to perform the task. Remember, evidence over the decades continues to expose an ongoing problem with care givers using improper techniques when assessing the blood pressure.

Devers, in a 2011 publication titled *The State of Quality Improvement Science in Health: What do we know about how to provide better care?,* questions whether or not quality improvement strategies are effective. The author identifies the impact of QI interventions often "fade over time as … professionals fail to routinize new practices and their attention shifts…" (p. 2). The technique of blood pressure measurement is learned early in most health care provider's education. Over the years blood pressure measurement becomes so routine that little consideration is given to re-evaluation for proper technique. And when the task is delegated to others rarely is the RN likely to directly supervise the delegate's knowledge or skill in performing the task. However, given that the incidence and type of errors have not diminished over time and the abundance of professional articles dedicated to the importance of proper blood pressure measurement technique, it appears there is an opportunity for quality improvement.

Nurses are responsible for properly functioning equipment, if equipment needs to be re-calibrated either learn how to do that yourself or contact the appropriate department within your organization. Nurses are responsible for all tasks delegated in that the person has the knowledge and skills to perform the requested task. The only way to know if they do have the required knowledge and skills is to evaluate the performance of the skill. This evaluation provides a perfect opportunity for education and reinforcement of the proper technique for a routine task such as blood pressure measurement. Don't forget, **how** you measure, really matters.

Websites with further information:

ACCF/AHA 2011 Expert Consensus on Hypertension in the Elderly: 4. Recommendations for Management found at http://www.medscape.com/viewarticle/742637_6

Accurate blood pressure measurement: Why does it matter? By Norman R. C. Campbell, MD and Donald W. McKay, PhD found at http://www.cmaj.ca/content/161/3/277.full

American Heart Association recommendations can be found at http://hyper.ahajournals.org/content/45/1/142.full

Blood-Pressure Measurement by Jonathan S. Williams, M.D., M.M.Sc., Stacey M. Brown, M.S., and Paul R. Conlin, M.D. in the N Engl J Med 2009; 360:e6 January 29, 2009 http://www.nejm.org/doi/full/10.1056/NEJMvcm0800157

JNC 7 Express The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (US Dept. of Health and Human Services, NIH, National Heart, Lung, and Blood Institute). http://www.nhlbi.nih.gov/guidelines/hypertension/express.pdf

Joint Statement on Delegation American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN). https://www.ncsbn.org/Joint_statement.pdf

Practice Guidelines: New AHA Recommendations for Blood Pressure Measurement by LIZ SMITH in *Am Fam Physician*. 2005 Oct 1;72(7):1391-1398. http://www.aafp.org/afp/2005/1001/p1391.html

Summary Report National High Blood Pressure Education Program / National Heart, Lung, and Blood Institute and American Heart Association Working Meeting on Blood Pressure Measurement. http://www.nhlbi.nih.gov/health/prof/heart/hbp/bpmeasu.pdf

The State of Quality Improvement Science in Health: What do we know about to provide better care? (Nov. 2011) by Kelly Devers. http://www.rwjf.org/files/research/73634.qs5.stateofqi.summary.pdf

NDNA Members Take This Opportunity to Honor Your Nurse Colleagues

Nominate a past or present NDNA member for one of the following awards to be presented at the NDNA Centennial Celebration September 21, 2012.

AWARDS	GENERAL DESCRIPTION
Outstanding Nurse (1) Current NDNA member only.	Has demonstrated leadership in advancing the profession of nursing through outstanding accomplishment or service of benefit to the profession which occurred during 2011-2012.
Centennial Recognition (More than one recognition may be awarded). Recipient must be a present or past NDNA member.	Has made a significant contribution to the field of nursing as a result of demonstrated commitment and leadership in NDNA.
Excellence in Nursing Practice (1) Current NDNA member only.	Demonstrates clinical expertise in area of nursing practice, serves as a client advocate, advances the scope and practice of nursing, and influences the practice of nursing through modeling the Standards of Professional Performance (ANA Scope & Standards).
Excellence in Nursing Education (1) Current NDNA member only.	Holds a position in which the primary function is education/teaching of nurses or other health care providers and demonstrates excellence in teaching or promotion of education, and influences the practice of nursing through modeling the Standards of Professional Performance (ANA Scope & Standards).
Excellence in Nursing Research (1) Current NDNA member only.	Conducts/conducted distinguished research in nursing and communicates findings, shows evidence of a history of nursing research activities, and encourages research activities within nursing and/or the public and influences the practice of nursing through modeling the Standards of Professional Performance (ANA Scope & Standards).
Excellence in Administration (1) Current NDNA member only.	Holds an administrative position in which nursing is an entity, demonstrates knowledge of nursing research, is an effective teacher/leader, and influences the practice of nursing through modeling the Standards of Professional Performance (ANA Scope & Standards).
NON-NURSING RECOGNITION	**GENERAL DESCRIPTION**
Recognition for Outstanding Media Coverage of the Nursing Profession (May be more than one).	Has produced an outstanding nursing-related article, news story or video presentation.
Recognition of a Friend of Nursing (May be more than one).	A non-nurse who has given/provided significant assistance to the nursing profession.

For complete criteria see the NDNA website at www.ndna.org or contact info@ndna.org

NOMINATION PROCESS

To nominate someone for an award listed above, complete the following steps:

1. Obtain a nomination form from the NDNA website www.ndna.org or by emailing Becky Graner and requesting a form info@ndna.org.
2. Complete the form by following directions on the form.
3. Include two letters of recommendation for the award from persons familiar with the nominee's achievements (at least one must be from an NDNA member). Please provide evidence of meeting the award criteria in the body of the recommendation letter.
4. Include a current vitae/resume and address from the nominee and indicate the nominee has been informed of the nomination (except for posthumous nominations for Centennial Recognition).
5. Send the completed packet by **August 15, 2012** to NDNA c/o Becky Graner 5265 Hwy. 1806, Mandan, ND 58554. You may fill out the form and save or scan/send as email attachment to Becky Graner at info@ndna.org.

Centennial Celebration Updates ~ 1912-2012

Becky Graner, MS RN
Nurse Consultant, NDNA

Becky Graner

NDNA's Centennial Year Celebration begins with local celebrations for Nurses Week May 6-12, 2012. The first meeting of the North Dakota (State) Nurses Association was held May 7, 1912 in Grand Forks. Complete notes from that meeting are found at the Prairie Rose Petal website. You can access those documents at www.ndna.org and click on Prairie Rose Petal in the left hand column. Once you land at the PR Petal website, scroll down to NDNA History Library. Click on the link; find notes from 1st meeting 1912. At this first meeting there were 155 charter members organized under a new constitution and bylaws. The objective of this newly formed organization was:

> ARTICLE II - Object
> The object of this organization shall be the raising of standards of nurses and nursing education; the furtherance of the efficient care of the sick, and the promotion of all interests of the nursing profession.

Today our "object" is our mission. By the time you read this the NDNA Board of Directors will have met in Bismarck for a strategic planning session where the mission, purposes and functions of NDNA will be evaluated for relevance. The application of the mission has guided the organization through 100 years of service to the nursing profession in North Dakota.

Any organization's purpose and function should be re-evaluated on a regular basis to ensure continuing relevance; in our case to engage the imagination and support of nurses who believe in the original hypothesis that a nursing organization should be about promoting the professional development of nurses. And in supporting nurses to grow professionally this organization helps the individual nurse enhance health care for all through practice, education, administration, research and development of public policy.

There is no doubt **history informs the future** and by careful review of past accomplishments and failures we see themes emerge that indicate there are threads in our history that need to be re-woven if we want a stronger "material" for the future. Our pattern is changing, thus the need for a different "feel" for the fabric of the organization. The generational differences already challenge us to think outside the box, technology demands we do things differently, and the changing health care climate is a steady reminder of the need to transform. With all these challenges we are handed the gift of an opportunity.

The Robert Wood Johnson Foundation initiative on the Future of Nursing at the Institute of Medicine was introduced over a year ago. The four key messages:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and information infrastructure.

have provided guidance to NDNA in realigning with these goals. All these actions as outlined in the initiative require the professional development of nurses. (http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx). The support for these initiatives from nurse leaders, educators, researchers and those at the bedside is immense. I urge you to learn all you can about this important work and to join in when opportunities present themselves. Don't look up a year from now and wonder where all this came from! As discussions and projects develop make sure your voice is heard.

As we celebrate our centennial year, come join us and help us make it a new landmark year; a year where nurses in ND joined together to launch the next 100 years. We need your input on how the organization of the future would best serve you.

Contact your local District leaders and participate in Nurses Week Celebration activities, then join nurses across the state in September when we celebrate NDNA's 100 year birthday.

Upcoming events:

ANA Foundation Document discussions scheduled for **Fargo Feb. 9, 2012** (weather permitting).

District meeting in **Bismarck/Mandan** tentatively scheduled for spring in conjunction with Nurses Week festivities.

Minot area is hosting the 10th annual collaborative conference **April 13th**–see the registration form in this edition of the *Prairie Rose*.

Member in the News

March of Dimes 2011 Legend in Nursing

Karen Macdonald was awarded the March of Dimes 2011 Legend in Nursing honor at the annual March of Dimes nursing awards in Fargo.

Karen, pictured with her sons, won this award based on her lifetime of service and leadership to the nursing profession. Karen Macdonald, described as "synonymous with leadership, advancement of nursing education and nursing practice", exemplifies the qualities of the Legend in Nursing: A living tribute to the outstanding contributions of a nurse that has advanced the field of nursing for future generations.

Karen is a life long member of the North Dakota Nurses Association, has served her profession in various roles both locally and nationally. Karen presently serves as the VP of Government Relations for NDNA and is the resident historian for the upcoming Centennial Celebration. Congratulations Karen!

10th Annual Northwest Region North Dakota Collaborative Educational Conference

"Bullying & Harassment: A Sepsis in Health Care"
Susan Strauss RN, EdD

April 13, 2012
8:00am–3:45pm
GRAND International
Minot, ND

Provided by:
District 1, North Dakota Nurses Association; Omicron Tau Chapter, STTI Honor Society of Nursing; and Roughrider Chapter, American Association of Critical Care Nurses

Presenter

Susan Strauss RN Ed. D. is a national and international speaker, trainer and consultant. Her specialty areas include harassment and bullying, organization development and management/leadership development. Her clients are from healthcare, education, business, law and government agencies from both the public and private sector. Susan conducts bullying and harassment investigations, works as an expert witness for harassment lawsuits, and coaches those managers and employees that need assistance in stopping their harassing or bullying behavior.

Susan has worked as an RN in pediatrics, medical-surgical, psychiatric, the OR, and public health. She has also been the director of quality improvement, education and development, and other healthcare leadership roles.

Dr. Strauss has authored books, book chapters, articles in professional journals, and written curriculum and training manuals. Susan has been featured on 20/20, interviewed for newspaper and journal articles such as the *Times of London, Lawyers Weekly, Harvard Education Newsletter*. She conducted research on bullying and harassment in healthcare for her doctorate.

Dr. Strauss has presented at international conferences in Botswana, Egypt, Thailand, Israel, and the U.S. and conducted sex discrimination research in Poland. She has consulted with professionals from other countries such as England, Australia, Canada and St. Maartin. She has her doctorate in organizational leadership, and is associate faculty at the University of Phoenix and DeVry University.

Name _____

Address _____

City, State, Zip _____

Phone _____

Email _____

I am a Member of:
_____NDNA
_____Omicron Tau, STTI
_____Roughrider Chapter AACN
I am interested in joining _____ and would like membership information.

Registration Fee: (Includes Lunch)
___$55.00 Non Members
___$45.00 Members
___$65.00 after March 26, 2012
___$25.00 for students
(No refunds after April 2, 2012)

Please make checks payable to Omicron Tau Chapter

Mail Registration and Fee to:
Mary Smith
C/O Dept. of Nursing
MSU
500 University Avenue West
Minot, ND 58707
Questions call 701-858-3251

Agenda

7:30am–8:00am	**Registration**
8:00am–8:15am	**Welcome/Opening Remarks**
8:15am–9:30am	**Bullying & Harassment: A Sepsis in Health Care** *Susan Strauss RN, Ed.D*
9:30am–10:00am	**Break/Exhibits**
10:00am–11:30am	**Bullying & Harassment: A Sepsis in Health Care** *Susan Strauss RN, Ed.D*
11:30am–12:30pm	**Lunch**
12:30pm–2:00pm	**Bullying & Harassment: A Sepsis in Health Care** *Susan Strauss RN, Ed.D*
2:00pm–2:15pm	**Break**
2:15pm–3:30pm	**Bullying & Harassment: A Sepsis in Health Care** *Susan Strauss RN, Ed.D*
3:30pm–3:45pm	**Questions/Evaluation**

The purpose of this conference is to analyze the concepts of bullying and harassment to prevent these negative behaviors in the workplace.

Contact hours for this continuing nursing education activity has been submitted to the Washington State Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Please Contact Mary Smith at District 1, North Dakota Nurses Association for more information about contact hours.

Conference Objectives

1. Define bullying and harassment based on the literature and federal and state laws.
2. Discuss nursing leadership's role in the prevention and intervention of bullying and harassment.
3. Discuss the misconduct within nursing practice incorporating The Joint Commission's Disruptive Behavior Standard, Nursing Social Policy Statement, Nursing Code of Ethics, and the Scope and Standards of Nursing Practice.
4. Identify theories, causes and contributing factors of bullying and harassment in nursing.
5. Examine the school nurse role in the prevention and intervention of bullying and harassment in K-12 education.
6. Practice communication techniques in confronting bullying behavior.

Conference Planning Committee

Judy Beck RN, MSN
Rhoda Owens RN, MSN
Susann DeForest RN, BSN, MS
Mary Smith RN, MS
Ashley DeMakis RN, BSN
Amy Thomas RN, BSN

Who Will Take Care of Mother?

by Mary Bruun, MSN, RN

When an elder is no longer able to live in their home safely and family is unable to provide care for that person, long term care is usually the answer to this question. Few decisions are as difficult to make as the one when a loved one is unable to live independently. Some of the concerns that come to mind are: "How will we pay for care?" "Which facility is the best?" And the biggest question of all "Who will take care of Mother in the nursing home?"

A family who has placed a loved one in a nursing home has many different emotions. They may feel guilty because perhaps they told their parent that they would never place them in a nursing home, the parent may have expected the son or daughter to care for them in their old age as they had done for their parents, or maybe the parent feels they are a burden. There is a multitude of emotions for both the family members and for the parent who is now living in a nursing home. The question remains "Who will take care of Mother in the nursing home?"

I will take care of Mother. I am the nurse on the unit where Mother now lives. I have over 20 years of experience in this nursing home. Why do I work here? Couldn't I get a real nursing job in the hospital? Wasn't I smart enough to work at a hospital? I am happy to share my story. Actually, I have worked in hospitals, both small and large. It was great experience, I did well and I liked it. But it wasn't where my heart was. I enjoyed working with the elderly most of all. Some people find it hard to believe that nurses might actually *prefer* to work in the nursing home setting. The nursing home, isn't that depressing? No, there is sadness and heartache at times, but the elderly are a fascinating group. They have so much history to share with us. They have rich lives and have seen more challenges and changes than any other generation!

There is so much about working with elders that is rewarding to me as a nurse. I share a laugh with a resident, share the joy when a picture of a new great-grandchild arrives in the mail, share in the simple things of their everyday life, and I share in their heartaches when they experience a loss or loneliness. One of the greatest blessings I have known working my with the elderly is being with them when they are dying. What an honor to hold their hand, to say a prayer, to offer support or just to be with them and their loved ones! And yes, to share in the tears. I hold close the memories of the wonderful people that it has been my privilege and joy to care for over the years.

There is one more thing you should know. Your Mother has done more for me than I will ever do for anyone. One Christmas Eve several years ago, the nurse who was to work the night shift was unable to work. I was the only one available. It was with a heavy heart that I left my own husband and three young children to celebrate Christmas Eve with my husband's parents. The roads were treacherous, but I made it to work. I felt like I had let my family down and I felt pretty sorry for myself as well! I listened to report and there was nothing major going on. The day staff was eager to leave and celebrate with their families. I began my evening med pass to the residents in the first room, second room, and the third room. In the third room I entered with the pills and inhaler for Mother. I smiled a weak smile and greeted her. Mother smiled broadly, clapped her hands and said "Well, there's my Mary! I am *so* glad that you are here!" Those words might not sound like much as you read them, but they meant the whole world to me that night and bring tears to my eyes every time I remember this wonderful lady. All I had to do for her was to show up! I have never felt so appreciated in all my life. She changed my whole night and it was one of the best Christmases that I have ever had.

Yes, I will take care of Mother. There are hundreds of nurses who have the same love for the elderly as I. My own mother now resides in a wonderful nursing home. There are many dedicated staff members who care for her not because it was the only job available, but because it is their life passion and their joy to care for the elderly. As a nursing instructor, I work to instill the love of elderly in students and to help them see all the elderly have to offer us. Geriatrics, like many nursing specialties, isn't for everyone, but for many it is the perfect choice!

The Parish or Faith Community Nurse

by Jean Bokinskie, RN, PhD, FCN
Director, Parish Nurse Ministry Program
Associate Professor, Nursing Department
Concordia College

Jean Bokinskie

Mary started her day in a staff meeting discussing plans for an upcoming bereavement service with plans to spend the afternoon making home visits with parishioners who were unable to get to church. However, the plans changed when the parish office received a phone call from a parishioner who needed spiritual support and emotional comfort from the priest and Mary. After spending a full day working in the cardiac catheterization unit, Dan spent his evening organizing the monthly blood pressure screening event and facilitating the biweekly grief support group at his church. And finally, Sue started her day by sharing the morning devotions and educational session for the senior exercise class. In the afternoon, Sue worked with area nursing students to lead a babysitting clinic for teenaged youth in the congregation. Three different nurses and three different work experiences–however, they are all serving in the role of a parish (or faith community) nurse.

Parish nursing is a community-based health promotion, disease prevention specialty practice of nursing with a concentration on spiritual care (Solari-Twadell, 1999). The practice of parish nursing is focused on caring for the whole person–body, mind, and spirit–within the context of the rites and rituals of a faith community.

A parish nurse (PN) is a registered nurse, currently licensed in the state of practice, who has completed a foundational faith community nurse/ parish nurse (FCN/PN) educational program through an educational facility. A PN serves a faith community as a lay professional either directly as a care provider or indirectly as a manager of care provided by other PNs or other lay faith-based health and healing ministers. A faith community has missional roots in a single or multi-faith tradition(s). It may be a formal setting (a church, parish, or synagogue) or an informal setting (homeless shelter or health care center).

The practice of parish nursing is defined by each state's nurse practice act and standards of practice. In 1997, the American Nurses Association designated parish nursing as a specialty practice of professional nursing (ANA, 1998). Parish nursing is defined as "the specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting wholistic health and preventing or minimizing illness in a faith community" (ANA, 2005, p.1). Although parish nursing practice shares many commonalities of other specialty practices it is not home health nursing or public health nursing within a church. PNs must frequently reflect upon their practice to ascertain if their practice is centered on spiritual care and if their practice is woven into the faith community's ministry.

As the specialty practice grew nationally and internationally, the term "parish nurse" was not appropriate for some faith traditions. Therefore, the title "faith community nurse" (FCN) was adopted as it was believed to be more inclusive of the practice (ANA, 2005). The American Nurses Association prefers the name "faith community nurse," however the term "parish nurse" is used primarily in the literature. In addition, other names for nurses in this role include church nurse, health ministry nurse, or congregational nurse.

According to Joel (1998), nurses are drawn into parish nursing because it encourages the expression of spirituality as a part of health and healing, while others become PNs out of a sense of vocational calling (Mosack, Medvene, & Wescott, 2006). Marlene Batterberry, RN, MS, a PN at Faith Lutheran Church, in West Fargo, ND, relates that as she was very interested in parish nursing as she neared retirement stating "it has fulfilled my retirement years as it gets me back to the basics of nursing by dealing with those that are ill and with their families." The PN role allows the nurse to practice wholistically by attending to the needs of the body, mind and spirit while in relationship to God, faith community, and colleagues. PNs often see this role as being a melding of the professional practice of nursing and ministry.

Historical Perspective of Parish Nursing

The seeds for the development of parish nursing were planted in the 1940s when the Reverend Granger Westberg was convinced that the body could not be treated without concern for the mind and spirit (1987). As a hospital chaplain, Westberg worked with doctors, nurses, clergy, and social workers to care for patients in a wholistic manner and to integrate the role of the church as part of the care team. He quickly found that nurses were best suited to integrate issues of faith and health for patients and to bridge the gap between the medical and faith communities. In an attempt to provide holistic health care in the late 1960's, Westberg and colleagues experimented with placing health clinics within churches by utilizing physicians, nurses and clergy as care providers (Westberg, 1999). As Westberg noted "it was clear that the nurses in each of these centers were the glue that bound these three professions together in a common appreciation of the healing talents of each." (1999, p. 35). In the early 1980's, Westberg found six churches willing to trial nurse-led health centers and provide access to health care services through faith-based communities. From the humble beginnings of six churches has grown a ministry that has surpassed the expectations of many. Thirty years later, there are PNs practicing in all 50 states and throughout the world working within a variety of faith communities, representing many different faith traditions (IPNRC, 2011a).

The International Parish Nurse Resource Center (IPNRC) reported that there are approximately 15,000 PNs practicing in all 50 states (2011a). This number is a conservative estimate as it reflects those reported by PN educating bodies who are partnered with the IPNRC and does not reflect the individuals who have completed non-affiliated IPNRC educational programs. Established in 1991 at Concordia College in Moorhead, Minnesota, the Parish Nurse Center provided foundational FCN/PN education, consultation to parish and congregational staff, and support PNs for health and healing ministry programs. In 2011, the name was changed to Parish Nurse Ministry Program to better reflect the educational focus of the program. In the Upper Midwest, the Concordia College Parish Nurse Ministry Program has provided foundational FCN/ PN education to nearly 1,600 nurses and lay church professionals who serve in an estimated 650 faith communities.

Parish Nursing Education

Although specific or mandatory educational requirements do not exist, a national curriculum was developed in the 1980s by experts within the field of parish nursing and continues to be available through educational bodies affiliated with the IPNRC. It is often referred to as the "endorsed" curriculum by PNs. Educational programs are offered in a variety of formats including on-line, hybrid, or classroom approaches. The IPNRC maintains a list of upcoming educational offerings, including contact information, cost, and program styles (www.ipnrc.org).

In addition to completing a foundational FCN/ PN educational program, the IPNRC recommends that the individual has a bachelor's degree in nursing and five years of clinical nursing experience (IPNRC, 2011b). Preparation at the baccalaureate level provides the groundwork for community-based nursing interventions, such as congregational assessments, population based program development, and program implementation (Hickman, 2006). Furthermore, the IPNRC (2011b) identifies that the PN should have experience in medical-surgical and community health nursing, as well as theological education or other related spiritual development activities.

Activities of a Parish Nurse

The PN role includes several functions within health and healing ministry (a) health advisor, (b) educator on health issues, (c) health advocate, (d) community & faith liaison, (e) volunteer teacher & developer of support groups, and (f) healer of body, mind, spirit, and community (IPNRC, 2011a). Activities within the PN role include the following examples, although the possibilities are limitless. A multi-denominational group of PNs organized a health fair where families attended and received educational materials on healthy lifestyles. Health promotion and screening related to hypertension, heart disease, diabetes, dental, musculoskeletal health and vision were included in the health fair. Another PN spends much of her time referring parishioners (primarily the elderly, low income and new immigrant families) to health care providers and advocating for services within the local community. Some PNs work with local baccalaureate nursing programs to provide clinical experiences within faith communities. Students develop educational materials, provide workshops, or lead exercise sessions, while gaining valuable experiences. A number of PNs have utilized the *Faithfully Fit Forever* program, a faith-based health promotion program developed by the Parish Nurse Ministry and Cardiovascular Rehabilitation Services, MeritCare Health Systems (2009). The program's purpose is to emphasize wellness, provide education on health related topics, initiate physical activity, and enhance individual spiritual life through devotions. For program information, please call Laura Alderman, Exercise Physiologist, at 701-234-6525 at Sanford Health, Fargo, ND. Many faith communities host weekly meals fellowship hours, and other food-related events. These offer an opportunity for nutritional education and role modeling. PNs have implemented the *Nurturing Youth Through Faith, Fitness and Food* program. This program developed through the Concordia College Parish Nurse Center (2010), addresses nutrition and activity issues of pre-teen children. The program includes models of devotional materials, exercise, and education concerning diet and exercise.

Many PNs spend time actively listening to parishioners' life stories and providing emotional support with life transitions–birth of a baby to the death of a loved one. The PN may visit individuals in their private homes, in acute care or in long-term care settings. And finally, the majority of PNs offer prayer and spiritual support as a part of their ministry. The PN may facilitate a prayer group, assist the clergy with a bereavement service, or provide a homily on health and healing during a worship service. The PN seeks to assist parishioners to see the relationships between physical, emotional and spiritual symptoms and various disease states, and help to find ways to promote wholeness. Batterberry relates that most of her time is spent in visitation and offering spiritual support "because my practice is with the ill and the elderly." She also notes that "for the PN there are multiple tasks to be done and I could be busy every day of the week… I never run out of things to do as a PN within my congregation."

Characteristics of Parish Nurses

In a dissertation study that focused on PNs primarily from the Upper Midwest (n=198), Bokinskie (2010) describes the typical PN as being employed in a congregational-based, unpaid model of practice. Most PNs identified that the size of their faith community was small (less than 600 individuals) and was located in either a metropolitan or rural area. In addition, they served solo or with one other PN. PNs have thirty years of nursing experience in inpatient hospital settings, but only eight years of service as a PN. In addition, they work about ten hours per week as a PN (Bokinskie, 2010). In 1997, Kuhn reported that paid PNs received $10 to $18 per hour; while Bokinskie (2010) noted that PNs received an hourly wage of $17 per hour. It is evident that the salary range has not increased in the last fifteen years. These findings suggest that individuals enter parish nursing later in their nursing careers (transitioning into full retirement) and finances are not a priority concern. These findings are consistent with other studies found in the literature (Bokinskie & Kloster, 2008; King & Tessaro, 2009; Kuhn, 1997; McDermott & Burke, 1993; McDermott & Mullins, 1989; Solari-Twadell, 2006).

As a PN educational program administrator, this author receives anecdotal reports of salary and hours worked. There are few individuals who work full-time as salaried PNs, with even fewer reports of salaries that are equivalent to other community-based practice areas for nurses. Most salaried PNs are reportedly paid for ten to twenty hours per week, but work many more hours in an unpaid capacity. In the United States, approximately thirty-five percent of PNs reportedly receive a salary for their services (IPNRC, 2011a). Some PNs reportedly receive stipends to cover mileage, personal liability insurance or program supplies (McDermott & Burke, 1993). Burkhart and Solari-Twadell (2006) found that only 22% of PNs (n = 255) reported that being paid was very important as a factor in fulfilling their role; while, 61% (n = 708) of PNs reported that being paid was unimportant to them. This finding is of concern as there are distinct advantages to receiving a salary. The advantages include formal power, enhanced personal commitment, increased program attention by faith community members, and a stronger pool of PN position applicants (Hickman, 2006).

Parish Nursing continued on page 13

Parish Nursing continued from page 12

Perceptions of the Parish Nurse Role

Positive and negative factors related to practice have been explored by researchers since the inception of parish nursing practice. In an early study of PNs who had participated in the Lutheran General program, Chicago, Il., Schreiner (1988) reported that PNs enjoyed the flexibility of the position and enjoyed the work; however they reportedly felt burdened by paperwork and frustrated with unmet parishioner needs. The PNs recommended that nurses who were considering serving as a PN had an awareness of church politics, established relationships with staff within and outside of the faith community, and developed programs slowly. McDermott and Burke (1993) surveyed PNs on satisfying and frustrating aspects of the role and identified that spiritual growth, the ability to practice nursing wholistically, and the opportunity to establish relationships were satisfying. Sources of frustration stated by the PNs were unrealistic expectations in the allotted time and role ambiguity. These frustrations are not unlike those expressed by nurses in other areas of practice.

Bokinskie and Kloster (2008) examined the factors of success and barriers to parish nursing practice over three years. The researchers found that PNs identified aspects of support as most important for a successful ministry. Actively practicing PNs reported the top five factors for a successful ministry as (a) clergy support, (b) congregational support/ involvement, (c) personal faith beliefs, (d) personal spiritual development, and (e) active health cabinet/ wellness council. The PNs in Bokinskie and Kloster's study (2008) also identified barriers to successful ministry as (a) unrealistic expectations of time, (b) lack of financial support, (c) lack of congregational and clergy support, (d) lack of assistance, and (e) "other" findings. These other findings included having a community already rich in health resources, poor attendance of or apathy about wellness/health among health cabinet members, lack of communication/coordination of services with other ministries, lack of family support, lack of personal skills, and lack of health/wellness as a priority in the church. These findings were consistent with other researchers (Bokinskie, 2010; Brudenell, 2003; Kuhn, 1997; McDermott & Burke, 1993; McDermott & Mullins, 1989; Schreiner, 1988).

Opportunities for the Future of Parish Nursing

The majority of the literature on parish nursing has focused on the history of the specialty, role of the PN, application of the nursing process and ways to initiate health promotion programs. It is evident from the literature review that the practice of parish nursing is focused on the care of the body, mind, and spirit of the faith community and its individual members. In order to grow this specialty practice of nursing, research must be conducted on the impact of the PN ministry within the faith community and disseminated in the literature.

As most PNs practiced alone or with one other PN, it is evident that the PN role is independent; perhaps for some it could be considered isolation. To work within this environment, PNs need to have excellent assessment skills, the ability to independently problem solve, and knowledge of community resources to assist with parishioner care when the need arises. These findings support the IPNRC (2011b) recommendation that the PN has past clinical experience and has a bachelor's degree in nursing as the nurse needs expertise in community assessment, knowledge of the referral process within and outside of the faith community, and an understanding of population-focused care (Hickman, 2006). The importance of networking within denominational groups and with other PNs in one's geographic area also is necessary to provide support and reduce the potential for isolation within the faith community setting. Networking with other PNs is also an excellent way to gather new programming ideas and assist in problem solving. The Parish Nurse Ministry Program offers a free quarterly newsletter that provides information on continuing education offerings, faith community programming ideas, and networking information (sign up at http://www.cord.edu/Offices/parishnurse1.php).

This wide variation in geographic location as well as the differences in size of faith community served by the PN may provide strengths and challenges for the PNs in relation to access to resources, support, networking, and information. It is likely that the PNs from the metropolitan area would have a wealth of community based resources available to meet the needs of the faith community members, while the PNs in the rural settings would need to mobilize local resources, travel a distance to obtain support services, or be innovative in accessing resources through non-traditional means or through web-based activities. Creative approaches to accessing resources, information and support may be necessary to develop and maintain a health and healing ministry for the PN in a variety of faith community locations and sizes. Many local health systems are willing to provide information to PNs for use within faith communities, while some health systems have programs available to support PN ministries within geographic regions. One such program is Sanford Health's Faith Community Nursing Ministry (lois.ustanko@sanfordhealth.org). The program's director, Lois Ustanko, RN, MHA, FCN, states that the program "assists congregations and faith-based organizations with the development of their health ministry program, including implementation of the faith community nurse role."

The lack of salaried positions for PNs remains a primary concern as the salary status has not changed in the last fifteen years. The lack of a competitive wage (or total lack of salary) will continue to limit the numbers of nurses able to serve as PNs. At the present time, most PNs are near or at retirement when they complete the foundational FCN/PN educational program and have less than eight years of practice in the PN role before a full retirement from nursing practice. These nurses come into the PN role with a wealth of clinical nursing knowledge, but are only able to serve in the PN role on a limited basis. This issue limits the years of available practice by the PN, the development of expertise in the ministry, and the growth of the PN program. Younger nurses are needed to encourage and support others to grow the practice as a career option. However a major barrier to enticing younger nurses is the financial considerations. Without funding options, it will be difficult to recruit and retain younger nurses into the PN ministry unless faith communities provide adequate salaries and benefits, and financial support for program development.

The opportunity exists for providing education to others about the activities provided by the PN. Education to faith community leaders and members, as well as to nurses in other clinical specialty areas, is necessary to provide accurate information about the PN role. It is important to clarify that the PN is not a substitute for the clergy, nor does the PN provide home care services, but the PN enhances the ministry of the faith community. The IPNRC website provides excellent educational resources for the initiation and support of a PN program (http://ipnrc.org).

This is an exciting time in the development and growth of parish nursing as a community-based practice within professional nursing. Along with this wonderful opportunity comes a challenge in creating and sustaining PN ministries within faith communities. For more information about parish nursing practice or educational opportunities, please contact the Parish Nurse Ministry Program at Concordia College, Moorhead, MN at parish-nurse@cord.edu, or 218-299-3825, or visit the web site at http://www.cord.edu/Offices/parishnurse1.php

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A 75-Year History of Nursing Education in North Dakota 1903-1978

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by Lucille V. Paulson

North Dakota, in 1979, has four baccalaureate degree, three diploma, and two associate degree programs in nursing, with a total enrollment of approximately 1500. Upon degree completion, the graduate is eligible to take the licensing examination for registered nurses. There are also four one-year practical nurse programs with an annual enrollment of about 225, qualifying the graduate to take the examination for licensed practical nurses.

These programs represent changes in the theory of education for nursing occurring over the past 100 years. From a practical training for hospital employment and private duty nursing programs have expanded to include that of a broader education in universities and colleges, preparing nurses for professional practice in many varied fields in institutions and communities.

Persons concerned with nursing education in North Dakota have been as progressive as any educators in the United States. They have been changed-oriented according to national surveys and educational trends. A record of the development of nursing education in North Dakota will be hereby attempted.

We can assume that in the early pioneer settlement years in North Dakota, nursing care of the sick was done by women in the family, neighbors, women with health-care experience, etc., as was necessary in any pioneer society. An occasional trained nurse may have been available in some communities. We know that Mrs. Emma Randall Lawrence, one of four nurses from St. Thomas' Hospital, London, was sent to Canada by Florence Nightingale, lived in Williams County from 1903 to 1915, and volunteered her services when needed. She was a charter member of the North Dakota Nurses' Association.

Increasing population in the late 1800's and early 1900's brought a need for medical and nursing care in hospitals. The first hospital established was St. Alexius Hospital, Bismarck, in 1884 and the second was Deaconess Hospital, Grand Forks, in 1892. Within the next 35 years, 18 other hospitals were started in the larger cities and in some smaller towns. In 11 of these hospitals a "training school for nurses" (the term used at that time) was started simultaneously with the opening of the hospital. Obviously, the goal was to provide a staff of workers. The list of the first of the 11 "Training Schools for Nurses" follows:

Deaconess Hospital, Grafton	1903
St. Luke's Hospital, Fargo	1908
General Hospital, Devils Lake	1908
Lakeside Hospital, Kenmare, later Deaconess)	1908
Bismarck Hospital, Bismarck	1909
Deaconess Hospital, Mandan	1909
Good Samaritan Hospital, Rugby	1910
Parkview Hospital, Jamestown (Later Trinity)	1913
Lutheran Hospital, Wahpeton	1917
Mercy Hospital, Williston	1920
Mercy Hospital, Valley City	1928

Other "Training Schools" were opened in hospitals which were already established. These, with the dates the schools opened were:

St. John's Hospital, Fargo	1901
Deaconess Hospital, Grand Forks	1905
St. Michael's Hospital, Grand Forks	1908
Deaconess Hospital, Northwood	1909
Mercy Hospital, Devils Lake	1910
St. Joseph's Hospital, Minot	1911
St. Alexius Hospital, Bismarck	1915
Trinity Hospital, Minot	1923
St. Andrew's Hospital, Bottineau	1929

By 1929, therefore, there were 20 "Training Schools for Nurses" in the state. The earliest was St. John's Hospital, Fargo, in 1901. There was no nurse practice act in North Dakota until 1915 to provide regulations or guidelines for curriculum, etc., so the early programs developed each in its own way. The length of the course varied from one to three years.

After passage of the Nurse Practice Act, members of the Board of Nursing were appointed and organized. One of their first objectives was to inspect all hospitals claiming to have "Training Schools." This was done by several board members beginning in 1916. Early inspection reports indicate that several small hospitals with training programs (not included in the 20 listed above) were not approved on first inspection or voluntarily did not continue more than a short time. These were:

Harvey Hospital, Harvey (Later St. Luke's) 4 students	2 years
Donohue Hospital, New Rockford 1 student	2 years
Carrington Hospital, Carrington 3 students	3 years
San Haven Sanitarium, Dunseith 3 students	1 year

The early inspection findings are interesting when compared with schools of nursing today. Nursing care in the hospital was almost entirely dependent on the students who were on duty 10 to 12 hours daily, often with little or no direct supervision. Formal classes were held at a late afternoon or evening hour–these were usually lectures by a physician. Clinical experience was limited in many hospitals as some had a daily patient load from six to 25. Student groups varied from one to 10 or more, having two classes a week. Class records were inadequate or absent and living quarters were also inadequate for students, who received stipends of $5.00 to $10.00 per month. Nursing care instruction was more or less individualized with emphasis on nursing procedures and techniques. Often this instruction was from student to student.

The 1915 Nurse Practice Act specified the course of study for schools of nursing. It consisted of a listing of subjects and required class hours in four sections. These were a two-month preparatory course, the remaining 10 months of the first year, the second year and the third year required demonstrations and clinics which were listed in detail. Hours of instruction were minimal and nursing experience was required in Medical, Surgical, Gynecologic, Pediatric, Obstetric and Operating Room Nursing. Recommended textbooks were listed. These requirements were a stimulant for improvement since they had a legal impact.

Standards and regulations were developed by the Board of Nursing and yearly inspections continued. Some of the smaller hospitals found it difficult to meet the requirements and discontinued their programs, usually on the advice of the Board. Up to 1931, the following programs were discontinued:

Deaconess Hospital, Northwood 31 graduates	Closed 1922
Mandan Deaconess, Mandan 10 graduates	Closed 1928
Lutheran Hospital, Wahpeton 15 students resigned	Closed 1931
St. John's Lakeside, Kenmare (Later Deaconess)	Closed 1931

Applications to the schools of nursing were numerous during the depression years of the 1930's due to much unemployment in fields open to young women and because families lacked funds to send a daughter for study beyond high school. Nursing students, at that time, received board and room and sometimes a small stipend. Therefore, for many young women, nursing seemed the best available field in which to obtain preparation. Until September 1, 1930, only one year of high school was required by law for entry into nursing school. Several unsuccessful attempts had been made for a revision of the law to require two years of high school, but it was not until 1939 that high school graduation was a legal requirement for admission. Long before this, however, the Directors of Schools were able to be more selective and nursing students were almost all high school graduates during the 1930's.

Several significant national surveys on nursing education were made during a decade or more beginning with "Nursing and Nursing Education" by Josephine Goldmark in 1923. The National Committee on the Grading of Nursing Schools published two reports–"Nurses, Patients and Pocketbooks" in 1928, and "Nursing Schools Today and Tomorrow" in 1934. Schools were never graded as originally intended as changes were being made rapidly. One other survey report, "Nursing Schools at the Midcentury" was published in 1950. It rated schools on the basis of six criteria regarding curriculum and staff. It classified them as Group I (the top 25%), Group II (the middle 50%), and Group III (the lower 25%). North Dakota schools were mostly in Group II. The 1934 report recommended some essentials of a good school of nursing. For example, one full-time instructor should be employed and a ratio of at least one staff nurse to six students should be maintained.

These reports focused attention on conditions in the schools in this state as well as elsewhere. Directors attended many conferences and meetings sponsored by the National League for Nursing Education. They were eager to do whatever possible to make improvements. Gradually, nursing instructors, many lacking preparation for teaching, and more registered nurses for staff positions were obtained. By 1939 and in the 1940's, efforts were made to strengthen the teaching of basic physical and social sciences by arranging for classes by qualified instructors in local colleges and, in a few instances, in the local high school. This was arranged in Fargo, Grand Forks, Bismarck, Minot, Bottineau, Devils Lake, and Valley City. Credit must be given to Clara G. Lewis, Executive Secretary of the Board of Nursing, for helping to make these cooperative arrangements.

A variety of clinical experience was lacking in many of the hospitals, especially in Psychiatric and Pediatric nursing. Therefore, affiliation contracts were arranged with hospitals out of state. A three-month Psychiatric Nursing Experience was made a State Board requirement in 1948. Often it was difficult to convince hospital administration of the necessity for this, as the loss of student services for a three-month period seemed impossible to consider. Objections were overcome, however, and Psychiatric Nursing affiliations were obtained in state psychiatric institutions, both near and far from North Dakota: Minnesota, Iowa, Montana, South Dakota, Wisconsin, and Illinois. Some schools also arranged for affiliations in Pediatric Nursing and Diet Therapy. By 1950, every nursing student was leaving the state for Psychiatric Nursing experience and instruction. The need then became evident to develop a teaching program within North Dakota. Efforts of the North Dakota Nurses' Association and the Board of Nursing convinced state legislators, and classes were provided for an educational and student residence building at the State Psychiatric Hospital, Jamestown. The educational program began there in 1954. Gradually all of the schools of nursing within the state transferred students there for a three-month period, rather than out of state. At present, students from two diploma and one associate degree programs obtain experience at the State Hospital. Other programs are utilizing local hospital psychiatric departments and mental health facilities for teaching experiences.

The United States Cadet Nurse Corps, in effect from July 1943 to October 1945, was a federally sponsored program to increase the nation's nurse supply. This had a positive effect on the schools because specific requirements had to be met in order to participate. The schools were partially reimbursed for the cost of students' board and room, tuition, books, and uniforms. Students also received a monthly stipend. All of the North Dakota schools participated in the Cadet Nurse Corps and enrollments increased, thus relieving the nursing needs in civilian hospitals during these war-time periods. Senior students were permitted to obtain additional experience in other approved civilian or government hospitals or in a public health agency during the last six months of their course. Many schools did arrange for such experiences. Some North Dakota hospitals, without schools, were approved for these senior experiences. Federal funds also were available under the Cadet Corps program to improve residence and educational facilities for nursing students, and several schools benefited by a new residence or additions and improvements.

When federal funds for the Cadet Nurse Program were discontinued, the hospitals again had to assume full financial responsibility for the uniforms, etc., and later some charge was made for board and room, during the pre-clinical period. The schools were trying to make improvements for the schools. There was great difficulty in obtaining qualified nurse instructors. Also, in some hospitals, limited clinical experience required extensive affiliations.

The smaller hospitals found it impossible to meet all the requirements to maintain a school of nursing. The Grafton Deaconess Hospital School of Nursing was terminated in 1944 upon recommendation of the Board of Nursing. The remaining students were then transferred to other programs. The General Hospital School in Devils Lake also closed in March, 1945, by action of the Board of Nursing.

Several attempts were made, about this time, to solve difficult problems and strengthen schools by combining or consolidating several hospital schools which were under the control of the same religious order. The Sisters of St. Joseph's School of Nursing was incorporated in January, 1947, by combining the programs at St. Michael's Hospital, Grand Forks; Trinity Hospital, Jamestown, and St. John's Hospital, Fargo. A large class was admitted in September 1947. Headquarters office was at St. John's Hospital until 1952, when it was transferred to the new St. Michael's Hospital, Grand Forks. Agreement was made with the University for pre-clinical science courses and pre-clinical students were housed in campus dormitories. Students were assigned to each of three hospitals for clinical experience after the first year. The school continued about 24 years.

The Mercy Hospitals of Williston, Valley City, and Devils Lake, all with a small school of nursing, discussed the possibility of a control school combining the three programs. However, the Williston school was closed in 1947 and in 1948 the other two Mercy Hospital schools were incorporated into one school, known as the Mercy School of Nursing of North Dakota, continuing about 13 years.

As early as 1910, the University of North Dakota, Grand Forks, offered a "Course for Nurses." This was a one-year course of academic subjects, mostly in the sciences, under the direction of Bertha Erdmann, RN. This year was followed by two years' clinical experience in one of several cooperating hospitals, some as distant as Chicago and New York. A diploma in nursing was granted from the University, but no degree. This early program continued until 1916.

In 1933, a course in Nutrition for nursing students at both Grand Forks hospitals was provided through the University Extension Division. The course continued for a number of years. Seven years later, in 1940, the University began providing physical and social science courses for credit for both Deaconess and St. Michael's Hospital Schools of Nursing and continued this as long as those programs were in existence.

After several surveys of the needs and facilities in the state, the nursing program at the University was

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reactivated in 1947 as a four-year program in nursing leading to a baccalaureate degree. The Division of Nursing was an autonomous unit and received its support from the University Medical Center. Beatrice Horsey was appointed Director in 1949. Clinical experience was obtained at Deaconess Hospital in Medical, Surgical, and Obstetrical Nursing. In addition, students spent four quarters at the University of Minnesota Hospital in the clinical areas of Psychiatric, Pediatric, Outpatient, Rural, and Advanced Medical/Surgical Nursing. Margaret Heyse was appointed Director in January 1948, but her title was changed to Dean in 1959, when the program was officially designated as the College of Nursing. Under her direction, much progress was made. Enrollments increased. Faculty gradually expanded from three or four to 25 full-time members in 1977; plus several part-time faculty. Currently, all clinical instructions and experience is selected locally or within the state under the direction and supervision of the University nurse faculty.

Another college program began in 1947 at Jamestown College, Jamestown. The first class was admitted in September of that year. This was planned as a combined program leading to a Bachelor of Science degree granted from Jamestown College and a diploma in nursing awarded by Jamestown Hospital. Lydia Hepperle was the Director. In July 1948, the Board of Nursing recommended that the college take full control of the program. The first class had affiliations at the University of Colorado, Denver, and later at Cook County Hospital, Chicago. The first class graduated in June 1951. Currently, clinical experience is obtained locally, with some at St. Luke's Hospital, Fargo.

By 1950, as a result of several closings and combinations, North Dakota had a total of nine hospital programs and two baccalaureate programs. The same year, St. Joseph's Hospital School of Nursing, Minot, changed its name to Sisters of St. Francis School of Nursing.

The Good Samaritan Hospital School of Nursing, Rugby, tried for many years to improve its program. Students spent six months at Minot State Teacher's College taking science courses. The Nursing Arts classes were conducted at Trinity Hospital. Further affiliations were made for 13 weeks at Cook County Hospital, Chicago. This continued for several years, but by 1950 only 14 students remained. A new class of 15 was admitted in 1951 but, considering the obvious difficulties involved in conducting the program, the administration advised the Board of Nursing in 1952 that no more students would be admitted. The school closed in 1954, when all remaining students had graduated.

Some national accreditation of nursing schools had been carried out by separate national nursing organizations beginning in 1938. After reorganization of the five national nursing associations in 1952, accreditation of nursing education programs became the responsibility of the new National League for Nursing. The accreditation process was a specific stimulus to school improvement. The first North Dakota program to achieve full NLN accreditation was the Sisters of St. Joseph School of Nursing, Grand Forks, in 1956. Other programs reached this goal at later dates. The list of accredited schools of nursing in the nation is published annually in the Nursing Outlook Magazine.

Mary College, Bismarck, began in 1956 as a junior college and affiliated with Catholic University of America. It was incorporated as a four-year college in 1959 with authority to grant baccalaureate degrees in nursing, teaching, and social work. A college building, seven miles south of Bismarck, was completed in 1960. The first nursing students were admitted in September of that year. Sister Mary Mark Braun, OSB, was appointed Director. St. Alexius Hospital school admitted no further students and that program was closed when the last students graduated in 1962. The hospital-clinical facilities were then made available to Mary College nursing students.

In April 1958, the Deaconess Hospital, Grand Forks, Board of Trustees voted to terminate the School of Nursing and no class was admitted that fall. The University nursing program had grown considerably with classes now equal or larger than the hospital program. Since both programs were using the same clinical areas for experience, the decision seemed to be the logical one. The Deaconess Hospital school graduated its last class in 1960 and the school was closed. The hospital-clinical facilities continued to be used by the University program. The new United Hospital (Deaconess and St. Michael's), built near the University, now provides easier access to an expanded and modernized physical facility for University nursing students' clinical experiences.

Nationally, the idea had been proposed that nurses could be prepared for licensure in a shorter period of time than the traditional diploma program of three calendar years if emphasis was upon educational experiences and not service to a hospital. Programs were developed in junior colleges with an Associate Degree in Nursing, after two academic years. These developed rapidly over the country. In North Dakota, this idea caught on and, in March 1966, the North Dakota Board of Higher Education approved the opening of an Associate Degree program in nursing at Dickinson State College in September 1967. The first class of 65 was admitted that fall with Irene Sage appointed as Director. Clinical experience is obtained at St. Joseph's Hospital and at local nursing homes. Psychiatric nursing is taught at Jamestown State Hospital. The curriculum is developed in a manner that permits a student, after one year, to qualify for practical nurses' licensing examination or continue for the second year to apply for an RN licensing examination.

A group representing the Fargo-Moorhead hospitals began discussions in 1965 with the North Dakota State University officials to determine the possibility of an Associate Degree program at that institution. A steering committee was appointed in October 1966, and continued meetings and discussions for several years. In December 1968, the North Dakota Nursing Needs and Resources Committee recommended to the Board of Higher Education that an Associate Degree program in Nursing be initiated at North Dakota State University, Fargo, and that a baccalaureate degree program be developed at Minot State College. At the January 1969 legislative session, a House Concurrent Resolution #13 establishing nursing programs at these two institutions–was introduced and passed. The plans for these programs were approved by the Board of Higher Education in March 1969.

The NDSU Associate Degree program admitted the first class of 67 in September 1969, with Sister Mary Heineu as Director. Two-year funding was provided by a grant from HEW Division of Nursing. Students receive experiences in a number of hospitals, clinics, and other facilities in the Fargo-Moorhead area.

The four-year degree program at Minot State College admitted its first class of 24 in September 1969, with Sister Mab Meng as Director. St. Joseph's Hospital is utilized for clinical experience. Some local funds were available for the first year. In April 1970, a federal grant to partially fund the program for four years was obtained.

The hospital schools of nursing also recognized that programs could be shorter than the traditional three calendar years, when primary objectives were educational rather than service needs of the hospital. Therefore, two remaining hospital programs, at Bismarck Hospital and Trinity Hospital, are now 27 months or three academic years in length, while the program at St. Luke's Hospital is 24 months long.

Three more schools were discontinued in 1971–Sisters of St. Joseph School of Nursing, Grand Forks; Sisters of St. Francis School of Nursing, Minot; and St. Andrew's Nursing Hospital School of Nursing, Bottineau. This reduced the number of hospital programs from 20 in 1929 to the present three programs.

The federal "Nurse Training Act of 1964" has provided some funds to collegiate, associate degree, and hospital schools of nursing for student loans, project grants for improvement of programs, grants to schools to help defray costs related to enrollments and some funds for construction. The latter provision has resulted in improved residences for students in hospital programs, along with well-equipped classrooms and libraries. New residences were built at Trinity Hospital, Minot; St. Luke's Hospital, Fargo; and Rugby Hospital, Rugby. Additions and improvements were also added to several others. One school, Bismarck Hospital School of Nursing, has been fortunate in receiving gifts of money from the Helene Fuld Foundation, New Trenton, NJ, at various times since 1966, totaling nearly $500,000. This money has been used to improve all the physical facilities in the nurses' residence as well as providing new, modern teaching equipment.

As a result, after the end of World War II, the shortage of nurses continued. One-year programs in practical nursing were being started all over the nation. A permissive licensure law for Practical Nurses became effective in July 1947, in North Dakota. Several hospitals in the state started practical nurse programs. All but one continued for only a few years. They were:

Bismarck Hospital–1948-50	9 months
12 graduates	
Mercy Hospital, Williston–1948-53	10 months
40 graduates	
St. Alexius Hospital, Bismarck–1947-53	9 months
45 graduates	
St. Andrew's Hospital, Bottineau–1950-53	1 year
6 graduates	
St. Joseph's Hospital, Dickinson–1952-72	1 year
? graduates	

This program closed when the Associate Degree program at the local State College increased enrollments.

The U.S. Office of Education, Department of Vocational Education, recommended that practical nurses be prepared in educational institutions and some federal funds became available for practical nurse education. Early in 1950, discussions and planning began for a Practical Nurse course at the State School of Science at Wahpeton. A first class of four was admitted November 1, 1950, for a basic course of four months, the remainder of the one-year program at affiliating hospitals. The first arrangements were at St. Andrew's Hospital, Bottineau, for 24 weeks and at St. Luke's Hospital, Fargo, for eight weeks. Under the U.S. Manpower Development Training Act, enrollments increased rapidly and many hospitals were used for experience at different times. Currently, affiliating hospitals are Dakota Hospital, Fargo; St. Francis Hospital, Breckenridge Hospital, Minnesota: United Hospital, Grand Forks; St. Andrew's Hospital, Bottineau; Dakota-Midland Hospital, Aberdeen, SD; St. Aloisius Hospital, Harvey; Jamestown Hospital, Jamestown, and Good Samaritan Hospital, Rugby.

Plans were made, during 1959, for a second Practical Nurse program to be established jointly by the Devils Lake Junior College and Mercy Hospital, of the city. The first class of 14 was enrolled in September 1960. The Junior College assumed full responsibility for administration of this program in July, 1965, and has continued to enroll sizable classes annually.

Discussions and plans began, in the spring of 1969, for a Practical Nurse program at the UND Williston Center, Williston. The curriculum and plans were admitted September, 1969, with Mrs. Lenada Larson as Director.

The most recent practical nurse program began in September 1977, at Standing Rock Community College, Fort Yates, with the admission of 15 Indian students.

This concludes the account of the changes in numbers and types of nursing education programs in North Dakota in more than 75 years. Other changes directly related to nursing education, however, have occurred.

Regarding students, the rigid regulations of 25 or more years ago, have been relaxed. Students may live at home if it is more convenient than at the dormitory. Married women and men are admitted. And students are more responsible for their own achievement and progress.

The focus of the curriculum has been changed from medicine to nursing. Instead of doctors lecturing and sometimes being responsible for an entire clinical course, academically qualified and experienced nurse instructors teach and supervise selected students to include community health and mental health, with much integration of material with clinical subjects.

The baccalaureate degree programs include basic college courses in the first years, concentrating on nursing with clinical experiences in the last two years. These programs have received acceptance by the Medical and Nursing professions and the public, after a period of some doubt regarding nurses' preparation in an academic setting. As enrollments gradually increased, and with generally good achievement records, the need for adequate physical facilities and space for the nursing departments was evident. Several degree programs began with one room for three or four faculty members with classes held wherever possible. The departments were moved from one available space to another as students and faculty increased. By 1975, the need for a permanent building or physical area for the nursing education department was recognized.

The University of North Dakota College of Nursing building was constructed on the campus with 2/3 Federal and 1/3 State funds and was dedicated October 22, 1976. It is a three-story building with the most modern of teaching equipment, class and lecture areas, offices, and student study areas. The building completion was a fitting climax to the 25th anniversary of the program. Mary College also constructed an addition to the college building for the nursing department the same year, dedicating it in September 1976. This, also, is complete with classrooms, faculty offices, and modern teaching equipment.

At Jamestown College, a dormitory building was renovated for the nursing department, providing adequate office space, classrooms, and other needed facilities. Minot State College has included nursing in the areas shared by other Allied Health Sciences at the College.

A pilot project, to prepare registered nurses for the expanding role of the nurse, began as a Family Nurse Practitioner program in September 1972, at the University of North Dakota Department of Community Medicine. Four RN's were admitted in the first class. Mickey Knutson, RN, MN, was the first Program Director. The Nurse Practitioner program consisted of four months at the University and eight months internship under the guidance of a physician preceptor in various areas in the state. This program has continued with increasing enrollments each year.

Continued learning by nurses is necessary because of rapid advances in medical science and changing patterns of nursing practice. Many degree graduates are returning to university campuses for a master's degree, qualifying for teaching and administrative positions. Diploma graduates are supplementing their preparation with required college courses to qualify for a Bachelor's degree. Many licensed practical nurses are adding to their preparation diploma programs to become a registered nurse. Capable nursing aides often enter practical nurse programs to prepare for LPN licensure.

Many workshops, conferences, and programs are planned by the North Dakota Nurses' Association or its Districts for registered and practical nurses and are well attended. Beginning in 1970, continuing education points could be earned by attendance at these meetings, which are recorded in the State Association office. Certificates of recognition, issued after stated periods, are an assurance to the individuals and employers that knowledge and skills are being kept current.

Change is a part of life and, without a doubt, there will be other changes in the health care field affecting the nursing profession. It is timely to recognize that many changes evolved because of the dedication of school directors, who provided the leadership through the years. Each suggested change was a challenge. The two-fold goal of the profession is for excellent initial preparation and continued up-grading of knowledge and skills for all registered professional and licensed practical nurses in order to provide optimum nursing service to maintain health and to give expert care in illness.

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