President’s Message

Roberta Young MSN, RN
President NDNA

The ANA Year of Ethics was present in the 2015 ANA Membership Assembly. The Code of Ethics for Nursing is a foundational document for our profession. Leah Curtin, ScD (h), RN FAAN, addressed the Assembly and summed up ethical behavior, attitude and actions as the keeping of our promise to patients.

Too simple? Maybe not. Think back to a time when you helped a nurse that was new into practice. What kind of promise was inherent in accepting that role? Did you promise to show the nurse the success paths that you had discovered over time? Did you promise to lessen their anxiety so they could bring all of their thinking skills to the forefront? Did you promise with them to perform safe nursing care and not cut corners? Did you promise to only speak positively about them to others and intentionally encourage them with your words?

(See-Provision 4 and 5. Code of Ethics for Nursing with Interpretive Statements. 2015.)

Think about your last intervention with a client, patient, or resident. What promises were you called to uphold? Did you keep your promise to view them as an individual with the ability to heal? Did you honor their right to self-determination without judgement but great person-specific education to build their capacity for decision making? Is it simple. Did you scrub the hub 15 seconds? Did you wash your hands at every appropriate opportunity? Did you set a healing environment so that the patient felt safe to tell you significant things about themselves that are pertinent to their healing?

(See-Provision 1, 2, 3 and 4, Code of Ethics for Nursing with Interpretive Statements, 2015.)

What may be harder to apply, or if we are honest, simpler to ignore, are the promises that pertain to ourselves. Do we take the time to be healthy at work, take breaks, drink fluids, and go to the bathroom more than once every 10 hours? Do we have cultivate healthy friendships, people we can laugh and cry with? Do we pay attention to our own health habits of eating well, being active, and ensuring restorative sleep. What about continual learning? We have professional journals at our fingertips and great websites like www.nursingworld.org, to seek answers to our questions, challenge our thinking and test our assumptions. (See-provision 5, Code of Ethics for Nursing with Interpretive Statements, 2015.)

I would encourage you to commit to take time to bring the Code of Ethics into your work setting to use with your teams. An idea would be to focus on one provision each month by encouraging dialogue about what this means to your practice area. Maybe assign nurse to exemplify a part of the provision with a story from their practice each month. When creating improvements in practice, assign a team member to review the new actions in light of the Code of Ethics, to ensure your new processes are aligned.

The last statement in the Afterword, (page 40) of the Code of Ethics with Interpretive Statements states, “ANA’s Code of Ethics...is the promise that nurses are doing their best to provide care for their patients and their communities and are supporting each other in the process so that all nurses can fulfill their ethical and professional obligations. This Code is an important tool that can be used now as leverage to a better future for nurses, patients, and health care.”

It is my privilege to work with all of you to keep this promise.
Can Leadership be taught?

After working over thirty-two years within the hospital in a variety of nursing roles, I decided I wanted to share my knowledge of nursing leadership with the next generation. Fortunately for me, I received the assignment to teach a class titled “Nursing Leadership, Management and Career Development” at North Dakota State University. As I reviewed the course objectives, they were appropriately measurable and attainable. Yet I found myself spending a lot of my true developing exercises that would be assessed at a gut level. As Einstein so wisely stated “not everything that can be counted counts, and not everything that counts can be counted.” I wanted these students to learn what it takes to be an effective leader but also learn the importance of granting empathy, support, and honest feedback those in leadership positions.

My professional experiences include being a charge nurse, a forensic interviewer for a child sex abuse clinic, a house-wide nursing administrator, and lastly the manager of a 33 bed Level III Neonatal Intensive Care Unit. This work history helped me identify areas that I deemed would benefit new professional nurses as they start their practice. I will outline one leadership exercise that senior nursing students participate in:

1. Teamwork.

I utilized team exercise quite frequently to create smaller learning groups thus enhancing opportunities to participate. This particular exercise is for the groups to look at a complex, busy medical/surgical unit and make nursing assignments for the next shift. They have felt that once they presented their rationale for assignments to the class that they were done for this lesson...this is actually where the real lesson began. The post- presentation discussion included:

- a. Of the 20 possible points, everyone will be assured 17 points (points are very important to students).
- b. Of the remaining points, they were to be allotted with the following parameters:
  - 10% of the group could receive the same amount of points that everyone else did.
  - 20% would receive additional three points.
  - 70% of the groups could receive one 1/2 points.
- c. Would receive no additional points.

Sound familiar? This is roughly the formula many facilities utilize in determining annual raises for their employees. Yearly raises can be some of the hardest mental and heart work a manager must do. Many view this exercise as difficult, and I was discussing this difficult assignment revealed to me what a teachable moment this activity created. Many groups decided the choices were too hard, and decided to give everyone one 1/2 points. Equal...but fair?

Questions that arose in the discussion:

a. For those that worked hard in and out of class in preparing the presentation, did they receive the same amount of points that everyone else did?

b. For those students that took a twenty minute call during the brainstorming session, that did not look at the material between classes and requested not to talk during the presentation, did they deserve the same amount of points that everyone else did?

As they worked together to honestly discern who deserved what, a second generation of questions arose. They included:

a. How they felt these types of reward formulas show parts of an organization’s culture, and what do these formulas really reward?

b. What sorts of behaviors does this kind of reward system bring out in professional nurses? What is the real impact on teamwork when using this type of system?

This exercise provided a fertile ground for students to employ parts of the American Organization of Nurse Leaders Nurse Executive competencies. The competencies include communication and relationship building, knowledge of the health care environment, leadership, professionalism and business skills. Some individuals may think these are “soft” skills, and reserved for former leaders. I have not championed this belief – I have wanted students to understand and expect that all nurses are leaders when they are practicing to the 0.1% extent of their scope of practice. The final product of the exercise was varied assignment of points based on values that the group decided were most helpful to achieve the desired outcome. Given the chance, the next generation will be able to share new ideas about leadership that they have not only read about, but practiced.

As they graduate in the spring, the faculty assures them that there are great role models waiting for them. As our newest peers enter your facilities, please raise your hands so they can see where their professional role models are. Remember that one key to retention and job satisfaction starts with a young nurse’s first job experience.
Tessa Van Doorne, MSN, RN is a native to Dickinson, ND and has worked her entire nursing career in ND. Tessa is the Clinic Manager for Sanford Health Occupational Medicine Clinic in Dickinson. Her role is to provide day to day oversight and leadership in nursing to the clinic. Previously she was a nurse Manager in Long-term care in Dickinson as well spent 4 years as the Medical Services Director at the Dakota Women's Correctional and Rehab center in New England, ND. Tessa obtained her Bachelors of Science in Nursing from Dickinson State University and graduated from Grand Canyon University in Phoenix, AZ with a Master's of Science in Nursing with an Emphasis in leadership in health care systems.

Tessa worked with Dr. Connie Kalanek and the ND Board of Nursing for her MSN practicum doing work on a rule revision with legislative rules dealing with scope of practice for Registered Nurses in ND. Tessa is also a member of the North Dakota Nurses Association, the North Dakota Nurses Association, and the National Management Association Chapter 581. Tessa is a member of the Southwest Fta coalition, the Southwest Regional Disaster Coalition, and also serves as a Board Member of the South Dakota Safety Association. She is also a ladies Auxiliary member at the local Eagles club in her community.

Tessa has a genuine passion for nursing in the state of ND and in nursing leadership. She hopes to be able to get nurses across the state involved as much as possible within the NDNA and other nursing related groups and associations.

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Tessa Van Doorne

**Vice President of Government Relations**
Kristin Roers

**Vice President of Communications**
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AFN45526 Coverage may not be available in all states.
NDBON, NDNA and NDCFN: What’s the Difference?

There is some confusion regarding the differences between the North Dakota Board of Nursing (NDBON), the North Dakota Nurses Association (NDNA) and North Dakota Center for Nursing. Hopefully, the following will help clarify some of the confusion.

A COMPARISON OF THE THREE ORGANIZATIONS

North Dakota Board of Nursing (NDBON)
919 S 7TH Street, Suite 504
Bismarck, ND 58504-5881
Phone: (701) 328-9777
Fax: (701) 328-9785
Mission: ND Board of Nursing assures North Dakota citizens quality nursing care through the regulation of standards for nursing education, licensure, and practice.
Description: • Governmental regulatory body established by state law under the North Dakota Century Code 43-12.1 Nurse Practices Act to regulate the practice of nursing and protect the health and safety of the public
• Regulates the practice of individuals licensed and registered by the Board
• Establishes standards of practice for RNs, LPNs, and APRNs
• Establishes standards and regulates nursing education programs
• Discipline licensees and registrants in response to violations of the Nurse Practices Act
Board Members: Daniel Rustvang, RN, Grand Forks; President
Jane Christianson, RN, Bismarck; Vice President
Clara Sue Price, Public Member, Minot; Treasurer
Diane Gravel, LPN, Fargo
Michael Hammer, RN, Velva
Janelle Holth, RN, Grand Forks
Mary Beth Johnson, RN, Bismarck
Bonny Mayer, LPN, Minot
Paula Schmaltz, APRN, Bismarck
North Dakota Nurses Association (NDNA)
1515 Burnt Boat Dr, Suite C #325
Bismarck, ND 58503
Phone: (888) 772-4179
E-mail: Director@ndna.org
Website: www.ndna.org
Mission: NDNA promotes the professional development of nurses, and advances the identity and integrity of nursing to enhance healthcare for all through practice, education, research, and development of public policy.
Description: • 501(c)(6) non-profit association
• Professional Association for Registered Nurses.
• Membership is 100% Registered Nurses.
• Constituent member of the American Nurses Association (ANA)
• Influences legislation on health care policies and health issues and the nurse's role in the health care delivery system
• Promotes the continuing professional development of Registered Nurses
• Advances the identity and integrity of the profession to enhance healthcare for all through practice, education, research, and development of public policy
• Promotes the Scope and Standards of Nursing Practice and the Code of Ethics for nurses
Board of Directors: Roberta Young, MSN, RN, Fargo; President
Tessa VanDoorne, MSN, RN, VP Membership Services
Donelle Richmond, BSN, RN, Walcott; VP Finance
Kristin Roers, MS, RN, Fargo; VP Government Relations
Jamie Hammer, MSN, RN, Minot; VP Practice, Education, Administration, Research
Jacki Bleece-Toppen, MSN, PMHNP-BC, Fargo; VP Communications
North Dakota Center for Nursing (NDCFN)
417 Main Avenue Suite #402
Fargo, ND 58103
Phone: (701)365-9408
Website: www.ndcenterfornursing.org
Mission: The mission of NDCFN is to guide the ongoing development of a well-prepared and diverse nursing workforce to meet the needs of the citizens of North Dakota through research, education, recruitment and retention, advocacy and public policy.
Description: • 501(c)3 non-profit organization
• All nurses and over 40 nursing organizations, education programs, grant programs, state agencies and other stakeholders are members and are invited to volunteer on ND Center for Nursing Leadership Team.
• Works to unify voice of nursing in North Dakota through connecting nursing organizations interested in policy issues.
• Develops statewide programming to fulfill mission across multiple areas including nursing education faculty and resources, workplace planning, research and development and practice and policy.
• Tracks supply, demand and education of nursing workforce.
Board of Directors: Mary Anne Marsh, Dickinson, President
College and University Nursing Education Administrators
Julie Hanson, Mayville, President-elect, ND Directors of Nursing Administration/LTC
Denise Andress, Hettinger, Secretary, North Dakota Area Health Education Center
Rosanne Diehl, Fargo, Treasurer, North Dakota Association of Nurse Anesthetists
Margaret Reed, Grand Forks, Past-President, North Dakota Organization of Nurse Executives
Stacey Pfennung, Bismarck, North Dakota Board of Nursing
Robert Young, Fargo, North Dakota Nurses Association
Julie Baustad, Rugby, North Dakota Organization of Nurse Executives
Dean Gross, Fargo, North Dakota Nurse Practitioner's Association
Jeanna Kojara, Cavalier, North Dakota Public Health Association, Nursing Section
Joann Lindemann, Kildeer, Nursing Student Association of North Dakota
Amanda Remyse, Bismarck, North Dakota Workforce Development Division
Carla Hansen, Fargo, Sigma Theta Tau Xi Kappa at Large Chapter
Nancy Johnson, Fargo, Consumer/Public Member

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Welcome New Members

Judi Dunn MS, CPP, RN-BC
Midwest Multistate Division Nurse Peer Review Leader

Over the last year and a half the Missouri Nurses Association and five other state nurses associations (SNAs) formed a collaborative, namely the Midwest Multistate Division (MW MSD), with the goal of promoting efficiencies and growth. State nurses associations participating in this collaborative include Iowa, Kansas, Missouri, Nebraska, and North Dakota. Each SNA will retain its own state identity while utilizing shared resources within the MW MSD. As part of this collaborative, the Midwest Multistate Division Continuing Nursing Education Unit (MW MSD CNE Unit) was formed.

How does this impact North Dakota nurses? Approved Provider Applications (both initial and renewal) have been streamlined, staff resources expanded, policies and procedures updated. A new website created specifically for the new Midwest Multistate (MW MSD) Accredited Approver Unit provides a wealth of information for current Approved Provider Units as well as those contemplating applying.

Exciting for North Dakota Nurses is the easy access for submitting Individual Activity Applications for contact hours. This is an ANCC option for nurse associations, organizations, and individuals who would like to provide continuing nursing education contact hours for educational events they are planning.

I encourage everyone interested in offering continuing nursing education to visit the new Midwest Multistate Division website at www,midwestnurses.org. There are updated forms, applications, educational resources and much more is planned to come!

As the Midwest Multistate Division Nurse Peer Reviewer Leader I am here to help in any way I can. Please contact me at NPRL@midwestnurses.org.

What is Going on in Continuing Nursing Education (CNE)?

Do you offer CNE courses?

Do you know the benefits of ANCC Accreditation?

- Nurses look for American Nurses Credentialing Center (ANCC) approved contact hours when selecting CE activities.
- ANCC accredited CE is the most effective and sustainable strategy to improve professional nursing practice.
- ANCC accreditation enjoys wide recognition and acceptance by licensing boards and other regulatory bodies.

These are just a few of the benefits. Contact us today to learn more!

You owe it to your nurses, you owe it to your patients, you owe it to your program... Achieve a higher standard of excellence with ANCC accreditation!

Learn more at: www.midwestnurses.org
573-636-4623, x102 or questions@midwestnurses.org

The ND Developmental Screening Toolkit is Here!

North Dakota Early Childhood Comprehensive Systems (ECCS) is creating a free toolkit that includes:

- The NDAAP’s medical recommendations for screening.
- Samples of evidence-based screening tools.
- A checklist for implementation.
- Recommendations for developmental screening and referral standards of practice.
- Samples of evidence-based screening tools.
- The NDAAP’s medical recommendations for screening.

You may receive an emailed survey from ECCS in an effort to help us learn about current practices among professionals who interact with children born to age 3. If you would like to participate in this survey, or access the toolkit, check out our new website: NDKids.org!

ECCS is a federally-funded program that brings together primary care providers, teachers, families, and caregivers to develop seamless systems of care for children in the critical formative years from birth to age 3. North Dakota ECCS is focused on increasing developmental screening of young children to identify and treat problems early, as well as educate parents and caregivers about healthy child development.

For more information or to request a copy of the toolkit, contact Mylinda Ogundipe, Program Director, at myogundipe@pcand.org or 701.223.9052. Visit our new website: NDKids.org.
Understanding Continuing Nursing Education

Submitted by Judi Dunn MS, CPP, RN-BC, Nurse Peer Review Leader, Midwest Multistate Division

All nurses understand the importance of maintaining competence and professional development. Healthcare is changing at such a rapid pace it is difficult to keep up with the terminology, let alone the many facets of providing quality care. Continuing nursing education takes on even greater importance today. It does take a “mind-shift” however, to move away from the old thought process of obtaining “certification” as people move toward educational activities that have measurable quality outcomes. Add into the mix the growing awareness that interprofessional education furthers the increase in quality patient outcomes. It is toward these desirable outcomes that accreditation of continuing education strengthens the educational activities and what is learned. In three main areas: continuing education accreditation/bodies; the American Nurses Credentialing Commission (ANCC); the Accreditation Council for Continuing Medical Education (ACCMCE) and the Accreditation Council for Pharmacy Education (ACPE) are working together on supporting the standards, terminology, forms, requirements and processes involved in providing continuing education to benefit both the practitioners and their clients.

These efforts are seen to help streamline the necessary assessment, gap analysis, planning, coordinating and evaluation of educational activities – all important steps that support quality continuing education. Unless the nurse is involved in CNE, one may not realize the detailed work behind the lecture, workshop or conference they attend. At times the “rules and requirements” may seem to get in the way as they do not allow for quick and easy “approval.” They do however help establish a “scope and standards of practice” that guides the educational activity to ensure valuable learning and professional development. These standards are what sets an accredited educational event apart from those that may be non-peer reviewed or state Board approved.

Today the options for continuing nursing education are exploding. No longer are there just lunch-n-learn lectures, or all day workshops. New technology such as webinars and on-line courses place the education at our finger tips 24/7 where ever we may be. It is important therefore, to make sure that the educational activities are offered by an ANCC Accredited Provider or Approved Provider. This information must be stipulated so that the learner is able to decide prior to the event whether the activity meets the necessary requirements for their specific licensure or certification.

Activities that have been approved directly by the Midwest Multistate Division or a Midwest Multistate Division Approved Provider meet the current ANCC criteria and requirements for quality continuing nursing education.

Chronic Back Pain Therapies

Clinical question: When treating adult patients with chronic back pain, does the use of alternative therapies in conjunction with pharmaceuticals reduce pain more effectively when compared to using only pharmaceutical pain treatment?

Articles:

Synthesis of evidence:
Chronic back pain is a significant health issue that has placed a great burden on both individuals and society. The number of prescription painkillers dispensed in the U.S. and the number of deaths from painkillers quadrupled between 1999 and 2013. “Nearly two million Americans, aged 12 or older, either abused or were dependent on opioids in 2013” (Center for Disease Control and Prevention, 2015).

When treating adult patients with chronic back pain, does the use of alternative therapies in conjunction with pharmaceuticals reduce pain more effectively when compared to using only pharmaceutical pain treatment? A total of 24 research articles were critically reviewed for the purpose of supporting the conclusion. We narrowed our research to six articles that rated high in both strength of evidence and quality. Review of the literature revealed the following key points:
- The systematic review conducted by Hutchinson, Ball, Andrews, & Jones (2012), found that acupuncture is more effective than no treatment but no conclusions could be drawn on the effectiveness over other treatment modalities.
- Ocac, Moldovan, Onac, Igna & Pop (2012), researched behavior therapy as a mean to reduce chronic back pain. This study concluded that behavior therapy in combination with medication, or in combination with medication and physiokinetotherapy, also results in better pain outcomes.
- Literature suggests a strong psychological element to the effectiveness of alternative therapies in the management of chronic pain.

Bottom line: While literature suggests that there is evidence to support that alternative therapies can reduce chronic back pain intensity for limited periods of time, there is very few studies comparing the use of alternative therapies in conjunction with pharmaceuticals to the use of only pharmaceuticals for the management of chronic back pain. Therefore, we must conclude that there is not sufficient evidence to support alternative therapies in conjunction with pharmaceuticals reduces pain more effectively when compared to only using pharmaceuticals for relief of chronic back pain.

Implications for nursing practice:
As health care professionals, it is important that we are aware of alternative therapies that may benefit those entrusted in our care. For individuals suffering from chronic back pain, there are safe alternatives to pharmaceutical treatment that may relieve pain and increase quality of life for limited periods of time. Determining the most effective alternative therapy will need to be individualized based on culture, personality, experiences, and beliefs regarding pain.
Control, 2014). The older seniors aged 75 years and beyond have reached a point where they have acquired two or more chronic health conditions; sadly about 21 percent of the frail elderly are living without children, and 80 percent are living with children such as divorce and an exodus from rural areas as children pursue employment opportunities (Yip, 2013).

### Moving On Not Moving Out

The dramatic increase in the baby boom generation presents new opportunities and an opportunity for health care, more specifically for nurses. Good nurses have a passion and love for nursing. In a recent descriptive qualitative study experienced nurses 55 years of age or older commented, “I love nursing,” “I was born to be a nurse,” “My profession is a gift from God,” “I was called to this work,” and “I could not imagine doing anything else” (Spiva, Hart, & McVay, 2011). It’s critical that we harness the experience, knowledge, and confidence these nurses have acquired over the years. Spiva et al identified these nurses have developed an ability to establish positive connections to patients and families, a familiarity with disease processes, and effective the organizational skills; they are also calm, dependable, and have a strong work ethic (2011). As more and more Baby Boomer nurses are aging, they’re more likely to be satisfied and more likely to want to remain in the job market; they just don’t want to do so at the bedside (Buehans, 2014). Retaining older nurses in some capacity preserves the important clinical expertise these individuals provide.

Faith community nursing (also called parish nursing) is a specialized area of professional nursing practice that provides the perfect opportunity to make the expertise of the Boomer nurses available to the aging population. Nurse practitioners within faith communities such as churches or faith based organizations such as homeless shelters are the primary focus of this nursing specialty (Palpant, 2009), 71 percent of the clients served by the faith community nurse are older adults between ages 60 and 80 (Pappas-Rogich, 2012). The role of the faith community nurse does not usually include medically managing patients and only collaborate with other healthcare providers. Faith community nurses offer their expertise for emergency processes, and effective organizational skills; they are also calm, dependable, and have a strong work ethic (2011). As more and more Baby Boomer nurses are aging, they’re more likely to be satisfied and more likely to want to remain in the job market; they just don’t want to do so at the bedside (Buehans, 2014).

### Easing Licensure Requirements to Retain Expert Nurses

Faith community nurses (aka parish nurses) and nurses who offer their expertise for emergency processes, and effective organizational skills; they are also calm, dependable, and have a strong work ethic (2011). As more and more Baby Boomer nurses are aging, they’re more likely to be satisfied and more likely to want to remain in the job market; they just don’t want to do so at the bedside (Buehans, 2014). Retaining older nurses in some capacity preserves the important clinical expertise these individuals provide.

Health promotion within the primary care nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009). The primary focus of this nursing specialty (Palpant, 2009).

### References


How many baby boomers are hitting retirement age every year and will continue to do so for the next 20 years generating dramatic changes in healthcare delivery (Barr, 2014). The young elderly aged 65-75 years are aware of the link between positive healthy lifestyles and well-being and are looking for assistance in health promotion and disease prevention strategies (Centers for Disease Control, 2014). The older seniors aged 75 years and beyond have reached a point where they have acquired two or more chronic health conditions; sadly about 21 percent of the frail elderly are living without children, and 80 percent are living with children such as divorce and an exodus from rural areas as children pursue employment opportunities (Yip, 2013).
Naloxone Administration in Suspected Opiate Overdose in a Homeless Health Clinic

Whitney Fear, RN, BSN, TNCC

Abstract: The Homeless Health Division of Family Health Care serves a diverse population of patients with a myriad of health conditions. These conditions include drug addiction and drug abuse. According to an informal statement by the Chief of Police for West Fargo, Michael Reitan, at a recent conference addressing mental health care in North Dakota, the Fargo-Moorhead area is likely to experience an increase in the recreational use of heroin. Per their research and statements from informants, the access to prescription narcotic medications for abuse has become cumbersome and, sometimes, impossible. Area drug dealers have created connections to bring heroin to the area in an attempt to meet the demand for those who once sought prescription opiates to get high.

Index Terms—naloxone, harm reduction, chemical dependency, nursing, public health

I. INTRODUCTION

The Homeless Health Division of Family Health Care serves a diverse population of patients with a myriad of health conditions. These conditions include drug addiction and drug abuse. According to an informal statement by the Chief of Police for West Fargo, Michael Reitan, at a recent conference addressing mental health care in North Dakota, the Fargo-Moorhead area is likely to experience an increase in the recreational use of heroin. Per their research and statements from informants, the access to prescription narcotic medications for abuse has become cumbersome and, sometimes, impossible. Area drug dealers have created connections to bring heroin to the area in an attempt to meet the demand for those who once sought prescription opiates to get high.

II. NALOXONE

Naloxone is a mu opiate receptor competitive antagonist. The drug is commonly been used to reverse intentional and accidental opiate overdoses in the hospital setting. There is emerging research and interest in utilizing this medication in the pre-hospital setting. The administration of the drug causes nearly instantaneous overdose reversal and is shown to reduce incidence of intubation, respiratory arrest, cardiac arrest, and other undesirable effects that are attributed to prolonged opiate overdose (Robinson & Wermeling, 2014).

III. PRACTICE CHANGE

In response to the opiate epidemic in the Fargo-Moorhead area and in continuance of responding to the emerging needs of the community, Homeless Health Services at Family Healthcare has recently implemented a policy for the pre-hospital administration of naloxone in the clinic. This policy exists as a standing order and can be administered following the Registered Nurse’s assessment of positive opiate overdose.

We are aware of the opiate abuse and dependence that some of our patients have experienced in their present and past. Unfortunately, there are sure to be more patients to add to that number due to the high frequency of substance abuse among those experiencing strife and poverty. It is an ever growing concern that a patient may come in after using a dangerous amount of opiates, or may even overdose in the clinic. Our medical team ever growing concern that a patient may come in after using a dangerous amount of opiates, or may even overdose in the clinic. Our medical team is emerging research and interest in utilizing this medication in the pre-hospital setting. The administration of the drug causes nearly instantaneous overdose reversal and is shown to reduce incidence of intubation, respiratory arrest, cardiac arrest, and other undesirable effects that are attributed to prolonged opiate overdose (Robinson & Wermeling, 2014).

IV. EVALUATION

We have chosen a form of the drug with a long shelf life. Also, the manufacturer will actually reimburse a portion of the unused, expired drug if returned by the ordering pharmacy. Determining if the process is clinically significant will require some tracking of clinical data. As unfortunate as a patient’s recent overdose was, it was encouraging to hear that the patient received Naloxone at the scene of their overdose and did not require any further medical interventions for this overdose. This is supportive that the pre-hospital administration of Naloxone can be quite significant.

V. CONCLUSION

September is National Recovery month. I can think of no better way to tell our patients that we support the recovery from addiction than to give them the chance to make it to recovery. Prolonged opiate overdose can result in invasive measures, such as intubation, that could possibly be avoided by the pre-hospital administration of naloxone.

When I attended the ceremony for National Overdose Awareness day in Fargo on August 31st, 2015, I was overwhelmed by the sight of 150 pairs of shoes. Those shoes once held the feet of an addict. Holding one of those pairs of shoes was a mother, whose son lost his life to a fatal opiate overdose.

The epidemic of opiate abuse and addiction is present in our state. It is infiltrating our communities and creating 150 empty pairs of shoes every day. Small practice changes, such as the pre-hospital administration of naloxone, are crucial to reducing the harm that this epidemic will cause to our charges.


Whitney Fear, RN, BSN, TNCC is the Homeless Health Case Manager and Shelter Outreach Nurse in the Homeless Health Division of Family Health Care. Family Health Care is a Federally Qualified Community Health Center with recent designation as a Patient Centered Medical Home, located in Fargo, North Dakota.
The Sacrifices Children Make
So Their Mommies Can be Nurses

Teresa Olin, MSN, RN

"Mommy, how many more sleeps until you're done with school?"

"Mommy, can you play with me for ten seconds?"

"Mommy, do you have time for some lunch?"

-Alyssa, age 4.

My daughter was a just a little over two years old when I began my journey through nursing school. She had to adjust to a new life in daycare (I was a stay-home-mom before this), being away from daddy (we lived a long distance away from campus so we stayed with relatives during the week and left daddy at home); and of course not getting my undivided attention. I can, without a doubt, say that she adjusted better than I did.

When I made the decision to return to nursing school I was not at all prepared for the dedication and commitment it would entail. My plan was to concentrate on my schoolwork during the day and again after my daughter was safely tucked in bed. I would definitely leave my weekends free! Gotta have some play time right? Was I a bit delusional; I would continually hear myself say, "In a little bit, mommy needs to finish this" or "Would you like to watch a movie while mommy does her homework?" Then I would have to watch those big brown eyes lower and hear a very soft familiar, "O.K. mommy." Once, my daughter became ill with the stomach flu. I had classes the next day, finals, a 12-hour clinical two days that same week and a Writing A Paper that coming weekend. The mommy part of me wanted her to stay with me but the nursing student knew I would not be able to do both, I had to choose. My in-laws lived 30 minutes away from where I went to nursing school. My mother-in-law took her. My daughter was amazing and gracious the entire time. No complaints, no crying, no butting an eye, this lovely woman rushed to my aid when I had meetings for his job back home. He was able to take her to the clinic to see a doctor prior to me sending her away. He told me she kept asking for me saying, "Where's mommy?" "I need her to hold me and rub my tummy to feel better." I was able to spend very little time with her before my mother-in-law took her. My daughter was amazing and gracious the entire time. No complaints, no crying, her dream of getting her Master's in Nursing Education. She handled it with pride, grace, understanding, patience and love.

To my daughter and all the children of nursing school mothers:

For all the times you rushed out the door so mommy wouldn't be late for class and get points docked.

For all the times, when you were just singing and playing by yourself, I told you to quiet down or go to a different room because I was writing a paper.

For all the times I had zero patience while I was reading about Tetralogy of Fallot.

For all the times I sent you away because I was too busy with clinicals.

For all the times I said, "No, not tonight," "Maybe later," and "In a little bit" because I had a test.

For all the times you gave me unconditional love when I was tired and exhausted from late night study sessions and took it out on you.

For all these times and many more, we thank you and love you from the bottom of our hearts!

This is dedicated to my 19 year old daughter, Alyssa, who continues to be my biggest cheerleader. At age 16 she once again sacrificed part of her life so her mother could return to school to accomplish her dream of getting her Master’s in Nursing Education. She handled it with pride, grace, understanding, patience and love.
Non-Pharmacological Interventions Compared to Pharmacological Interventions with Intravenous Starts in the Acute Care Setting

Appraised by: Samantha Thykeson, RN
Mayville State University RN-to-BSN student

Clinical question:
In patients under the age of sixteen years of age, what is the effect of non-pharmacological interventions compared to pharmacological interventions with intravenous starts in the acute care setting?

Articles:


Synthesis of evidence:
Both pharmacological and non-pharmacological interventions are used to help decrease anxiety, distress, and pain when starting an IV in pediatric patients. They could even be used together in some cases. Of the pharmacological intervention, the weaknesses and strengths that come with the EMLA cream intervention include: the cream had to be applied at least 60 minutes prior to the IV start and a semi-occlusive dressing may need to be applied as the cream might get wiped or washed off if patient isn’t careful (Kleiber et al., 2002). Some of the strengths to the use of EMLA cream include: the required time to apply is minimal, the patient can implement EMLA cream and it is reusable and can be beneficial to patients of all ages, not just pediatrics (Baxter et al., 2011).

Of the non-pharmacological interventions, one study used bubbles, musical story books, and sound story books for their pediatric patients ranging from age 2-8 years old, headsets for music in 9-12 year olds, and participants older than 13 chose their own music (Pace et al., 2000). Virtual reality was used in another study in which the patients were able to interact before, during, and after the IV insertion (Gold et al., 2000). Singing was another form of distraction used. In this study, the parents of the control group were encouraged to sing to their child (Hartling et al., 2013). In another study, parents (mainly mothers), were using their own distraction techniques to help reduce anxiety, distress, and pain during IV insertion (McCarthy et al., 2010). In one final article by Tak and J. van Bon (2006), the participants in the information group were given a picture book about IV insertion and participants in the distraction group were shown a 6 minute video on a funny cartoon.

The variety in those interventions illustrated that the options were age appropriate for the group being studied, and the pediatric patients were never limited to try only one intervention. The last study researched was about a device, Buzzy, which combined cold, vibration, and distraction to pediatric patients getting an IV inserted. The strengths to this intervention are it can be used for patients of all ages, not just pediatrics, is quick to use, and can be reused. It can last up to 380 needle attempts (Baxter et al., 2011). You don’t have to wait 30 minutes like you do for a cream to be absorbed into the skin. The weakness of this device is obtaining a frozen ice pack and the cost of each device.

Bottom line:
To help pediatric patients reduce their anxiety, distress, and pain during an IV insertion, different interventions can be used. It is recommended that something is used to help distract and decrease anxiety in these patients. The interventions can either be pharmacological or non-pharmacological. Each of the studies showed that all of the interventions have worked, however they may not be a first line of choice. This could be due to time management, limited understanding, or little cooperation. “Providing patients with choices about aspects of their care enhances their feelings of control and thus may reduce the pain of invasive procedures such as IV insertion” (Jacobson, 2006, p. 1034).

Implications for nursing practice:
Pharmacological and non-pharmacological interventions have been used to decrease anxiety, distress, and pain in pediatric patients who have needed an IV start. A few pharmacological interventions mentioned include EMLA cream, ELA-Max cream, and vapocoolant spray. Non-pharmacological interventions include distraction with activities such as bubbles, music, and singing and use of ice pack/vibration, and virtual reality.

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**FEATURED PRESENTERS**
- Teresa Olin, MSN, BSN, RN  
  NCLERX-REN Review Course (Instructor, Kaplan, Inc.)
- Through the Eyes of ND Nurses: Peer Bullying and Incivility
- Tammy Buchholz, MSN, RN, CNE  
  Associate Director for Education, North Dakota Board of Nursing: “The Year of Ethics, YOUR Year to Get Involved!”

Non-members and students are welcome to attend! Don’t miss the amazing items in the silent auction!

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2.0 contact hours

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Report from ANA Membership Assembly

Jane Roggensack

Robert Young, President, Carmen Bryhn, Director of State Affairs and I had the privilege of attending the 2015 ANA Membership Assembly in Washington, DC on July 21-25. Our days were busy and filled with business, however, we also found time to connect and network with our colleagues.

July 22 was Lobby day and members met with their legislators to advocate for a number of issues. We met with legislative aides in the offices of Senators Hoeven and Heitkamp and Representative Cramer to discuss bills related to Title VIII refunding and a recommendation to refund Title VIII in its entirety although we discussed with our Congressmen’s offices what could be cut if it needed to be. Home Health and the recommendation to allow APRNs to order received a lot of discussion with their legislators to advocate for a number of issues. We met with legislative aides in the offices of Senators Hoeven and Heitkamp and Representative Cramer to discuss bills related to Title VIII refunding and a recommendation to refund Title VIII in its entirety although we discussed with our Congressmen’s offices what could be cut if it needed to be. Home Health and the recommendation to allow APRNs to order received a lot of discussion.

Here are a few updates from ANA:

• ANA represents 3.4 million RNs now (up from 3.1 million)
• New Ethics Symposium increasing income for ANA
• Value Pricing pilots: $15 per month and $174 per year is best and all saw 78% growth, removed ANA only and state only memberships and encouraged joint membership - will be bringing to 2016 membership assembly for bylaws changes/vote
• 2014 Clean Financial Audit
• Ended 2014 with a negative $4.3 million (NDNQI Budget - post sale and unfavorable variances including membership dues, conference fees, etc., but one year’s worth of reserves)
• 2014 dialogue forums: scope of practice, palliative care, interprofessional teams
• Scope of Practice: developed panel that identified ten critical areas to explore with work being done in subcommittees, etc.
• Interprofessional teams: task force, joint published report, changing thought that physician must lead team
• Palliative care: much education
• Leadership and Marketing/Communications working on rebranding initiative to include a new logo. Currently in discussion regarding culture and where the organization wants to be in the future.

There are a number of new ANA Initiatives that are in progress which include a Leadership Institute in to provide education with specific tracks, a partnership with Hilton, new member benefits such as long term care insurance and financial planning services to name a few with ANA reaching out to states to garner support and offer at state level as well and they are in the development phases of offering the Microsoft Office Suite of products to the CSNAs.

Once again this year Dialogue Forums/Topic Discussions were held and the topics discussed included a licensure jurisdiction discussion in which the ANA Board of Directors was charged with continued discussions with NCSBN that ANA’s position on licensure should lay with the location of the nurse and not the patient. Other topics included Public Reporting, Ethics, Infection Prevention and recommendations were developed for the ANA Board of Directors. The proposed bylaws revisions were voted upon and all technical amendments were approved as well as the Membership Assembly was reauthorized until after the 2017 Membership Assembly. The results of the elections are as follows:

• Treasurer: Ginge Harshby-Meade, MSN, RN, CAE, NEA-BC, Indiana State Nurses Association
• Vice President: Ernest James Grant, PhD, MSN, RN, FAAN, North Carolina Nurses Association
• Board Member – New Graduate: Jesse M. L. Kennedy, RN, Oregon Nurses Association

There were two awards presented at Membership Assembly this year. The ANA President’s Award was given to Lois Capps (D-CA) who has been a strong supporter of nursing during her tenure in the legislature and the ANA Year of Ethics Award was given to a Navy nurse who refused to force-feed prison detainees at Guantanamo Bay and followed his professional, ethical obligations. I appreciated the opportunity to once again represent North Dakota at Membership Assembly.
The American Nurses Association has declared 2015 to be the Year of Ethics and in January released a new edition of its Code of Ethics for Nurses with Interpretive Statements, which is the professional code for RNs to re-examine the essential role ethics plays in the nursing profession. Having a strong ethical foundation is a key component to a successful career. Yet, even the best nurses may find themselves struggling with ethical concerns on the job.

Here are five considerations for nurses when facing ethical challenges.

**Know yourself**

It’s important to have a strong sense of personal ethics to build upon in your profession. “Knowing who you are and what you stand for personally and professionally provides a foundation to speak up and speak out about issues that support or oppose,” reads the new Code of Ethics for Nurses with Interpretive Statements.

The code is “the professional code of ethics for RNs and the profession to which the RN belongs,” said Carol Kelly, RN, NEA-BC, Institute of Ethics, and an ANA member. Upholding the code “is the 2015 ANA Ethics Symposium being held in Baltimore, MD, June 4-5.”

**Live your values**

Just knowing your values and ethics isn’t enough. “Knowing what you believe, we are required to speak them and live them in our daily actions,” Rushton said. “We are required to speak them and live them in our daily actions. This takes courage, wisdom and resilience. Living our values means that we have to take seriously the fifth provision of the ANA Code — our obligation to care for ourselves so that we can care for others.” Because ethical issues are part of daily nursing practice, every nurse has an obligation to have the knowledge, skills and abilities to recognize and address them.

**Listen to your gut**

“If you know yourself and are consistent about living your values, you’ll be able to rely on that voice inside your head saying something is wrong,” Rushton said. “One of the things I talk to my students about all the time is that you need to listen to your gut,” said Sarah Shannon, PhD, RN, associate professor of Biobehavioral Nursing and Health Systems at the University of Washington School of Nursing and adjunct associate professor of Biobiotics and Humanities at the University of Washington School of Medicine, and a Washington State Nurses Association member. “With this clarity, your responses may be reactive, unreflective and potentially damaging to you and to others.”

**Check in with others**

Having said that, Shannon said it’s important to remember that the gut is “a great barometer but a lousy compass.” Just because you know you’re in an ethical quandary doesn’t mean you know what the next step is. “Consult with others, such as your shift manager or head of nursing, when a sticky ethical situation arises.”

Translating ethical decision-making into everyday nursing practice is challenging. Building a network of colleagues who can help you think through ethical situations is a priceless resource. A great place to connect with experts and building your network is the 2015 ANA Ethics Symposium being held in Baltimore, MD, June 4-5.

**Practice with respect**

The first provision of the revised Code highlights each nurse’s responsibility to practice with “respect for the inherent dignity, worth, unique attributes and human rights of all individuals,” said Carol Taylor, PhD, RN, professor of nursing at Georgetown University and senior clinical scholar at the Kennedy Institute of Ethics, and an ANA member. Upholding that worth can provide a foundation for ethical action.

“Taken seriously, this means that each of us must practice with zero tolerance for disrespect, for our patients, their family members, our colleagues and ourselves,” Taylor said. Taylor recommended practicing with a colleague who describes a patient in negative terms to make it easier to speak up next time, such as by saying, “I’m no goody-two-shoes, but I’m trying hard to meet each patient with respect.” If disrespect is a widespread problem, huddle and call attention to your organization’s zero-tolerance policy for disrespect to empower everyone to bring quick attention to violations.

For additional resources go to ANAs Career Center at http://careers.ana.org.
The American Nurses Association (ANA) is pleased to announce that ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, has been chosen as one of Modern Healthcare’s 100 Most Influential People in Healthcare. This program honors individuals in health care who are deemed by their peers and an expert panel to be the most influential individuals in the industry. Cipriano and ANA’s efforts to add more nurses to health care decision-making boards are also highlighted in the magazine.

The “100 Most Influential” honorees come from all sectors of the industry, including hospitals, health systems, physician organizations, insurance, government, vendors and suppliers, trade and professional organizations, and patients’ rights groups. Cipriano and the other honorees are currently highlighted in the Aug. 24 print edition of Modern Healthcare and online at http://www.modernhealthcare.com/community/100-most-influential/2015/.

ANA Sets ‘Zero Tolerance’ Policy for Workplace Violence, Bullying

Position Statement Calls on Health Care Employers to Implement Violence Prevention Programs

SILVER SPRING, MD – The nursing profession “will no longer tolerate violence of any kind from any source,” the American Nurses Association (ANA) declared in a new position statement on violence in health care workplaces released today. “Taking this clear and strong position is critical to ensure the safety of patients, nurses and other health care workers,” said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. “Enduring physical or verbal abuse must no longer be accepted as part of a nurse’s job.”

ANA’s position statement, developed by a panel of registered nurses (RNs) representing clinicians, executives and educators, addresses a continuum of harmful workplace actions and inactions ranging from incivility to bullying to physical violence. The statement defines bullying as “repeated, unwanted harmful actions intended to humiliate, offend and cause distress,” such as hostile remarks, verbal attacks, threats, intimidation and withholding support.

The statement calls on RNs and employers to share responsibility to create a culture of respect and to implement evidence-based strategies. The statement cites research showing that some form of incivility, bullying or violence affects every nursing specialty, occurs in virtually every form of incivility, bullying or violence in health care workplaces released today.

Among the position statement’s recommendations to prevent and mitigate violence, in addition to setting a “zero tolerance” policy, are:

• Establishing a shared and sustained commitment by nurses and their employers to a safe and trustworthy environment that promotes respect and dignity;
• Encouraging employees to report incidents of violence, and never blaming employees for violence perpetrated by non-employees;
• Encouraging RNs to participate in educational programs, learn organizational policies and procedures, and use “situational awareness” to anticipate the potential for violence; and
• Developing a comprehensive violence prevention program aligned with federal health and safety guidelines, with RNs’ input.

To prevent bullying, among ANA’s recommendations are that RNs commit to “promoting healthy interpersonal relationships” and become “cognizant of their own interactions, including actions taken and not taken.” Among recommendations for employers are to:

• Provide a mechanism for RNs to seek support when feeling threatened;
• Inform employees about available strategies for conflict resolution and respectful communication; and
• Offer education sessions on incivility and bullying, including prevention strategies.

ANA has several resources to help RNs and employers address and prevent bullying in the workplace, including the booklet, Bullying in the Workplace: Reversing a Culture, and a bullying “tip card.”
Nursing is making connections using social media. Recently, the College of Nurses of Ontario reported that 60% of Ontario's nurses engage in social networking (Anderson & Puckrin, 2011).

Social networks are defined as “web-based services that allow individuals to 1) construct a public or semi-public profile within a bounded system; 2) articulate a list of other users with whom they share a connection; and 3) view and traverse their lists of connections and those made by others within the system” (Boyd and Ellison, 2007).

These online networks offer opportunities for rapid knowledge exchange and dissemination among many people, although this exchange does not come without risk. Nurses and nursing students have an obligation to understand the nature, benefits, and consequences of participating in social networking of all types. Online content and behavior has the potential to either enhance or undermine not only the individual nurse's career, but also the nursing profession.

Benefits
• Networking and nurturing relationships
• Exchange of knowledge and forum for collegial interchange
• Dissemination and discussion of nursing and health related education, research, best practices
• Educating the public on nursing and health related matters

Risks
• Information can take on a life of its own where inaccuracies become "fact"
• Patient privacy can be breached
• The public’s trust of nurses can be compromised
• Individual nursing careers can be undermined

ANA’s Principles for Social Networking
1. Nurses must not transmit or place online individually identifiable patient information.
2. Nurses must observe ethically prescribed professional patient–nurse boundaries.
3. Nurses should understand that patients, colleagues, institutions, and employers may view postings.
4. Nurses should take advantage of privacy settings and seek to separate personal and professional information online.
5. Nurses should bring content that could harm a patient’s privacy, rights, or welfare to the attention of appropriate authorities.
6. Nurses should participate in developing institutional policies governing online conduct.

References:
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