Sarah J. Carmody, MBA
Recently I saw on a reader board the following quote: ‘There is no substitute for hard work. Never give up. Never stop believing. Never stop fighting.’ This made me think of the work that DNA does on behalf of all Delaware nurses. DNA will not give up nor stop impressing on the legislature and policy makers that the education, skills, training, competence, and compassion nurses possess are what patients deserve and should expect and that nurses should be at the table participating in healthcare policy at all levels of government. Sarah Bucic, DNA member recently demonstrated what hard work and perseverance can accomplish. She, along with other stakeholders, worked for almost two years to pass House Bill 456 which will eliminate the use of lead paint on outdoor structures. This is the first bill of its kind in the nation and will hopefully serve as the model language for other states to pass legislation to eliminate lead from the environment.

Maryellen Sparks MSN, APRN, CBN
Maryellen Sparks earned her BSN, MSN, and completed a Post-Master’s Adult/Gero primary care NP from the University of Delaware. She is a Certified Bariatric Nurse by American Society of Metabolic & Bariatric Surgery and has worked as a bedside nurse, as well as a clinical nurse specialist for over 35 years. Maryellen currently serves as the Coordinator/Manager of the MBSAQIP Bariatric Nutrition Program at Saint Francis Healthcare working with diabetic, cardiac, cancer, medical and surgical weight loss patients. She has been a member of the Professional Development Committee for the Delaware Nurses Association for 15 years, as well as a member of Sigma Theta Tau Internation Honor Society of Nursing, in addition to volunteering as a BLS/ACLS instructor. Maryellen can be reached by email at msparks@che-east.org or directly at (302) 421-4221.
Spirituality Background

Spirituality and religion are not necessarily synonymous! The concept of spirituality is not universal in meaning; there are almost as many definitions of spirituality as there are people. The distinction between spirituality and religion described by Hodge (2014) is as follows: Spirituality can be viewed as an ontologically driven impulse toward union or relationship with God (or ultimate transcendent reality), whereas religion can be understood as an expression of the spiritual relationship that unites an individual with a moral community that shares similar experiences of transcendent reality. (p. 318)

A more open-ended definition of spirituality that is used for the purpose of introducing the topic is from the palliative care consensus group that defined spirituality as:

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. (Puchalski et al., 2009, p.887)

Lewis Newman (2004) in her model for understanding the differences between Faith, spirituality, and religion described by Hodge (2014) is as follows: 

The distinction between spirituality and religion universal in meaning; there are almost as many synonymous! The concept of spirituality is not simply religious knowledge, as well as provided the tools essential to discern and work with spiritual issues. Nurses need to attain a comfort level addressing spirituality. Hopefully these authors have increased your awareness and knowledge as well as provided the tools essential to enhance your spiritual nursing practice.

References


As my presidency comes to an end, I am happy to pass the torch to our new president Gary Alderson. As both a nurse and a lawyer, Gary brings a great deal of knowledge and legal expertise to the table that are great assets as DNA addresses changes occurring in healthcare today. Over the past year as president elect, Gary was instrumental in assisting DNA in updating our Bylaws and addressing legislation that affects nursing practice. Please join me in welcoming Gary.

As I write this, I think of how my involvement in Delaware Nurses Association began. My journey started by going to a required professional board meeting in my MSN. I was nervous and intimidated at meeting individuals who were so involved in moving Delaware policies forward, thinking I am not at all knowledgeable about politics. However, from this first meeting I felt included and wanted to be involved.

I loved the networking and meeting some great nursing experts who have assisted in my thinking and career goal enhancement. I am always in awe at the greatness of nursing in the United States and especially in Delaware. Each nurse I have met along my journey has showed that caring for patients and their communities is very important for them.

Though I will no longer be president, I will continue my involvement with the Delaware Nurses Association and would love to see more Delaware nurses join. Involvement in your professional organization is a dear issue to me as most of you know. Changes to our practice can occur so rapidly that nursing must remain vigilant. Nurses need to be involved, or at the very least support through Delaware policies forward, thinking I am not at all knowledgeable about politics. However, from this first meeting I felt included and wanted to be involved.

I wish all of you a very merry holiday season and a healthy and prosperous New Year!

DNA Reporter • Page 3
Forgotten factor that was relegated by healthcare prevention or the healing process. Faith was the considered the impact of spirituality in disease and service to those in need (Striepe, 2002, p. 17). Emotional needs. She also emphasized prevention ministering to the spiritual as well as physical and or no exposure to health education or promotion. Nurses in churches have existed for ages; however, American Nurses Association in 1998, there remain designation as a specialty practice of nursing by the nurse consultant and faculty educator for the Westberg Institute, formerly the International Parish Nurse Resource Center, in Memphis, TN. La Vaida may be contacted through email at ckparish@aol.com or (302) 656-2660.

Despite Faith Community Nursing (FCN) designation as a specialty practice of nursing by the American Nurses Association in 1998, there remain nurses and students who are not familiar with this professional practice in diverse faith traditions. Nurses in churches have existed for ages; however, there are many congregations where their “nurses” are lay individuals who serve as assistants to the pastor and aid congregation members who, in the experience of worship, may need care or assistance. These “nurses” may have had minimal or no exposure to health education or promotion practices.

Nursing has its roots in Christianity. Florence Nightingale felt that the nursing role included ministering to the spiritual as well as physical and emotional needs. She also emphasized prevention and service to those in need (Striepe, 2002, p. 17). Until recently, most medical studies failed to consider the impact of spirituality in disease prevention or the healing process. Faith was the forgotten factor that was neglected by healthcare providers to the chaplain’s office. Fortunately, things are beginning to change (Christian Medical and Dental Association [CMDA], 2014).

Faith Nursing, now recognized as Faith Community Nursing (FCN), was developed by a Lutheran minister, Granger Westberg, hospital chaplain, professor of practical theology and teacher of medical students. His work was based on his belief that healthcare transcends physical care, because true healing involves the whole person in the context of their community. Originally developed in 1984 as a partnership between Lutheran General Hospital in Park Ridge, Illinois and six area congregations, this new eccumenical movement soon grew to encompass nurses and churches around the country and, now, around the world (Westberg Institute, 2016).

FCN is a nursing practice specialty that focuses on the intentional care of the spirit, the promotion of an integrative model of health, and the prevention and minimization of illness within the context of a faith community. Such practitioners consider the spiritual, physical, psychological, and social aspects of an individual to create a sense of harmony with self, others, the environment, and a higher power. Consequently, healing is the process of integrating the individual’s body, mind, and spirit to create wholeness, health, and a sense of well-being for that person (‘Faith Community Nursing,’ 2017).

Spirituality has no universally accepted definition or meaning in the nursing literature. Some describe the spirit as the life principle at the center of our being, integrating and transcending the biological and psychosocial nature. They see spirituality as a “basic or inherent quality in all humans that involves a belief in something greater than the self and a faith that positively affirms life” (Trelaor, 2002, p. 181).

Nurses begin faith community nursing at different levels of spiritual experience and maturity. Some may have a seminary degree or have taken spiritual formation courses. Others have a lifelong faith community experience with extensive knowledge of their faith and how to communicate it. Because caring for the spirit is the focus of the faith community and faith community nursing, learning spiritual care skills is very important (Smucker & Weinberg, 2009).

Educational preparation for FCN practice has been developed by the Westberg Institute’s “Foundations of Faith Community Nurse Practice.” The training, specifically designed for health ministry, is necessary to understand the focus and task of the ministry. The Foundations Course is a 38 hour course focusing on the entry-level knowledge necessary for FCN practice. This course is a blended format with classroom and/or online work to complete the requirements for Continuing Education. Its sections include spirituality, professionalism, wholistic health, and community. Courses are offered by hospitals and universities as well as other sites around the nation. A listing of current educational opportunities can be found on the Westberg Institute’s website.

In April, a gathering of over 200 international nurses convened for the 2018 Westberg Symposium conference, “Expanding horizons of FCN Practice” in Memphis, TN. The symposium, hosted by the Westberg Institute, a wholistic model and wellness clinic in Memphis has become the premier gathering and network for faith community nurses from around the globe. This three day gathering has become a place of healing and health explored FCN’s impact on health outcomes.

Approaches to the practice of faith community nurses in connection faith and health have evolved and ongoing, therefore, at the conclusion of the 2018 Westberg Symposium, Faith and Health Seminars were offered as an opportunity to enhance learning and gain innovative ideas and direction for connecting faith and health in the care of ourselves and others.

Of particular interest was “The Nuts and Bolts of Effective Transcultural Care” four hour training that enhanced skills and knowledge in caring for persons before and after discharge from the hospital. Dr. Carol “Candy” Piatt titled “Faith Community Nurses” advertised as bridging the gap between hospital and home looked in detail at the role the nurse plays in coming alongside individuals in a vulnerable period of time, including non-medical support that a congregational health ministry team can provide. It gives opportunity for volunteers within the congregation to live out the gospel message of brother/sisterhood.

“Healthy People 2000: A Role for America’s Religious Communities” research study concluded that more than any other institution in our society, the local congregation has a claim and a call to minister to people in need (Marty, Solberg, & Pittman, 1990). It challenges congregations and individuals within those congregations to continue in partnership with health care professionals to foster the quality of life by stepping out into territory that, today, seems uncharted (Marty et al., 1990).

Presently, over 100 nurses in Delaware have taken the Foundations of Faith Community Nursing course and accepted the challenge to bring their professional gifts and talents to the open doors of their faith traditions to close the gap in health care. Although the supply of faith community nurses is woefully low, today, more nurses are needed to embrace their spirituality and bring to the marketplace an avenue for consumers struggling to understand the challenges of faith care reform. Today, more nurses are needed to embrace their spirituality and bring to the marketplace an avenue for consumers struggling to understand the challenges of faith care reform. Today, more nurses are needed to embrace their spirituality and bring to the marketplace an avenue for consumers struggling to understand the challenges of faith care reform.
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Addressing Spirituality in Healthcare

Linda Murray Branco, PhD., LPC, NCC
Maryellen Sparks MSN, APRN, CBN

Linda Murray Branco earned her PhD and MS in Pastoral Counseling from Neumann University. She is a nationally certified counselor and a licensed professional counselor (PA and DE) in private practice. Linda served as Director of the Pastoral Care Department at Saint Francis Healthcare in Wilmington, DE for ten years where she primarily ministered in the Intensive Care and Emergency Departments. She currently serves as Director of Mission Integration for Saint Francis Healthcare and is the chair of the Ethics Committee. Linda is also an adjunct professor in Pastoral Clinical Mental Health Counseling at Neumann University in Aston, PA. Linda can be reached by email at branco@che-east.org or at her office (302) 421.4578.

Spirituality is recognized as an integral part of healthcare. One of the more difficult aspects of this recognition is the ability to define spirituality because many have a very personal meaning and experience of spirituality. Often, spirituality is linked to religion; however, some people confidently state that they are 'spiritual,' yet express no specific religious preference. This article will focus on the definition agreed upon by Dr. Christina Puchalski and colleagues who met for a Consensus Conference in 2009 with the goal to "identify points of agreement about spirituality as it applies to health care and to make recommendations to advance the delivery of quality spiritual care in palliative care." Dr. Puchalski and associates defined spirituality as:

... the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. (p. 887)

Nurses manage a multitude of issues and concerns when ministering to their patients, recognizing the physical, mental, and spiritual aspects of a patient's condition, and tasked with addressing these needs for the patient. According to Auschwitz survivor Viktor Frankl (1975) "It is not possible to stress enough that it is only this threefold wholeness which makes man complete." It is this shared human connection that assists nurses in responding to their patients who may be experiencing pain, uncertainty, fear, loneliness, anger, and any number of other emotions. Hajar (2017) cited a modern version of the Hippocratic Oath that illustrates the inclusion of these personal, human-to-human attributes when caring for patients. Penned in 1964 by Dr. Louis Lasagna, this version of the oath includes, among others, the following pledge:

"I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug." (para 26, Table 2)

While we may not have a universal definition of spiritual care, we can glimpse the practice of spiritual care and recognize shared components in the delivery of spiritual care. The following examples from my pastoral experience with patients and nurses may provide some deeper understanding and even a familiar resonance with your personal engagement in the practice of nursing.

Ministry with a servant’s heart - I encountered a colleague from nursing in a patient’s room just as she was tending to a patient who was bathed and dressing the patient. The patient expressed how much she enjoyed washing her patients’ feet, especially elderly or homeless patients, for whom she recognizes each one’s difficulty in reaching to wash his/her own feet. I was struck by the echo in her actions with the Last Supper, and especially by the humility she expressed.

Pastoral presence - Some years ago I grew to know a patient who made the decision to transition to hospice care. He had no living family members, and his close friend was herself in a nursing home. The patient was struggling to breathe and exuded anxiety, although he stated he was "at peace" with his decision. Even after we had talked and prayed, his anxiety was still evident. I asked him if he would like to hold my hand, and he readily grasped it as if never to let go. Soon his breathing relaxed and he drifted off to sleep, still clutching my fingers.

Listening and acting on a ‘hunch’ - Several years ago, a nursing colleague in Home Care asked if I would visit one of her patients, a woman from out-of-state recuperating in the Delaware home of her daughter. In her late 80’s, the patient had recently undergone knee replacement surgery, was doing very well in every regard, and yet was unable to be cared for at home and administered due to ongoing pain. Following her nurse’s suggestion of a consult from Pastoral Care, I visited the patient and listened as she spoke of the loss of her deceased husband, missing her friends and her pastor, her ‘life’ in her own home. After talking about her struggles, the patient relaxed tremendously and admitted to feeling so much better. Through this conversation, we realized the patient’s pain was more heartache than postsurgical – she was lonely. With time and some recommendations for local social and spiritual contacts, the patient did well and was discharged from Home Care.

Seeking assistance from Pastoral Care - Nurses in the Outpatient Cardiovascular Rehabilitation Center often request input from Pastoral Care staff. I visited a patient in her late 60’s whose continued high anxiety was impeding her cardiac rehab progress. In addition to her chronic heart condition, she was also going through a nasty divorce, and admitted she was uncertain about her maternal future. We talked privately over the course of several visits, after each of which the patient repeated her gratitude. She expressed how troubled she was by her divorce and reluctance to discuss it with anyone in her family or social network. With me, a comfortable stranger, she was able to share her fears and concerns openly and readily accepted suggestions of relaxation techniques.

As healthcare providers we minister to patients in a variety of ways -- washing their feet, holding their hands, listening and affirming their hopes, fears, and dreams. As we do this, we may name the space between the holy, sacred, spiritual, to the space of healing and love to the space of uncertainty and personal connection. The art of medicine, the practice of spiritual care allows us to name the space of human connection and to engage in a kind of healing that is beyond medicine.

References

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become comfortable asking their patients questions regarding how their spirituality affects their hospital stay, their illness, their family, and their own personal connections with a higher power.

Pullen, McGuire, Farmer, and Dodd (2015) noted the importance of spirituality in nursing education and the need to incorporate the essence of spirituality assessment into curriculum in preparing nursing students. In order to increase nursings ability to assess the spiritual needs of patients, the way nurses are prepared to practice must be addressed first. Spirituality is a difficult concept for nursing students to understand and incorporate into practice. It is important for nurse educators to use every opportunity to introduce student nurses to the concept of spirituality in practice early in their academic careers. Ohbien (2017) noted that modern nursing text books in fundamentals and medical surgical nursing now address the importance of teaching nursing students the need to incorporate spirituality into practice. What text books however do not do is help nursing students to understand their own spirituality so that they are comfortable in exploring the concept with their patients.

Nursing instructors both in the classroom and in the clinical area must incorporate activities such as reflection, simulation, and assessment into the learning process to help increase nursing students level of comfort in providing spiritual care. The emphasis in the educational process needs to help student nurses identify their own spirituality in order to assess a patient’s spirituality. Gerber (2011) further noted that focusing on the spiritual needs of patients rather than delegating this need to the hospital chaplain is essential in nursing practice. However, if a student nurse is uncomfortable with a spiritual assessment, knowing the other resources available to assist the patient in meeting their spiritual needs is just as valuable.

One of the most important lessons for a student nurse to learn is to have a caring and empathetic presence. As nursing students explore the concept of spirituality and gain a greater awareness of their own spirituality, meeting the needs of the patient becomes easier. There are many different tools available to assess spirituality in patients. Some are rather lengthy and this in and of itself lends to the problem due to time constraints and other task facing the nursing role. As further noted by Pullen et al. (2015), nursing interventions that are evidence-based can lead to positive outcomes and life satisfaction with health care decisions. Nurse educators must incorporate clinical teaching, small groups, hands on experience with the knowledge, skills, and abilities to first know themselves so that they can meet the needs of the patients they are providing care to. Spirituality must be threaded throughout all nursing courses in a curriculum. Students need to have clinical experiences which incorporate exploration of their spiritual needs as well as the spiritual needs of the patients.

Knowing that nurses and nursing students struggle with the concept of incorporating spirituality into the care of their patients, the question then becomes how can nurse educators in academia better prepare nursing students to provide spiritual care and transform this practice into their level of comfort will increase and their ability to meet the needs of patients holistically advance in practice. With all that we know about spirituality and the research to date, it is imperative that nursing education incorporate spiritual care in preparing nursing students so that these students as nurses meet the needs of their patients, society, and most important their ethical obligation to care for themselves.

References


Caring: Spiritual Praxis of Nursing

Denise S. Morris, Ed.D., MSN, RN

Denise S. Morris received her Doctorate in Education from Wilmington University, her Masters in Nursing from Wesley College and her primary nursing diploma from Beebe School of Nursing. She is currently teaching graduate nursing courses at Wesley College and is the Department’s MSN Program Director. A strong advocate for inquiry based education and active participatory learning, she involves students in research and evidence based practice in a variety of community and small group settings focused upon health promotion and wellness. Her professional experiences include critical care; home care nursing; nursing administration and nursing education. Dr. Morris can be reached via email at denise.morris@wesley.edu

Caring is viewed by nursing professionals as a wide range of behaviors including physical care, therapeutic arts, caring for others, empathy, and presence (Summer, 2008; Cavendish et al., 2003; Mayeroff, 1971; Chinn, 1991; Noddings, 1984; & O’Brien, 2003). Patients desire interactions that display a state of engagement or receptivity, which encourages becoming a duality between the one caring, and the one cared for where both are fully present in the moment (Noddings, 1984; Watson, 2007; Buber, 1971; Reed, 1991; & Taylor, 2002). While the term caring has a wide variety of expressions to describe nursing service, the bases of these phrases are the central theme for the essence of the discipline of nursing (Watson, 2007; Barnhardt, 1994).

Despite the logic of this human caring transaction theory, the nursing profession has sustained a division of its philosophy into two widely differing and often-contradictory paths. These divisions are identified as that of nursing science and that of nursing art (Watson, 2007). While early nursing leaders were attempting to validate the discipline of nursing through the establishment of empirically based processes of investigation and theory construction, the origin and the foundations of nursing were subjected to suppression. According to McN toss (2004a) “science values cure, not care which the emphasis of nursing is” (p113). Patients are no longer human beings, but diseases and cases. In this paradigm shift, empathy has been lost and replaced with the pursuit of technical expertise in an attempt to validate our science according to the rules of medical model (Sviadek, 2008).

According to Bent, Moscatel, Baize and McCabe (2007), nursing is an inherently spiritual praxis which requires nurses to share in experiences of others. Yet the work place culture of spiritual neutrality and a depersonalized approach to caring has fostered the suppression of spiritual discussions. Spirituality, or the sacred self, is defined as a “universal human phenomenon that recognized the wholeness of the individual and their connectedness to a higher being” (Cavendish et al., 2003, p.116). Theorists and practitioners of nursing have long emphasized the need for complementary and alternative forms of caring which embraces the spirit and its interconnectedness between the overall health of the mind and body (Banks, 1980; Bensen, 1997; Dosssey & Keegan as cited in Cavendish et al., 2003). Noddings (1984) stated: “Caring involves stepping out of one’s own personal frame of reference into the others” (p. 24). This transcendental connection of the spirit or sacred self with the other is the empowering force we possess and yet suppress as nurses today. According to Jung (as cited in McN toss, 2004), the sacred self is defined as “the internal God, or spirit that promotes self-actualization and allows humans to face their soul” (p.33)

The distinctiveness of our profession has been sacrificed because we do not have a foundation from which the social and scientific theories can emerge united. We struggle to define a paradigm suitable for our unique discipline and consequently lose direction for our practice and research. According to Grant, O’Neil, and Stephens (2004), “Nursing was born in the spirit and is now looking back to see what has lost” (p.265). Nursing professionals are champions of holistic caring and therefore must be involved in upholding standards and ethics, as well as supporting fellow nurses in the advancement of the profession through the renewed use of complementary and alternative forms of caring (Summer, 2008). The primary goal of holistic nursing is to support and improve the human condition, and this can best be achieved through the integration of traditional and holistic modalities (McElligott, 2008). Further, the unity nurses share in these experiences of caring will propel each professional toward a higher sense of self (Watson, 1985).

While there has been a recent resurgence in integrated healthcare across the country (Berger, Leach, and Shaffer, 2003), the premise of holistic, complementary, and alternative approaches has failed to make open connections with the spirit. Consequently, the history of the spiritual connection in nursing, values in caring, alternative forms of caring, and healing must be examined in order to determine a framework for connecting the spirit in partnership with the science of caring. From where did nursing derive its knowledge for such areas of caring? What are these caring practices? Are these caring practices universal? Does it mean to be a healer? Were these the lost spiritual foundational of nursing, as emphasized by Grant and Grand (2004) that are referenced? Because Paganism is founded in the ontological assumption that all things are connected to nature and the spirit, pagan nurses may be more comfortable providing holistic care ways and may be more responsive to the humanity and holism in the care of their patients than their Judeo-Christian or strictly scientifically minded counterparts. Limited understanding prohibits open collaboration between peers who embrace these alternative forms of spirituality and those who hold to the traditional. By understanding the perceptions and experiences of pagan nurses, the path to the recovery of our historical roots in holistic care methods might be revealed. Caring ways are universally centered in the spiritual, yet nurses do not claim or engage the power of the sacred self. The promotion and celebration of complementary and alternative forms of caring in order to foster healing.

In practice nurses evolve spiritually because of human interaction. They are challenged, they are strengthened, and they are changed. This process necessitates preparation at the instructional level in order to prepare nurses for spiritual transformation. Without this preparation, nurses are faced with this personal process alone. As nurses learn to value and activate their own spirit, and to respect and to honor their patient’s spirits, true healing plans might be developed and outcomes improved and sustained.

References


are two parts to compassion fatigue: in a demanding relationship with needy individuals’

Compassion fatigue (CF) was coined in the early 1990's and has been defined as “a state of physical or emotional burnout or disintegration! Sheppard (2016) encouraged that developing strategies to intentionally replenish reserves will help nurses to work from a locus of abundance versus lack. Nurses need to be given the tools and resources not only to care for patients’ spiritual well-being but to enhance their own! Ideally nurses need a Tool Box they can access to refill their own reservoirs. A couple of examples mentioned in the literature are: Tea for the Soul™ and Blessing of Hands (BOH) for nurses as means of supporting nurses’ reconnection with the meaning and purpose of nursing. “Tea for the Soul™” spiritual care association staff are served tea and other treats by chaplains or spiritual care departments along with an open invitation to discuss issues they face caring for patients with goal of reducing healthcare providers stress. Supportive resources such as inspirational readings or resource materials are available upon request. Creation of a nurturing environment by the chaplains encourages and fosters staff to practice “collaborative decision-making and reflection, enhances coping and resiliency giving a deeper meaning of their work” (“Nurturing Caregivers with Tea for the Soul”, 2017). St. Francis Healthcare in Wilmington, Delaware, much like the rest of the country, celebrates the beginning of Nurses Week with the Blessing of Hands (BOH). There is a plethora of descriptions of the nuances of the BOH ceremony.

Self-Care While Providing Spiritual Care to Patients!

Avoiding Compassion Fatigue: Put Your Oxygen Mask on First!

Maryellen Sparks MSN, APRN, CBN
See Guest Editor for complete bio on page 1

Health Care Chaplancy Network (HCCN) and the Spiritual Care Association (SCA) published a White Paper in 1979 titled Spiritual Care and Nursing: A Nursing Specialty which acknowledged the history of nursing and the role of spiritual care in the delivery of health care. The White Paper was the first draft of the current standard for spiritual care and was the central piece of the early 1990's and has been defined as “a state of physical or psychological distress in caregivers, which occurs as a consequence of an ongoing and not-so-efficient process in a demanding relationship with needy individuals” (Van Moë, Kompane, Benoît, Bakker, & Nijman, 2015, p. 3). 

Hughes et al. (2017) addressed the issue of compassion fatigue affecting nurses constantly providing spiritual care and the positive impact that creating constructive coping strategies for self-care would have mitigating their distress. Compassion fatigue (CF) was coined in the early 1990’s and has been defined as “a state of physical or emotional distress in caregivers, which occurs as a consequence of an ongoing and not-so-efficient process in a demanding relationship with needy individuals” (Van Moë, Kompane, Benoît, Bakker, & Nijman, 2015, p. 3). Hughes et al. (2017) addressed the issue of compassion fatigue affecting nurses constantly providing spiritual care and the positive impact that creating constructive coping strategies for self-care would have mitigating their distress. The first part contains issues such as exhaustion, frustration, and depression, typical associated with Burnout (BO). The second part is the negative feeling driven by concerns such as hypervigilance, avoidance, fear, and increased irritability and characterized by secondary post-traumatic stress (S/PTS). (p. 3)

Compassion fatigue is pervasive and unacknowledged in healthcare and especially nurses. At greatest risk are nurses that routinely form intimate caring, compassionate relationships above and beyond the call of duty with patients and/ or their families, particularly if nurse’s individual boundaries aren’t enforced. Sheppard (2016) reported that specialties requiring high intensity long-term care such as oncology; critical care; dialysis; gerontology; etc. areas which typically experience frequent death outcomes escalate the possibility of compassion fatigue. The emotional distress resulting from the exposure to a patient’s traumatic experiences further intensifies compassion fatigue. Often patients and/or their family members remind nurses of someone significant to them resulting in extreme stress and emotional fatigue. Sheppard (2016) noted risk factors for CF include the following: Nurses, who skip breaks, take extra shifts, or come in on their days off out of a sense of duty may be at greater risk for compassion fatigue. One of the greatest risks for compassion fatigue comes from the feeling of their own self-worth. Sheppard (2016) identified the initial indicators of compassion fatigue are emotional often exhibited as extreme irritation, moodiness, exhaustion, and aloofness towards patients, families, and colleagues. If these behaviors are not confronted the nurse may develop a sense of themselves as a generalized individual. This distress is frequently manifested as insomnia, excess anxiety, rumination, and forgetfulness, which may result in an overwhelming sense physical and mental exhaustion. Exhaustion coupled with extreme tension may be expressed as somatic complaints like headaches, nausea, shortness of breath, and backaches. Sheppard (2016) cited compassion fatigue’s long-term impact on work performance potentially increasing the risk for errors, call outs, inattentiveness, crankiness, counter to caring and compassion necessary for healing. Sadly prompting some “nurses (to) self-medicate with alcohol or drug use/abuse, (while) allowing their emotional pain to continue unaddressed” (Sheppard, 2016).

Sheppard (2016) reviewed potential strategies to reduce compassion fatigue. Awareness is critical to identify compassion fatigue as a personal and professional risk. This can be accomplished by practicing self-reflection and mindfulness, as well as expressing self-kindness and self-compassion. It is important for nurses and providers to acknowledge personal boundaries and enforce personal boundaries in their life or risk disintegration! Sheppard (2016) encouraged that nurses respond to personal stressors by pursuing making self-care and self-compassion priorities. If mental or physical symptoms arise such as insomnia, nightmares, depression, anxiety, nurses are recommended to seek assistance from employee assistance program (EAP) or a mental health professional. Hughes et al. (2017) discussed the importance of a spiritual reservoir of resilience for nurses versus a state of depletion noting that difficulties arise when nurses are providing a higher level of care for others than he or she is caring for their own selves. Many sources recommended meditation, prayer, and maintaining relationships in a faith community as ways to develop a reservoir of resilience. One example cited in the White Paper was St. Bernard of Clairvaux, a 12th century Christian monk, in his Sermon of Songs the following as an example: The man who is wise, therefore, will see his life more as a reservoir than a canal. The canal simultaneously pours out what it receives; the reservoir retains the water until it is filled, then discharges it supplying other with loss to itself. (Hughes et al., 2017, p.17)

Developing strategies to intentionally replenish reserves will help nurses to work from a locus of abundance versus lack. Nurses need to be given the tools and resources not only to care for patients’ spiritual well-being but to enhance their own! Ideally nurses need a Tool Box they can access to refill their own reservoirs. A couple of examples mentioned in the literature are: Tea for the Soul™ and Blessing of Hands (BOH) for nurses as means of supporting nurses’ reconnection with the meaning and purpose of nursing. “Tea for the Soul™” spiritual care association staff are served tea and other treats by chaplains or spiritual care departments along with an open invitation to discuss issues they face caring for patients with goal of reducing healthcare providers stress. Supportive resources such as inspirational readings or resource materials are available upon request. Creation of a nurturing environment by the chaplains encourages and fosters staff to practice “collaborative decision-making and reflection, enhances coping and resiliency giving a deeper meaning of their work” (“Nurturing Caregivers with Tea for the Soul”, 2017). St. Francis Healthcare in Wilmington, Delaware, much like the rest of the country, celebrates the beginning of Nurses Week with the Blessing of Hands (BOH). There is a plethora of descriptions of the nuances of the BOH ceremony.

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Opportunities throughout all of Patient Care, including Specialty Areas

Bayhealth is the largest healthcare provider in central and southern Delaware. We are comprised of two acute care centers Kent and Milford Campus, the freestanding Emergency Department in Smyrna as well as numerous satellite facilities and employed physician practices encompassing a variety of specialties. We are a Magnet Designated Hospital, which recognizes healthcare organizations for quality in patient care, nursing excellence and innovations in professional nursing practice. Magnet is the leading source of successful nursing practices and strategies worldwide.

As a reputable community based health system, we are focused on the diverse needs of our patients delivering evidence-based award winning care. Bayhealth is a technologically advanced not-for-profit healthcare system with more than 3,700 employees and a medical staff of more than 400 physicians and is an affiliate of Penn Medicine for Heart and Vascular, Cancer and Orthopedics. We are a Certified Primary Stroke Center, Our committed staff of employees, physicians and volunteers work together to deliver our mission of improving the health status of all members of the Bayhealth community while demonstrating our values of compassion, accountability, respect, integrity and teamwork.

Our professional nurses provide high quality, safe care, and are committed to professional growth! Teamwork is emphasized and the nursing culture is empowered through shared governance. Professional nursing practices are performed using processes in accordance with hospital policy, procedures, and nursing philosophy. We are seeking RN’s who are DRIVEN of compassionate care in a way that creates a healthy community and supports our Planetree philosophy of patient and family centered care.

Bayhealth is currently building a new hospital and outpatient facility - Bayhealth Sussex Campus - in southern Delaware set to open in 2019.

At Bayhealth, Nursing excellence is our standard. Apply Today - Leadership positions are also available! Graduates Welcome! https://www.bayhealth.org/careers
CE Corner
Does an applicant need to disclose to the participants how COI was resolved?

The process for resolving the conflict of interest does NOT need to be disclosed to the learners. In fact, it should not be. It is an internal process on the part of the Provider (Individual Activity Applicant or Approved Provider) to decide how they will address the issue and resolve the conflict of interest.

The following information does need to be disclosed to the learners:
• The individual’s name with the conflict of interest
• The type of relationship
• The name of the commercial entity

Example: John Smith is on the speaker’s bureau for Eli Lilly.

Individual Applicants
Individual educational activity applicants are required to submit a 60-day post-session follow up form to DNA that includes the summative evaluation results. The (Survey Monkey) link to submit required information may be found on the DNA website.

As part of the DNA quality assurance plan, DNA may request providers of approved activities to submit a report on specific criteria and any action taken (if any) to improve the activity. The reporting will be on educational activities approved during the preceding 12-months.

CE Training
If you would like to schedule an online training on CE design, please contact the DNA office at (302) 733-5880 or send an email to Sarah Carmody at sarah@denurses.org.

Approved Programs and Providers

<table>
<thead>
<tr>
<th>Approval Number</th>
<th>Conference Title</th>
<th>Presentation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-06-02</td>
<td>Beyond Alzheimer's Disease: What Else Could It Be?</td>
<td>August 15, 2018</td>
</tr>
</tbody>
</table>

*Introductory price is valid October 1, 2018–January 31, 2019. Registration fee must be paid in full. Thereafter, the annual membership fee is $154/annually.

VOTING IS NOW OPEN!

Are you a Delaware licensed LPN, RN, or APRN and have a colleague worthy of Top Nurse recognition? Nominate them for an Excellence in Nursing Award. Voting is open to Delaware Nurses through January 29.

VISIT: WWW.DENURSES.ORG for category descriptions and to cast your vote.

The winners will be announced in Delaware Today’s May 2019 issue and celebrated at the Excellence in Nursing Awards on May 16, 2019. Visit DelawareToday.com/nursing for event information.

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www.psl.org

LPN Members
Delaware Nurses Association

Introductory price $115/annually*
Membership Activation Form

LPN Benefits
LPN members enjoy discounts to DNA educational activities and events, receive the quarterly DNA Reporter, nursing updates via the DNA E-News, and networking opportunities.

Mail Delaware Nurses Association 4765 Ogletown-Stanton Rd, Suite L10, Newark, Delaware 19713

Essential Information
First Name/MI/Last Name       Credentials
Mailing Address Line 1       Highest level degree earned
Mailing Address Line 2       Phone Number [Home] [Work]
City/State/Zip               Email Address

Professional Information
Employer                      Current Position Title: (ie: staff nurse)
Type of Work Setting: (ie: LTC, Ambulatory Center) What is your primary role in nursing?
[ ] Administrator/supervisor staff
[ ] Discharge planner/case manager
Practice Area: (ie: pediatrics) [ ] Educator
[ ] Office nurse
[ ] Researcher/consultant
Current Employment Status: (ie: full-time nurse) [ ] Quality assurance/infectious control
[ ] Staff nurse
[ ] Not currently working in nursing
[ ] Other nursing position

*Introductory price is valid October 1, 2018–January 31, 2019. Registration fee must be paid in full. Thereafter, the annual membership fee is $154/annually.
DNA Membership Activation Form

Mail Delaware Nurses Association, 4765 Ogletown-Stanton Rd, Suite L10, Newark, Delaware 19713

Essential Information
First/MI/Last Name_________________________________________Credentials_________________________
Mailing Address Line 1_________________________________________Highest level nursing degree earned__________
Mailing Address Line 2_________________________________________Current Position Title: (ie: staff nurse)________________________
City/State/Zip__________________________________________________________Phone Number________________________

Professional Information
Employer: ____________________________________________________________
Current Position Title: (ie: staff nurse)________________________
Type of Work Setting: (ie: hospital) ______________________________________
Practice Area: (ie: pediatrics) ____________________________________________
Currently Employment Status: (ie: full-time nurse) ____________________________

Select Which Membership is Right for You
Full DNA/ANA Membership
Enroll in this new membership and enjoy discounts and participation at the state and national levels
Price: $247/annually or $21.09/monthly, electronically
DNA State-Only Membership
Employed full-time/part-time
Price: $119/annually or $13.75/monthly, electronically
ANA National-Only Membership
Employed full-time/part-time
Price: $191/annually or $16.42/monthly, electronically
Reduced Membership
Full-time student, new graduate from basic nursing education program (within 6 months of graduation, first year only), 62 years or older not earning more than social security allows, not employed
Price: $123.50/annually or $10.79/monthly, electronically
Special Membership
62 years or older and not employed
Enjoy discounts and participation at the state and national levels
Price: $61.75/annually or $5.64/monthly, electronically

Monthly Payments
Choose your way to pay that’s right for you!
DNA is centrally billed through our national organization, the American Nurses Association. This means ANA manages the billing on behalf of the Delaware Nurses Association.

What is your primary role in nursing?
☐ Advanced Practice Registered Nurse
☐ Clinical Nurse/Staff Nurse
☐ Nurse Manager/Nurse Executive (including Director/CNO)
☐ Nurse Educator or Professor
☐ Not currently working in nursing
☐ Other nursing position

Choose the way to pay that’s right for you!

Electronic Deduction | Payment Authorization Signature*

Online
You can join DNA instantly online.
Visit www.denurses.org

Welcome New & Returning Members

Kenneth Brayboy
New Castle

Lateasha Collick
Middletown

Jacqueline Desalvo
Dover

Shelia Dirocco
Delaware

Leticia Ditomasso
Middletown

Maria Eyekpimi
Smyrna

Deborah Fattori
Oxford, PA

Keith Fushlock
Middletown

Deborah Gigliotti
Talleyville

Kayla Green
Newark

Lorraine Grier
Newark

Catherine Haut
Wilmington

Jasmine Heath
Dover

Susan Hensler
Selbyville

Angela Johnson
Wilmington

David Krassucki
Wilmington

Danielle LeGates
Lewes

Rhonda Magee
Millisboro

Robin Maguire
Wilmington

Melissa Minse-Brown
New Castle

Sebastian Molina-Flores
Wilmington

Darlene Mowell
New Castle

Agnes Mikuwaepe-Ndmaza
New Castle

Helen Ryan
Wilmington

Catherine Salvato
Magnolia

Sharon Shaffer
Lancaster, PA

Connie Shelley
Newark

Keiosha Shelton
Frankford

Alissa Swingle
Seaford

Ruth Thoed"t
Seaford

Joanne Wescott
Seaford

*By signing the Monthly Electronic Payment Deduction Authorization, or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to change the amount by giving the above signed thirty (30) days advance written notice. Above signed may cancel this authorization upon receipt by ANA of written notice of termination. ANA will charge a $5 fee for any returned drafts or chargebacks. Full members must have been a member for six consecutive months or pay the full annual dues to be eligible for the ANCC certification discounts.
With AutoPay $55/mo for line 1 with SWP discount and $40/mo for line 2. SD video streams up to 480p, music up to 500 kbps, gaming up to 2 Mbps. Data depriorization during congestion. Other mo. charges apply.** Prepaid card req. new acct. activ. with 1 ported line on Unlimited Basic and validation at sprint.com/verify.

Be sure to mention this code.

Corporate ID: HVRT_ZZZ

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Visit a local Sprint Store: sprint.com/storelocator

**Monthly charges exclude taxes & Sprint Surcharges [incl. USF charge of up to 17.9% (varies quarterly), up to $2.50 Admin. & 40¢ Reg. /line/mo. & fees by area varying, 5–37%]. Surcharges are not taxes. See sprint.com/taxesandfees.

Limited time offer. Actv. Fee: Up to $30/line. Credit approval req. Sprint Unlimited Basic Plan deprioritzes includes unlimited domestic calling, texting, 2GB LTE Mobile Hotspot/VPN & P2P & data. MPH reduced to 3G speeds after 2GB/line. Third-party content downloads are add'l charge. Data speeds vary by device. Select HD/ultra HD is included for phones. See sprint.com/complimentary. Subsidized devices incur an add’l $55/mo charge. Additional usage may be reflected on 1/4 GB. Quality of Service (QoS): Customers who use more than 50GB of data during a billing cycle will be deprioritized during times & places where the Sprint network is constrained. See sprint.com/networkmanagement for details. Usage Limitations: To improve data experience for the majority of users, throughput may be limited, varied or reduced on the network. Sprint may terminate service if off-network roaming usage is in excess of: (1) 100MB or a majority of KB. Prohibited use rules apply — see sprint.com/termsandconditions. Prepaid Card Offer: Sel. SWP with qualifying corp. id. While supplies last. Limit 2 per new acct. Addt. qualifying promo to be used for 90 days & good standing at time of provisioning. Allow 15–20 min. for delivery. End: 12/31. Credit approval req. Select HD/ultra HD is included for phones. Sprint reserves the right to change or cancel the offer at any time. Prepaid Smartphone, Card is issued by MetaBank®, Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark, and the circles design is a trademark of Mastercard International Incorporated. Prepaid Smartphone offering is subject to credit approval. Additional terms & conditions apply. See store or sprint.com for details. © 2018 Sprint. All rights reserved. Sprint & the logo are trademarks of Sprint.