President’s Message

Greetings Colleagues

Roberta Young MSN, RN

I am so excited about this year’s important theme for Nurses Week: Culture of Safety: It starts with you. This theme builds on 2015’s Year of Ethics; the outcome of ethical practice should be a culture that breathes and lives safety. ANA defines a culture of safety as “core values and behaviors resulting from a collective and sustained commitment by organizational leadership, managers, and health care workers to emphasize safety over competing goals.” (http://www.nursingworld.org) The important call to action in that definition is choosing safety over competing goals. Think back to a recent day in your practice setting and the potential competing goals that could have been a barrier to safety. How did you navigate that? Did you speak up when a peer didn’t do complete hand hygiene? Did you ask for help in repositioning a patient or decide to do it on your own? Did you take the time to listen with intention to how a patient was telling you how they are really taking their medications?

Culture is a difficult beast to tackle. It is not black and white; so you can’t wrap it up in a nice policy and tie a bow around it. But at the same time can be hard as a rock to move. If you want to improve or change the culture of safety where you practice, start by identifying what supports decision making and actions of safety and what rivals that aim. Transparency, being willing to talk about what has not gone well and a robust reporting system of near misses and safety issues, is sometimes at odds with trying to avoid being embarrassed, or fear of retribution. Chassin and Loeb, speak about a key trait of a highly reliable organization is preoccupation with failure. They go on to discuss that highly reliable organizations resist the temptation to over simplify causative factors, but are willing to dig deep. They resist the easy path of blaming singular causative factors. Health care organizations with a robust culture of safety have attributes of trust, report and improve. There has to be the trust that as a nurse I will and can report safety issues without fear, meaning I trust my peers and supervisors to take me seriously and will act. In turn, as leaders are we promoting the trust to report by following through, communicating solutions and not trivializing concerns. Persistence and the continually to act to improve will feed the culture of safety. [M, Chassin, & J, Loeb. The Milbank Quarterly Vol.91, No. 3, 2013, (pp459-490)]

Nurses are perfectly suited to observe, understand and identify safety issues. Our values and code of ethics demand that we observe, speak up, report and put ourselves in the middle of improving care practices including communication. We are compelled to be humble and open to learning from what went wrong, where we failed in our promise to the patients and families we are privileged to serve. Yep, hard work, but oh so worth it. If your practice culture allows for this work that means you are also in a trusting, caring, healthy environment.

I would say you are making Florence proud! Wishing you energy for keeping our commitment to a safe culture.

To learn more check out http://www.nursingworld.org search key words culture of safety.
Greetings! Coming into 2016 as the VP for Membership I just want to share my story and reasons for getting involved in NDNA.

Most of our lives can be separated out into chapters. For many of us, there is a chapter where we decide it is the right time to get more involved in our profession as nurses. It comes at different times for all of us, and that is okay. Most importantly, if it is something that is important to you as a nurse, you will know when it’s your chapter.

For as long as I can remember I have always been what I would consider myself “Suzy volunteer.” As far back as kindergarten, the teachers would tell my parents I was always the first one to raise my hand or the student to volunteer to go first. Most of us in the nursing profession just know that it is our calling, and I did too.

Chapter One for me was when I was a CNA at a nursing home in Dickinson and entering college at DSU. I knew I wanted to be a nurse so this seemed to be the natural thing to do. I decided to take my high school job. I took a year of generals and worked hard as a CNA and needless to say this was not the chapter in my life to get involved.

The next chapter was nursing school. Personally, nursing school to me is like being pregnant. The time seems to go so slow and some days I wanted to toss my hat in the ring and end that when that baby or diploma arrives, you wouldn’t have it any other way. Everything in the making was worth it. In undergrad, I got involved a little. I worked with our department of nursing camp although I didn’t get involved in NSAND, because this was my not my chapter either. To be honest it just wasn’t something I thought about. I graduated with my AASPN in 2006 and my BSN in 2008. Shortly after graduating I took a leadership position at the ND state Women’s prison as a nurse. It was an amazing networking and I was able to meet a lot of people across the state in the nursing world. At this conference I met Carmen, our Director of State Affairs and that brings me to all of you. She encouraged me to look into NDNA and to get involved in the NSAND. One of my first thoughts was “I have no idea what NDNA really does, but I think I should look into it.” I got on the website and afteri a few weeks I joined NDNA and became a member. I was just a “dues paying member” for about a year. I utilized some CEU’s and didn’t get involved much. In July of 2014 I took a new job as Clinic Manager at Sanford Occupational Health where I am still working currently.

The last chapter is now. I received an email about my first chapter point for a high school job. I took a year of generals and worked hard as a CNA and needless to say this was not the chapter in my life to get involved.

The first chapter is now. I received an email about my first chapter point for an NDA. I took a leadership position at the ND state Women’s prison and this is where I found my passion for leadership in nursing. I then had a son enter my life in 2010 and of course he kept me very busy and getting involved more into nursing just didn’t fit in my schedule in this chapter.

The year 2012 is what I can consider was MY chapter. I made a personal decision that no matter what I would go back to school and earn a Master’s in Nursing before I turned 30. As a full-time, single working mother I did it; I enrolled in grad school and I jumped in full force. Although one would think this was the worst time to get involved, this is when it was right for me. At the end of my program I needed to find a mentor to do hours with for my practicum. I reached out to an undergard instructor and she directed me to the executive director of The Board of Nursing. I was terrified; most of us avoid the board of nursing. In my research I was thinking I can’t just call this lady, she was a super star in my mind. But, I did it I called her and that was it from there. It was her that got me involved. I first got involved in The Center for Nursing on volunteer groups. I worked with them to log hours for my program. Once I was involved I was hooked and continued until I graduated and in April of 2014 (at the age of 28 by the way). One of the projects we worked on was the 100th celebration of the Board of Nursing. I was then asked to be on the panel to represent past, present and future of nursing in ND. This of course all was amazing networking and I was able to meet a lot of people across the state in the nursing world. At this conference I met Carmen, our Director of State Affairs and that brings me to all of you. She encouraged me to look into NDNA and to get involved in the NSAND. One of my first thoughts was “I have no idea what NDNA really does, but I think I should look into it.” I got on the website and after a few weeks I joined NDNA and became a member. I was just a “dues paying member” for about a year. I utilized some CEU’s and didn’t get involved much. In July of 2014 I took a new job as Clinic Manager at Sanford Occupational Health where I am still working currently. The last chapter is now. I received an email about my first chapter point for a high school job. I took a year of generals and worked hard as a CNA and needless to say this was not the chapter in my life to get involved.

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“Spring won’t let me stay in this house any longer! I must get out and breathe the air deeply again.” – Gustav Mahler

When March finally arrives, my mind and heart start believing that winter is going to come to an end. My energy needs a boost, and my thinking needs some “spring cleaning.”

I have been teaching an Interprofessional Education course this spring. I was completing the unit on Crucial Conversations. As usual, as I teach something, I am reminded to use the information, and continue my growth in the subject.

I am a Certified Crucial Conversation trainer, and admit that at times of low energy I forget to apply these critical skills. The skill I am going to use for “spring cleaning” is the ability to ask one’s self when conversations start to fail (Patterson, Grenny, McMillan, & Switzler, 2012). The bedrock of this skill is to approach this self-talk with a pure heart, and detective-like instincts. This is due to the fact that sometimes the person we are the least honest with is ourselves. So I will set the stage:

1. Thought: “I don’t feel fulfilled in my job.”
2. Insert the Crucial Conversation skill of Focusing On What I Really Want (Patterson, Grenny, McMillan, & Switzler, p. 114, 2012). It starts by asking a series of surprisingly hard questions:

   • What do I really want? For me. For others. For the relationship (whatever that may be).
   • What am I acting like I want?

To be honest, I sometimes hate the second question “what am I acting like I want?” as it ushers in the reality that I have responsibility associated with my behaviors and thoughts. Being a person who tries to live with integrity, I can see the work I have ahead of me!

On to the answers which will inform my plan to move toward a better outcome:

- What do I really want? For me: I want to feel like a valued member of my team(s). For others: I want others to know I value their unique skills/talents. For the relationship: That we understand the power of teamwork, and we take time to identify the things are teammates do to increase the power of our group.

- What am I acting like I want?
  • I am acting too busy to have one more thing put on my plate. I am withdrawing from group activities because I feel too exposed.

THE GAME CHANGING QUESTION!

- How would I act that would help me attain the goals I have identified?
  • I need to work on being more engaged.
  • Work at seeing the positive of situations – with sincerity.
  • Give detailed feedback to teammates – which goes beyond “good job.” It is specific as to what your teammate did a good job at.
  • Ask for help. Ask for feedback, and be open to the feedback.
  • Create team goals through real conversation.

Sounds easy, right?

Now I am going to use a conversation that many nurses share with me. It starts like this . . . “Work is crazy.” “There are so many negative people at work!” and “Nobody has time to do what they need to do!” If you recognize yourself in these statements, I challenge you to open your heart, and really look at what you want, and then ask yourself if you are acting in accordance with what you really want is brave work – and the outcomes can lead to a whole new world.

The NDNA Nominating Committee for 2016 is Jami Falk, Karla Haug, and Sandy Boschee. These elected members will be looking for NDNA members who wish to serve on the NDNA board for 2017-2018. Board positions that will receive nominations are President, VP of Finance, VP of Practice, Education, Administration & Research and Director at Large: New Graduate. If you are interested in any positions or have questions about the positions email us at info@ndna.org. Make sure your email address is up to date with ANA/NDNA and watch for emails to follow this summer regarding nominations!

Meet your nominating committee!

Karla Haug, MS, RN is a member of the Nominating Committee and is an Assistant Professor of Practice and Director of the LPN-BSN programs at North Dakota State University. She served as the faculty advisor to the NDSU Student Nurses Association for 10 years. “Being a role model to students through active involvement in NDNA is very important to me. I believe that is it through that role modeling that we can shape the nurses of tomorrow as well as the profession of nursing.”

Jami Falk, RN, MSSL, CNML is the Veteran Health Administration’s West Region Community Based Outpatient Clinic Nurse Manager and Acting VISN 23 Patient Medical Home Coordinator for North Dakota, South Dakota, Iowa, Nebraska and Minnesota. She works out of the VA Clinic located in Bismarck, ND and oversees the Primary Care clinical and administrative functions within four rural clinics in North Dakota. Over the past 13 years Ms. Falk has served as a front line Labor and Delivery RN, ICU nurse, ICU and Dialysis Nurse Manager, Inpatient Mental Health Nurse Manager, Acting Associate Chief Nurse of Primary Care and currently as the West Region CBOC Clinic Manager. Through these positions she has been involved in ensuring that front line staff has the education, training and knowledge they need to successfully take care of patients while working on ensuring quality nursing care is provided. She is a graduate of the University of Jamestown, certified as a Contracting Officer Representative, and also holds a Certification in Nurse Manager Leadership through AONE Association of Nurse Executives. She recently graduated with a Master’s of Science in Strategic Leadership through the University of Mary in Bismarck, ND.

Sandy Boschee is the Director of Acute Care at Trinity Health in Minot, ND.

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Dakota College at Bottineau distance site at Trinity St. Joseph Campus, Minot, ND. This is a 12-month, non-tenure, benefited position.

Dakota College at Bottineau (DCB) is seeking an instructor to teach courses in its nursing program to undergraduate students in practical nursing and associate degree nursing programs. Responsibilities include planning, implementation, teaching, and evaluation of student learning experiences in the classroom and clinical areas with nursing students enrolled in the Dakota Nursing Program

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Christie Odell
Shannon Blandell
Sandy Reagan
Chloe Van Lone
Kristen Hillebrand
Sharrar Lacher
Martha Glatt
Kimberly Sklebar
Melinda Kraakmo

Presentation Medical Center in Rolla, ND, is seeking a Family Nurse Practitioner to staff our clinic. A provider can expect compensation for this position to be approximately $105,000 annually. There is also the opportunity to provide occasional coverage in our ER for additional compensation. Benefits include medical, dental and vision insurance, along with malpractice insurance and reimbursement for CME. Excellent student loan repayment options available as PMC is a NHSC facility and with a HPSA score of 20. Relocation assistance is available. Providers who apply should be ATLS, ACLS and PALS certified.

For more information about this position, contact Chris Albertson, Human Resources, at 701-477-1949, chrisalbertson@pmc-rolla.com.

Presentation Medical Center in Rolla, ND is a Field Nurse Practitioner to staff our clinic. A provider can expect compensation for this position to be approximately $105,000 annually. There is also the opportunity to provide occasional coverage in our ER for additional compensation. Benefits include medical, dental and vision insurance, along with malpractice insurance and reimbursement for CME. Excellent student loan repayment options available as PMC is a NHSC facility and with a HPSA score of 20. Relocation assistance is available. Providers who apply should be ATLS, ACLS and PALS certified.

For more information about this position, contact Chris Albertson, Human Resources, at 701-477-1949, chrisalbertson@pmc-rolla.com.
Member Spotlight

By Jacki Bless Toppen
Featuring Lindsey Holter BSN, RN

For this Member Spotlight, we are getting to know more about Lindsey Holter. While most young nurses are just getting acclimated to the climate of the nursing profession, Lindsey is well on her way to making a mark for herself in the nursing world. Lindsey is passionate, driven, and despite her brief experience with the nursing profession; it is already clear to me that she has developed the maturity that she will need to be successful. Lindsey was kind enough to share some of her insights into what has gotten her to this point in her career, what traits she looks for in her professors, and what she believes can define a nurse as being extraordinary.

You just completed nursing school. Tell us a little about your experience.

I had a remarkable overall experience at the University of North Dakota. I enjoyed working with professors who truly had a passion for what they were teaching. I was able to have experience in long term care, labor and delivery, cardiac/telemetry, critical care, and many more areas of nursing, which helped me to feel that my program wanted me to be a competent, well-rounded nurse.

When did you know you wanted to become a nurse? What other careers did you consider?

Prior to starting nursing school, I had several ideas of what I wanted to do – Physical Therapy, Occupational Therapy, and Psychology. One fall day, however, as I was shadowing inpatient physical therapy, I brought a patient back to their room and saw the hustle and bustle up on the unit and had a moment to speak to the nurses. It was then and there that I realized PT and OT would not fulfill me in the same way that nursing would. I went on to get my BS in Nursing and BS in Psychology at UND.

You are just about to start your first nursing job. What other careers did you consider?

I was hired at Altru Health System in Grand Forks, ND to the Surgical Critical Care Unit (SCCU) following my senior preceptorship. I chose critical care because I feel that I work well under pressure, and I had always found the multisytem class content exciting. I find that critical thinking comes naturally to me, but I also consider myself very teachable and look forward to honing my skills in a critical care setting.

One of my professors particularly instilled in me the importance of a supportive and patient-centered unit culture. Altru’s SCCU was an easy choice based on the teamwork, support, and collegial atmosphere that I noticed during my preceptorship. The unit also goes above and beyond to provide a comforting atmosphere for their patients.

What was your biggest challenge while you were in nursing school?

I think my biggest challenge was to become a person who can go with the flow. I had always been a Type-A, and in some instances, I still am. But I realized that nursing is not a contest that rewards those who are most stressed, and I tried in many ways to decrease my anxiety from being too busy. I realized that patients don’t want a nurse who looks or sounds stressed, and at the end of the day, it benefits us to move more slowly because we will make less mistakes and have more face-to-face time with our patients.

What prompted you to join NDNA?

I strongly believe that if a person has the opportunity to offer their input, no matter how small it may seem, they should do that. In this spirit, I know that being a member of NDNA, ANA, and AAGN is an opportunity for me to have a say in the policies and regulations placed on me in my practice. I hope that every nurse out there knows that professional organizations protect us and serve our best interest, but especially so if we all have a voice in it.

How do you think NDNA can engage new graduate nurses who may not be knowledgeable about the benefits of a professional organization?

I believe NDNA should have representatives speaking to pre-nursing students and current nursing students at each school, each semester. It was not until my second semester of nursing school that I realized that professional memberships can have a great impact. We can work collaboratively to bring the best outcomes, not only for our patients, but ourselves as well by creating safe and supportive nursing environments. More education on legislation in school might help students realize their ability to impact the future of nursing.

What is an accomplishment that you are most proud of?

In summer 2015, I worked as a Summer III Student Nurse Extern on the Medical Cardiology Unit in Rochester, MN. The experience was certainly the most career-shaping of my life. It helped me realize that a patient-centered, collaborative model of care is not only the cornerstone of a good hospital, but it is imperative for good outcomes. I was so proud to have the kind of attitude that fit in to the culture of a hospital like Mayo.

What do you think makes a nurse extraordinary?

I believe that nurses who understand the gravity of their interactions with patients tend to be the most extraordinary. I believe that extraordinary nurses understand that the patient does not care how many injections you gave them or what clinical skills you used; they care that you held their hand, or explained something better so they understood. It is easy to treat nursing as just a job – to get frustrated, angry, upset… but it is the best and most extraordinary nurses that can use failure and frustration to motivate change.

Who is someone who inspires you?

My professors from UND – honestly most of them, but especially Rennae Millette and Kelli Zeidlik. These two have helped shape my attitude toward nursing and have inspired me to go beyond the average and work toward a better nursing future that includes nurses as critical members of the healthcare decision-making team from the top down.

What do you like to do in your free time?

At this point, home renovations with my husband! I also like to read, and I’ll be honest… Netflix was my best friend during the cold, cold months of this winter.

What goals do you have for yourself (personally or professionally)?

A personal goal that is close to my heart is to help others who are going through a similar journey to mine. It is a joy to help them through this time in their lives, and I look forward to continuing to help those in need.

Professionally, I hope to one day be an NDNA board member, and even someday move toward the board of ANA to help shape our practice. As the Nursing Student Association of North Dakota said – our profession needs to be #beyondaverage – and it starts with us.

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North Dakota Nurses Association Supports Raise it for Health Coalition’s Efforts

The North Dakota Nurses Association’s Advocacy Platform includes “collaborating with agencies for decreased tobacco use.” On March 16th, NDNA joined the press conference announcing plans to pursue a tobacco tax increase through an initiated ballot measure this election ballot in November 2016. The following information includes an article from the American Lung Association and the basics and benefits of this initiated ballot measure. Please help support these efforts across our state!

Tobacco Tax – A Winning Solution

Kristie Wolff
Program Manager
American Lung Association
in ND

On February 3, 2016, the American Lung Association released its 14th annual State of Tobacco Control Report. This report tracks progress on tobacco control policies at the federal and state level. Grades are assigned in a variety of areas - including strength of smoke-free laws, access to cessation services, support for comprehensive tobacco prevention programs, and level of tobacco taxes - based on whether these policies are adequately protecting citizens from tobacco-related death and disease.

Amidst otherwise good “grades”, North Dakota received an “F” for its current tobacco tax rates. At only 44 cents per pack, North Dakota’s cigarette tax is among the lowest in the nation, a tax rate that has remained since its last increase in 1993.

Why Support Higher Tobacco Taxes?

Tobacco tax increases are one of the most effective ways to reduce smoking and other tobacco use, especially among kids.

- Fewer people use tobacco
- People who continue to use tobacco consume less
- People who have already quit are less likely to start again
- Young people are less likely to ever start using tobacco

Tobacco taxes are widely accepted by the public and even supported by many tobacco users. Statewide public polling consistently shows this to be true here in North Dakota. Residents across all demographics - age, gender, political affiliation, and geography - overwhelmingly support tobacco prevention efforts, including those to increase tobacco taxes.

How Do We Compare?

The national average of state cigarette excise taxes is currently $1.61 per pack, but individual state rates vary widely, from just 17 cents per pack in Missouri to $4.35 per pack in New York.

To give a picture of current rates regionally, North Dakota still remains significantly lower than our neighboring states:

- South Dakota - $1.53/pack
- Montana - $1.70/pack
- Minnesota - $3.00/pack

This puts our regional average cigarette excise tax at $2.08 per pack, putting North Dakotans, especially North Dakota kids, at a much higher risk of tobacco addiction, initiation, disease and even death.

What’s the Cost of Tobacco in ND?

While the average retail price in the U.S. of a pack of cigarettes is $5.96 per pack, smoking-caused health care costs and productivity losses associated with just one pack of cigarettes is estimated to be a minimum of $19.16 per pack. That cost difference is often covered by non-tobacco using taxpayers. Higher tobacco taxes save money by reducing tobacco-related health care costs, including Medicaid expenses, over the long-term.

The true costs of tobacco use, however, reaches far beyond the monetary costs. Smoking continues to kill more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined, and thousands more die from other tobacco-related causes, such as fires caused by smoking (more than 1,000 deaths/year nationwide).

The numbers don’t lie:

- ND adults who die each year from their own smoking - 1,000
- Annual health care costs in North Dakota directly caused by smoking - $326 million
- Portion covered by the state Medicaid program - $56.9 million
- Residents’ state & federal tax burden from smoking-caused government expenditures - $823 per household
- Smoking-caused productivity losses in North Dakota - $232.6 million

(>Maynot include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking.)

Having one of the lowest tobacco taxes in the nation is not something that we should be proud of. Our state can achieve significant health and revenue gains by increasing tobacco taxes on cigarettes and other tobacco products like smokeless tobacco and cigars. It is time to raise the tobacco tax for the health of our citizens and to effectively protect our youth from a lifelong addiction to nicotine and the deadly consequences of tobacco. Please talk to your local, state, and federal officials about the impacts of low tobacco taxes and that they care and will do to move North Dakota’s “F” grade to an “A”.


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Honoring Choices North Dakota Update: What Matters Most

Nancy Joyner, RN, MS, APRN-CNS, ACHPN®
President, HCND

Honoring Choices North Dakota (HCND) was officially incorporated in 2015 as statewide initiative promoting advanced care planning in North Dakota. The HCND Vision is “to create a culture across ND where continuous (ongoing) advanced care planning is the standard of care and every individual’s preferences for future healthcare decisions are documented and upheld.” HCND’s Goal is “to assist statewide community partners with the development and implementation of a comprehensive advanced care planning program (Joyner, N. & May, S., 2015, part II, Choices North Dakota website, 2016).”

HCND has adopted the Respecting Choices® definition of advanced care planning (ACP) as a person-centered, ongoing process of communication that facilitates individuals’ understanding, reflection and discussion of their goals, values and preferences for future healthcare decisions (Respecting Choices®, Gunderson Health System, 2016). A fundamental theme is advanced care planning: an individual’s preferences for future healthcare care decisions are discussed and communicated; those preferences are documented; and ultimately translated into medical orders. According to the American Bar Association Commission on Law and Aging (2012), life transitions are remembered by the five “Ds”:

- Death of family or friend
- Divorce
- Receiving a new Diagnosis
- Experiencing a significant Decline in health
- Making a decision

Advance care planning is not a one-time event in a person’s life but rather a life-long conversation initiated in early adulthood. This implies that after age 18, the adult should discuss their healthcare preferences, goals, values, and wishes for the future. The sooner these discussions occur, the less likely the need to make decisions when unexpected injury or accidents occur, which renders one unable to speak for themselves, at those times, the individual has the opportunity to work with and become educated and empowered to make decisions for themselves, at those times, the individual preferences for future healthcare decisions are discussed and communicated; those preferences are documented; and ultimately translated into medical orders. According to the American Bar Association Commission on Law and Aging (2012), life transitions are remembered by the five "Ds":

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Another example of the growing interest in advancing care planning in North Dakota are the local National Healthcare Decisions Day events the week of April 10-16. National Healthcare Decisions Day (NHDD) is "an annual, national, multi-sector day of action to inspire, educate and empower the public and providers about the importance of advance care planning.

This year’s theme for National Healthcare Decisions Day (NHDD), It Always Seems Too Early. Until It’s Too Late, reflects the importance of early conversations about an individual’s healthcare preferences. More information about NHDD and their resources are available on the Honoring Choices North Dakota website at www.honoringchoicesnd.org.

References

Nurses in North Dakota and other states will have the opportunity to work with and become ACP facilitators as this significant role expands. By becoming aware of the importance of ACP through education and discussion nurses will be better informed to become highly skilled patient advocates.

For more information about advance care planning, ACP facilitator training and how to partner with Honoring Choices North Dakota in the important work of improving advanced care planning in North Dakota or your community, contact:
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or
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For questions please call Jill,
Director of Nurses at 701-852-1255.

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Minot, ND 58701

Honoring Choices North Dakota Update: What Matters Most

Nursing in North Dakota and other states will have the opportunity to work with and become ACP facilitators as this significant role expands. By becoming aware of the importance of ACP through education and discussion nurses will be better informed to become highly skilled patient advocates.

For more information about advance care planning, ACP facilitator training and how to partner with Honoring Choices North Dakota in the important work of improving advanced care planning in North Dakota or your community, contact:
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The Center for Medicare and Medicaid Services believes these conversations are so important that effective January 1, 2016 they are paying physicians and other qualified health professionals for engaging in advance care planning with their patients. This is not just a conversation for seniors or those at the end of life, all adults can benefit from thinking about what their healthcare choices would be if they are unable to speak for themselves. Waiting for a crisis or waiting for the healthcare provider to bring up the topic is not an effective plan. Proactively discussing preferences before an emergency protects the patient and family from more difficult uninformed decisions in the future.

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Whitney Fear RN, BSN, TWCC
Whitney Fear is the RN Case Manager and Shelter Outreach Nurse at Homeless Health Services in Fargo.

Over the past several months, I have been encouraged by colleagues to consider writing an article on patient advocacy in vulnerable populations. While this was quite humbling, I struggled to think of a way to convey this concept in a manner which hasn’t already been utilized. What words would be compelling enough to explain just how important defending the rights of vulnerable populations can be?

Ethics, advocacy and social justice are already concepts embedded into our nursing education. However, they are completely useless in the face of societal stigma. The harsh fact of the matter is that a great deal of the difficulty in working with this population lies within broken systems and colleagues who lack the understanding of their situations. I don’t blame them. We all experience an intense amount of pressure from society to conform. How can one expect to empathize with something they don’t understand? I suppose you could say I am lucky in this sense. Their world is my world. I grew up on the Pine Ridge Indian Reservation in South Dakota, a region which is riddled with poverty, mental illness and chemical dependency. Statistically speaking, I was more likely to end up an alcoholic than I was to graduate high school. It is just as challenging for me to understand that lack of empathy from colleagues who lack the understanding of their populations. While this was quite humbling, I have no scientific design or data to corroborate what I feel has been an absolute success. I will share that I saw students with reluctance and fear transforming into students who truly understood the strife of my patients. Their scope of the world was expanding. Students shared experiences like mine. It will tell them they have to fight, they have to work for themselves and eat a lot of chocolate. Colleagues might make you feel like an outcast. If you are still angry, unrelenting, asserting and moving forward, then you are probably just the right kind of person for the job. They will have good company, with the most amazing group of professionals that I have ever had the privilege of working with.

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But one thing I have learned with the trash. I’m going to die, don’t you realize that!!? Might as well just toss me away now.”


The only thing I find unacceptable is ignoring those who need help the most. I have a lot of hope that at any time, with any opportunity, their lives could change. I use that hope to attend community workshops, shelter visits, awareness events and wherever else my Outlook calendar has me going. I was introduced to a concept at one of these workshops that felt so refreshing to me. It was the idea of a compassionate community. Compassionate communities strive for reducing stigma, increasing awareness, designing care that works for people in systems, and ensuring that the community is all inclusive.

I saw my chance to act on this concept by increasing my availability to nursing students as much as possible. I want to help build compassionate nurses with a tenacity to demand social justice and ensure health care equality. I see an opportunity to nurture students that have that certain je ne sais quoi for patient advocacy. I know, like many nurses in my position know, that advocating for vulnerable populations cannot be taught completely from a book. I am willing to be honest. They have to get angry about injustices. They have to decide to be unrelenting. They have to learn how to be assertive, really assertive. When the rest of the crowd is moving backward, they have to find the courage to push against them. They have to make people feel they can change the world. They have to find the courage to push against them. They have to find the courage to push against them.

In North Dakota, we are in a crisis with mental health services and experiencing a severe drug epidemic. For the first time, I found myself in a precepting position rather than a preceptor. I want to help build compassionate health care providers. The only thing I find unacceptable is ignoring those who need help the most. I have a lot of hope that at any time, with any opportunity, their lives could change. I use that hope to attend community workshops, shelter visits, awareness events and wherever else my Outlook calendar has me going. I was introduced to a concept at one of these workshops that felt so refreshing to me. It was the idea of a compassionate community. Compassionate communities strive for reducing stigma, increasing awareness, designing care that works for people in systems, and ensuring that the community is all inclusive.

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One patient’s story is the verbalization of many.

They are completely useless. They have no control over their own mind due to mental illness. I am often asked how I can do what I do, or if I am afraid. I am certainly afraid. My heart sinks for every patient I encounter who is homeless. Many were noticing, for the first time, the prevalence of poverty in the community. All of those ah-ha moments had a common theme, they had connected with one or more of my patients they had never before had a face, name and story to mine. Offer unique clinical experiences at your people too. They need anyone they can get. Consider clinicals with nurses doing work similar to mine. I travelled to North Dakota to teach nurses doing work similar to mine. I travelled to North Dakota to teach about trauma informed care. Challenge your peers to see mental illness and chemical dependency with the same urgency as they would when dealing with physical illness.

Whether you work alongside me, or in a completely different setting, do not allow apathy for manifestations of chronic health conditions and high mortality rates. I cannot be at all places, at all times for my people. To my colleagues, to my nursing students and wise educators, I ask you that you help to care for my people. Make them your people too. They need anyone they can get. Consider clinicals with nurses doing work similar to mine. I travelled to North Dakota to teach about trauma informed care.

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Use of Chlorhexidine Gluconate with Critically-Ill Patients

Clinical Question:
In critically-ill patients, does the use of daily chlorhexidine gluconate bathing compared to regular soap and water decrease the risk of bloodstream infections?

Articles:

Synthesis of Conclusions:
The first study reviewed was a randomized control trial conducted by Bleasdale et al, in 2007. The study took place in a 22-bed medical ICU at the Benedictine Living Center of Garrison, where patients had an intravascular catheter and were admitted for at least 48 hours. The study lasted from June 8 through December 20. The second (MICU A) and ran the CHG intervention from October 2005 to October 2006. The study was taken from 43 hospitals that contained 74 ICUs that were chosen from the Hospital Corporation of America. The sample size consists of 7,926 patients tested in the first six months, which was implemented as the baseline. Following that was an 18-month intervention period that consisted of 9,878 patients. The study consisted of three strategies (arms): arm 1 (screening and isolation), ICU patient that had a catheterization was taken. The CHG arm also had fewer patients but equal patient days which exposed a vaguely longer length of stay. (Bleasdale, 2007).

A second article, by Septimus et al, (2014), conducted a randomized control trial that consisted of adult ICU patients that were admitted from July 1, 2009 to September 30, 2011. The study was taken from 43 hospitals that contained 74 ICUs that were chosen from the Hospital Corporation of America. The sample size consists of 7,926 patients tested in the first six months, which was implemented as the baseline. Following that was an 18-month intervention period that consisted of 9,878 patients. The study consisted of three strategies (arms): arm 1 (screening and isolation), ICU patient that had a catheterization was taken. The CHG arm also had fewer patients but equal patient days which exposed a vaguely longer length of stay. (Bleasdale, 2007).

In critically-ill patients, the use of daily chlorhexidine gluconate bathing compared to regular soap and water decreases the risk of bloodstream infections.

Bottom Line:
With a full review of the evidence, it suggests that the use of daily chlorhexidine gluconate bathing in critically-ill patients decreases the risk of bloodstream infections compared to the average use of soap and water as three articles supported the CHG soap. Only one article did not indicate that CHG reduced the chances of bloodstream infection either. This improves patient prognosis, decreases use of antibiotics. The sample size was large enough to determine if the use of CHG bathing affected CLABSI rates (Popovich et al, 2010).

Implications for Nursing Practice:
Based on the research articles and the evidence presented, facilities with critical-care units, healthcare providers, and infection control teams, should consider implementing the daily use of chlorhexidine gluconate bathing in critically-ill patients. To facilitate this, the facility would be required to change cleansing protocols, buy the CHG soap, and instruct the nursing staff with how to properly administer the intervention.
Clinical Question:

Does decreasing the patient-to-RN staffing ratio to 4-to-1 improve patient outcomes and decrease medication errors?

Articles:

Aiken, Clarke, Sloane, Sochalski, and Silber (2002) conducted a cross sectional analyses of linked data, level IV quantitative study based on data collected from 210 nonfederal adult general hospitals in Pennsylvani that determines the relationship between staffing levels on patient outcomes and factors that influence nurse retention, burnout, and job dissatisfaction. Data was collected using cross sectional analyses of linked data from 10,184 staff nurses surveyed; 232,342 general/orthopedic/vascular surgery patients discharged from the hospital between April 1, 1998 and November 30, 1999. Aiken et al (2002) found that by decreasing the RN-to-patient staffing ratio, the likelihood of readmission and dying within 30 days of admission dramatically decreased. There also was a decrease in nurse burnout and job dissatisfaction, as it had been increased in the past. So, in hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30 day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction.

A retrospective, correlational study was conducted by Frith, Anderson, Tseng, and Fong (2012). This study analyzed secondary data from administrative databases of one hospital containing 801 weekly staffing intervals and 31,080 patient observations from July 2008 to June 2010. Nine units, all from a single hospital met criteria for this analysis. The hospital had a variety units where medication errors occurred, but only medical-surgical units that occurred in the medical-surgical units were included in the analysis because nurse staffing was similar in these areas and the study was the variable of interest. This study had an adequate sample size of 801 weekly staffing intervals and 31,080 patient observations from July 2008 to June 2010. This study found that as the RN hours increased, the medication errors decreased. Conversely, as the LPN hours increased, the medication errors increased. The relationship between nurse staffing of RNs and LPNs and the occurrence of medication errors was examined. According to Frith, Anderson, Tseng, and Fong, “the current study shows that increasing the number of RN hours and decreasing or eliminating LPN hours can be a strategy to reduce medication errors” (p. 288).

Needleman et al (2011) conducted a retrospective, observational study where they used data from a large tertiary academic medical center. The study involved 197,961 admissions and 176,696 nursing shifts of 8 hours each in 43 hospitals units to examine the correlation between mortality and patient exposure to nursing shifts during which staffing by RNs was 8 hours or more below the staffing report (Needleman 2011). They also looked at the association between mortality and high patient turnover owing to admission, transfers, and discharges. They determined that there was a high correlation between RN below target level with increased mortality, and high patient turnover.

Zhu, X et al (2012) conducted a cohort study that focused on the relationship between nurse-to-patient staffing ratios in relation to patient outcomes. They conducted a study using the China Nurses Survey tool and the Hospital Consumer Assessment of Healthcare Providers and Systems to analyze the nursing care and patient outcomes. The results showed that inadequate nurse staffing results in missed but needed nursing care and negative patient outcomes. The research also supported that better staffing levels is an effective strategy for improving mortality and patient outcomes. This study included a sufficient sample size of 7,650 nurses and 5,430 patients.

Synthesis of Evidence:

Four studies were reviewed; three studies appraised the practice of decreasing the patient-to-RN ratio to decrease adverse patient outcomes, and one study compared nurse staffing of RNs and LPNs and the occurrence of medication errors.

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Bottom Line:

Of the four articles reviewed, three articles suggested that a decreased patient-to-RN drastically improves patient outcomes and decreases medication errors. This is a huge part of patient safety in today’s hospital settings. The last article strongly suggests that an increase in RN to LPN staffing decreases medication error incidence.

Implications for Nursing Practice:

As a nurse or unit manager, take into consideration the staffing ratios and patient safety. It is important to have quality care given to patients and that staffing levels are met. When assigning patients, take into consideration the patient’s acuity. Try to equally disperse the patient load between nurses on your floor in order to improve patient outcomes and decrease medication errors. When hiring, take into consideration licensure and education. A higher rate of RNs will improve quality of care.
Subcutaneous Fluid Rehydration vs IV Fluid Rehydration

Four studies were reviewed to answer the PICO question which included 3 randomized controlled trials and one systematic review. This first study is a randomized control trial done by Allen et al. (2009). This was to assess the efficacy, safety and clinical utility of recombinant human hyaluronidase (rHFSC) facilitated subcutaneous rehydration in pediatric patients 2mo -10yrs, when IV access is problematic to receive hydration therapy, while receiving therapy, and after receiving therapy. Tools that were used were the Gorelick 10 item scale (Dehydration score); weight change at the end of infusion; a survey at patient discharge from the ED; a questionnaire to parents who performed the assessment, number of attempts and time required for catheter placement, pain was assessed by using the FLACC scale (Face, legs, activity, cry, consolability scale; for those <3 years old), and the FACES pain scales for those 3 years old and older, a questionnaire was administered to patients' parents/legal guardians to assess their satisfaction with therapy and The National Cancer Institute's Terminology Criteria for Adverse Events and Common Toxicity Criteria. The interventions were randomly assigned using sealed envelopes, kept at the nurses’ station, opened upon patient’s randomized assignment. The randomization was achieved using a computer-generated sequence of randomization blocks of different lengths with the block size kept constant within each study site. The nature of the interventions “...was not an option and IV access was not obtainable because of continued IV rehydration. The clinical effectiveness was well received by clinicians and parents due to the ease, usage and safety of administering rHuPH20. Infusion sites were monitored for signs and symptoms of redness, swelling, irritation, and pain that were seen in the ER of 9 different hospitals. Finally the other weaknesses included the child’s perceived pain and parental recollections of the child’s pain due to the difficulty in providing reliable recollections of the event. Another weakness noted in this study is the lack of close monitoring of oral replacement therapy (ORT) in the children. Finally the other weaknesses include a small group and no control group for a closer comparison. In conclusion 94% of the pediatric patients that were seen in the ER for mild to moderate dehydration were successfully rehydrated using subcutaneous infusion using rHuPH20. It seemed to be safe and effective when oral rehydration therapy was not an option and IV access was not obtainable due to poor IV access in children when dehydrated. The second study reviewed was a randomized trial conducted by Spandorfer et al. (2013) as twenty-four United States hospitals. Seventy-three randomly assigned patients were assigned to the rHFSC therapy while 75 patients were assigned to the IV therapy. A strength of the study is that it is a randomized trial. Multiple measurement tools were used in this study to assess patients before receiving hydration therapy, while receiving therapy, and after receiving therapy. Tools that were used were the Gorelick 10 item scale (Dehydration score); weight change at the end of infusion; a survey at patient discharge from the ED; a questionnaire to parents who performed the assessment, number of attempts and time required for catheter placement, pain was assessed by using the FLACC scale (Face, legs, activity, cry, consolability scale; for those <3 years old), and the FACES pain scales for those 3 years old and older, a questionnaire was administered to patients' parents/legal guardians to assess their satisfaction with therapy and The National Cancer Institute’s Terminology Criteria for Adverse Events and Common Toxicity Criteria. Seven hundred and forty-five patients participated in the rHFSC group and all 73 of them had a SC line placed successfully on the first attempt. No side effects were shown from patients receiving rHFSC therapy; however, it had multiple positives by requiring less time for rehydrating the patients, having patient and parental satisfaction and ease of performance. Limitations of the study included the FDA limiting the total SC fluid volume augmented with recombinant human hyaluronidase in a single infusion to 200mL in infants and children under 3 years old and most centers did not have protocols allowing use of an SC line in the inpatient setting, which limited data on rHFSC compared to IV therapy which caused an imbalance in the amount of fluid received by the subcutaneous route.

The third study was a randomized trial conducted by Slesak et al. (2003) over a 20 month period. The purpose of this study was “to compare the acceptance, feasibility, and adverse effects of subcutaneous and intravenous rehydration in dehydrated geriatric patients and clinical changes exhibited by the patients” (p. 155). The study included 96 patients aged 60 and over in the geriatric ward of the Geriatric Department of the Tropenklinik Paul-Lechler-Krankenhaus in Tubingen, Germany that presented with signs of mild to moderate dehydration needing parenteral fluids on admission or during their stay in the geriatric department. The intervention in this case was receiving SC rehydration vs. IV rehydration. The interventions were randomly assigned using sealed envelopes, kept at the nurses’ station, which contained one intervention or the other. The study data was collected using a standardized patient form, the Likert-scale, as well as doctors and nursing scoring. The patient form was used to collect the information regarding the patients’ comfort level throughout the treatment. The Likert-like scale was used to measure the effectiveness of the treatment. The nurses provided the care the treatment was delivered by randomly scored the overall feasibility of the therapy with regard to the practical implementation and occurrence of complications. The doctors assessed for signs of dehydration upon admission and again the

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In recognition of the impact nursing has on patient outcomes and the quality of care, the American Nurses Association (ANA) has designated 2016 as “Culture of Safety” and the tagline is “Safety 360 Taking Responsibility Together.” Keeping with this focus, the theme for National Nurses Week 2016 (May 6-12) is “Culture of Safety—It Starts with You.”

Overarching Key Messages

• Safety is everyone’s responsibility. There is no hierarchy. Safety requires empowering every voice.

• A culture of safety is one where nurses feel supported, listened to and understood. A culture of safety fosters transparency, accountability and results.

• Nurses foster open conversations about safety issues, such as fatigue, stress, safe patient handling, workplace violence, incivility and bullying.

• Nurses prioritize safe staffing and help connect individual, team and organizational safety goals.

• National Nurses Week celebrates the contributions nurses make every day to make positive changes for patients.

• Nurses ensure the delivery of quality health care to patients, families and society.

• Nurses are recognized by the public for upholding high ethical standards. An annual Gallup survey shows that the public has ranked nursing as the top profession for honesty and ethical standards for 14 years straight.

• Nurses have a critical responsibility to uphold the highest level of quality and standards in their practice, including fostering a safe work environment.

• Nursing leaders ensure resources are available to achieve safety results, providing resources for adequate staffing, equipment and education.

• Nurses use quality measurements to improve patient outcomes.

• The American Nurses Association (ANA) has a long-standing commitment to ensuring the health and wellness of nurses in all settings. ANA supports improving the work life of health care providers: what’s good for nurses is good for patients.

Additional Background and Examples

It has been 15 years since the Institute of Medicine (IOM) issued the call for a safer health care system in its landmark reports To Err Is Human and Crossing the Quality Chasm.

To Err Is Human found that between 44,000 and 98,000 hospitalized patients die each year from preventable medical errors. Many nurses were shaken by the report, as “do no harm” is at the core of nursing.

The follow-up report, Crossing the Quality Chasm, had a broader focus and suggested a roadmap for reforming the nation’s health care system. Taken together, these two reports have shaped the modern patient safety conversation.

ANA endorsed the National Patient Safety Foundation report which reiterates the importance of establishing and sustaining a culture of safety. The report emphasizes “the wellbeing and safety of the healthcare workforce.” ANA supports the concept that a healthy nurse leads to a healthy community.

Recent studies suggest U.S. patients experience a far greater number of adverse events each year than even suggested by the IOM 15 years ago. A 2013 study published in the Journal of Patient Safety revealed that preventable adverse events accounted for 210,000 to 440,000 deaths of hospital patients every year. There is still work to be done and nurses will play a key role.

Nurses have been instrumental in improving the quality and safety of health care particularly when it comes to hospital-acquired conditions. According to the Agency for Healthcare Research and Quality (AHRQ) these conditions declined 17 percent between 2010 and 2014. There were 2.1 million fewer hospital-acquired conditions, 87,000 saved lives, and $20 billion in savings.

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- Bethany I Registered Nurse

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In 2010, the Institute of Medicine released a landmark report, The Future of Nursing: Leading Change, Advancing Health, which recommended increasing the number of nurse leaders in pivotal decision-making roles on boards and commissions that work to improve the health of everyone in America. The Nurses on Boards Coalition (NOBC) was created in response to this, as a way to help recruit and engage nurses to step into leadership roles.

The NOBC represents nursing and other organizations working to build healthier communities in America by increasing nurses’ presence on corporate, health-related, and other boards, panels, and commissions. The coalition’s goal is to help ensure that at least 10,000 nurses are on boards by 2020, as well as raise awareness that all boards would benefit from the unique perspective of nurses to achieve the goals of improved health in the United States.

We encourage each and every one of you, over 3 million strong, to visit www.nursesonboardscoalition.org, sign up to be counted if you are on a board and read more about the efforts being made to help build the future of our profession.
Subcutaneous Fluid Rehydration vs IV Fluid Rehydration continued from page 13

next day. Patient diagnosis, sex, weight, height, duration of stay blood pressure, pulse, hematocrit, serum sodium, serum creatinine, and signs of dehydration were all recorded upon admission and reassessed after they received the SC or IV hydration. This study was looking at hydration success, acceptance, feasibility, and adverse effects of both methods of hydration. There was not a significant difference in the effectiveness of rehydration between the IV method and the subcutaneous method. The only extraneous variable that could not be controlled in the trial was any underlying medical condition the patient may have had. After review the evidence, if was suggested by Slesak et. al. that the two forms of hydration, IV and subcutaneous, are equally effective, safe, and well tolerated by the patient with the only more punctures and more time involved in placing IV catheters, which is less economical.

The fourth study was a systematic review conducted by Remington and Hultman (2007) to compare hypodermoclysis (HDC) to IV methods of fluid replacement. Eight studies were reviewed including two randomized control trials (RCT) and 6 cohort studies. The search included hypodermoclysis, clysis, fluid therapy, subcutaneous, dehydration, and rehydration. They searched the databases Medline, CINAHL, the Cochrane Library, Embase, and the Joanna Briggs Institute for literature published between 1996 and 2006. Dissertations abstracts were included in the search in order to find unpublished research. Data was independently extracted by each author and any disagreement was discussed without any third party involvement. Weaknesses of the studies noted in the review included: small sample size, nonstandardized evaluation methods, nonstandardized limited conclusions, and other extraneous variable related to baseline differences, and intention-to-treat analysis. According to Remington and Hultman (2007), “When administered properly, HDC is as effective as and safe as IV hydration and potentially less expensive. Advantages include lower cost and greater patient comfort.” It is also suggested that more research be done on this topic.

Bottom Line: Based on the four studies we reviewed one can conclude that subcutaneous fluid rehydration is as effective as IV fluid rehydration. Advantages of subcutaneous fluid rehydration include: ease of placement, less pain and distress, and fewer resources utilized. This would warrant a change of practice to utilize subcutaneous fluid rehydration more or to further study subcutaneous fluid hydration in order to make a change in practice.

Implications for Nursing Practice: Evidence suggests that subcutaneous hydration is an effective alternative to IV hydration in treating mildly-to moderately dehydrated patients. In addition, subcutaneous hydration is less painful, is more cost effective, and promotes patient-nurse trust. Considering the advantages, we encourage implementing a pilot project in the ED.

May, June, July 2016
The North Dakota Nurse

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