NURSES, along with their nurses' uniform.

or any other pin that clearly identifies them as registered nurses are encouraged to proudly wear the official ANA "RN" pin every day for Nurses’ Week.

During this special week, all registered nurses in America and NHNA are proud to recognize registered nurses who promote and maintain the health of this nation, the ANA represents the nearly 3.1 million registered nurses nationwide to its members.

In honor of the dedication, commitment, and tireless effort of nurses, on May 6, 2011, the NH Nurses’ Association is joining the American Nurses Association in recognizing Nurses—Trusted to Care, this year’s theme for National Nurses Week, held May 6-12, every year. (May 12th being the birthday of Florence Nightingale, founder of modern nursing.) One goal for this special week is to raise awareness of the value of nursing and help educate the public about the role nurses play in meeting the health care needs of the American people.

Later during Nurses’ Week, on May 11th, NHNA will hold its own celebration event—including a special continuing education program on social networking and its impact on nursing practice (see centerfold)—and some good old fashioned in-person networking!

The ‘trust’ theme is particularly fitting since for the 11th year, nurses were judged the most honest and ethical profession, according to a Gallup poll released in December. Eight out of 10 Americans judged nurses to have "high" or “very high” ethical standards.

In honor of the dedication, commitment, and tireless effort of the nearly 3.1 million registered nurses nationwide to promote and maintain the health of this nation, the ANA and NHNA are proud to recognize registered nurses everywhere for the quality work they provide seven days a week. 365 days a year.

During this special week, all registered nurses in America are encouraged to proudly wear the official ANA “RN” pin or any other pin that clearly identifies them as registered nurses, along with their nurses’ uniform.

On January 20th, over 100 NH nurses took part in our annual legislative Town Hall Forum—this year conducted for the first time via video conference technology—allowing for regional participation. Six host sites were utilized: NH State Hospital in Concord; Lakes Region General in Laconia; Dartmouth Hitchcock Medical Center in Lebanon; Wentworth-Douglass in Dover; Littleton Hospital, and Harbor Homes in Nashua.

Each year participants in this open forum, formerly held just in Concord, discuss proposed NH legislation which has the potential to impact nursing practice and/or healthcare for NH citizens. After pre-screening by our Government Affairs Commission to focus on relevant bills, the Forum identifies and prioritizes those bills requiring action by nurses—or at least a watchful eye—as well as determining whether there are legislative proposals that NHNA should itself introduce.

This year the state budget deficit is having a profound impact on healthcare at many levels—and even upon the State Board of Nursing (BON). Additionally, the makeup of the NH legislature has changed substantially since last year’s session—so the ‘players’ and their reactions are largely unpredictable. All of which makes for a challenging session.

On hand to walk Town Hall participants through this maze were Govt. Affairs Chair, Judith Joy, RN, PhD; former chair Ginny Blackmer, APRN (participating from the Laconia site); lobbyist for NHNA, Bob Dunn of Devine, Millimet and Branch; and two experienced State Representative RNs: Laurie Harding (D) and Alida Millham (R). Joy, Blackmer and Dunn provided background on the NH legislative process and the workings / authority of various committees. Reps. Harding in Concord and Millham at the Laconia site, shared perspectives on the tone and direction of various hearings they had observed to that point. They emphasized what NHNA already knew: This legislative session will have tremendous impact upon health care. They also underscored that the exceptionally large number of new legislators need input from knowledgeable sources to make informed decisions.

Next, Margaret Walker, BON Executive Director, and Board member Kathleen Hartman MSN, RN, reported on significant budget cuts they had been advised would be required so that more BON licensing revenue could go into the state’s General Fund. They discussed what such operating cuts would mean to the four primary charges of the Board: licensure; scope of practice, education and discipline. Essentially, staff and all services would be drastically cut—reducing the Board’s ability to protect public safety. Although they emphasized that the budget process was just beginning they expressed conviction that there would be significant impact on the Board budget.

Since the BON is supported in total by licensing fees and not from State funds members of the Nursing Association leadership raised the question of the legality of decreasing services being paid for by license fees. Reducing support to the Board should result in a reduction of fees—not having those funds go to “pave roads” or other state services—which would be tantamount to imposing an additional tax on nurses. Lobbyist Bob Dunn and Rep. Harding reported that indeed other professional licensing entities are also being asked to give more to the general fund—and to reduce costs through consolidation of Boards.

Town Hall continued on page 8

Please be sure to notify us with address changes/corrections. We have a very large list to keep updated. If the nurse listed no longer lives at this address—please notify us to discontinue delivery. Thank You!

Please call (603) 225-3783 or email to office@nhnurses.org with Nursing News in the subject line.
NURSING NEWS
Vol. 35 No. 2
Official publication of the New Hampshire Nurses' Association (NHNA), a constituent member of the American Nurses Association. Published quarterly every January, April, July and October. Library subscription rate is $24. ISSN 0029-6538
Editorial Offices
New Hampshire Nurses, 210 N. State St., Concord, NH 03301. (603) 225-3783, FAX (603) 228-6672, E-mail Avery@NHNurses.org
Editor: Susan Fetzer, RN, PhD
NHNA Staff
Avery Morgan, Executive Director
NURSING NEWS is indexed in the Cumulative Nursing Index to Nursing and Allied Health Literature (CINAHL) and International Nursing Index.
For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@aldpub.com. NHNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.
Acceptance of advertising does not imply endorsement or approval by the New Hampshire Nurses Association of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. NHNA and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser's product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the organization.
VISION STATEMENT
Cultivate the transformative power of nursing.
Adopted 10-20-2010.
MISSION STATEMENT
NHNA, as a constituent member of the American Nurses Association, exists to promote the practice, development and well being of NH nurses through education, empowerment and advocacy.
Adopted 10-20-2010.
PHILOSOPHY
Membership and participation in the professional organization affords each nurse the opportunity to make a unique and significant contribution to the profession of nursing. The membership of the New Hampshire Nurses' Association, individually and collectively, has an obligation to address issues related to the development and maintenance of high standards of nursing practice, education and research. We participate in the proceedings of the American Nurses Association (ANA) and support and promote ANA Standards and its Code of Ethics.
We believe that the profession of nursing is responsible for ensuring quality nursing practice and that continuing education in nursing is essential to the advancement of the profession and the practice of nursing.
We believe that nurses function independently and collaboratively with other professionals to enhance and transform the health care system while promoting quality practice environments that advocate for the economic and general welfare of nurses.
Adopted: 5860  Revised: 1991  Revised: 12/24/07
Page 3 • New Hampshire Nursing News
April, May, June 2011

LETTER FROM THE PRESIDENT

“Future of Nursing” initiatives in NH
Anita Pavlidis MS, RN

As an educator, I find that the rhythm of my life center on the academic calendar. Coming quickly is the end of the school year and with that, the graduation of a new generation of nurses. The nursing world they enter today is far different than when I entered nursing many years ago. Nursing today is not what it was five years ago nor will it be the same five years from now.

These are exciting times for nursing with new opportunities and challenges. I recently returned from a national meeting where nurses from all over the country discussed the trends in nursing and it was noteworthy that New Hampshire was part of, and even on the cutting edge of important changes.

In October 2010 the Institute of Medicine (IOM) released “The Future of Nursing: Leading Change, Advancing Health.” (See a report summary in the Jan-March issue of Nursing News, archived on the NHNA website.) NHNA will convene a series of videoconference sessions to increase understanding of many of the facets of the IOM report - and facilitate statewide discussion about how its goals can be accomplished here in the Granite State. But for the moment, I want to give an overview and report on important efforts already underway.

The IOM report cites many “barriers” preventing nurses from being able to respond effectively to a rapidly changing health care system and health care delivery system. In 2008, the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine released “The Future of Nursing” two year grant for $250,000. The Tufts Health Plan Foundation provided $250,000 in matching funds. All three states are actively engaged in all projects.

Three goals of the collaboration are to:
1. Leverage a broader nursing education community to increase the numbers and diversity of nursing faculty through scholarship support;
2. Increase nursing school capacity through the use of centralized clinical placement systems;
3. Design a nursing education curriculum throughout the New England that better meets the needs of our current health care environment.

An invitation was extended to nurse leaders and educators to join the collaborative. In NH, three partnerships* sought to support nursing programs and their practice partners to:
• Analyze existing school curriculum and nursing orientation programs for content related to the Nurse of the Future Nursing Core Competencies;
• Develop a formalized plan to implement a seamless curriculum to support nurses to more effectively transition through their levels of nursing education;
• Design an implementation plan for a pilot model to incorporate Nurse of the Future Nursing Core Competencies into a seamless, coordinated curriculum.
*These NH partnerships include:
• St. Anselm College, Concord Community College, and Southern NH Medical Center
• NHTI - Concord’s Community College, River City College, and Catholic Medical Center
• Manchester Community College, Franklin Pierce University, and Elliot Hospital.

The efforts of this collaboration will result in educational models and practice partnerships that will prepare graduates for required future competencies. Anticipated completion date for all aspects of the grant is December, 2011. This initiative has been so successful that members of the grant, “Partners Investing in Nursing”* (PIN), have recently been asked to present the work of NH at a national conference.

Another branch of the same grant is the establishment, (in collaboration with Massachusetts Centralized Nursing Clinical Placement System), of the NH Centralized Nursing Clinical Placement System. As the need for nurses grows and schools of nursing continue to expand their enrollments, the demand for clinical placement sites to educate the students has become very competitive. RWJF has funded the computerized system that provides a central platform for all participating clinical agencies and schools to review and submit requests for placement of students. The system has been in place in New Hampshire, for over two years. This state wide system has been an increase of available sites. The current work of the group centers around providing a common on-line Orientation Program for all participating schools and health care systems. The ideal system will meet agency requirements and increase the amount of time at the bedside for students. NH anticipates fully implementing the system within the year but already, there have been positive outcomes through the close collaboration of education and practice.

The third arm of the grant is funding for a Nurse Scholars Program to improve the nurse faculty shortage. Four NH recipients have been funded to continue in their work in doctoral programs.

These are only a few of the changes occurring in NH and healthcare that provide opportunity for nurses to “make a difference” in the future of nursing. The ANA website www.nursingworld.org offers a summary of Health Care Reform with other national trends in nursing and healthcare.

And the opportunities and challenges continue. Healthcare reform will demand our attention on how to best meet the needs of our patients in these turbulent times. NHNA members throughout the state are a part of all these partnerships and new opportunities. Active participation in NHNA is a great way to meet other nurses who share your vision, values, and share being an advocate for nursing as part of an effective professional organization working to advance nursing’s agenda. I encourage all ‘not yet members’ to join — and, as our newest nurses enter the workforce, that we all mentor and support them — as it will take all of us together to direct our future and meet the challenges and opportunities ahead.

NURSING NEWS is indexed in the Cumulative Nursing Index to Nursing and Allied Health Literature (CINAHL) and International Nursing Index.

NHNA Staff
Avery Morgan, Executive Director
NURSING NEWS is indexed in the Cumulative Nursing Index to Nursing and Allied Health Literature (CINAHL) and International Nursing Index.

For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@aldpub.com. NHNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Acceptance of advertising does not imply endorsement or approval by the New Hampshire Nurses Association of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. NHNA and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser’s product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the organization.

VISION STATEMENT
Cultivate the transformative power of nursing.
Adopted 10-20-2010.

LETTER FROM THE PRESIDENT

Three goals of the collaboration are to:
1. Leverage a broader nursing education community to increase the numbers and diversity of nursing faculty through scholarship support;
2. Increase nursing school capacity through the use of centralized clinical placement systems;
3. Design a nursing education curriculum throughout the New England that better meets the needs of our current health care environment.

An invitation was extended to nurse leaders and educators to join the collaborative. In NH, three partnerships* sought to support nursing programs and their practice partners to:
• Analyze existing school curriculum and nursing orientation programs for content related to the Nurse of the Future Nursing Core Competencies;
• Develop a formalized plan to implement a seamless curriculum to support nurses to more effectively transition through their levels of nursing education;
• Design an implementation plan for a pilot model to incorporate Nurse of the Future Nursing Core Competencies into a seamless, coordinated curriculum.
*These NH partnerships include:
• St. Anselm College, Concord Community College, and Southern NH Medical Center
• NHTI - Concord’s Community College, River City College, and Catholic Medical Center
• Manchester Community College, Franklin Pierce University, and Elliot Hospital.

The efforts of this collaboration will result in educational models and practice partnerships that will prepare graduates for required future competencies. Anticipated completion date for all aspects of the grant is December, 2011. This initiative has been so successful that members of the grant, “Partners Investing in Nursing”* (PIN), have recently been asked to present the work of NH at a national conference.

Another branch of the same grant is the establishment, (in collaboration with Massachusetts Centralized Nursing Clinical Placement System), of the NH Centralized Nursing Clinical Placement System. As the need for nurses grows and schools of nursing continue to expand their enrollments, the demand for clinical placement sites to educate the students has become very competitive. RWJF has funded the computerized system that provides a central platform for all participating clinical agencies and schools to review and submit requests for placement of students. The system has been in place in New Hampshire, for over two years. This state wide system has been an increase of available sites. The current work of the group centers around providing a common on-line Orientation Program for all participating schools and health care systems. The ideal system will meet agency requirements and increase the amount of time at the bedside for students. NH anticipates fully implementing the system within the year but already, there have been positive outcomes through the close collaboration of education and practice.

The third arm of the grant is funding for a Nurse Scholars Program to improve the nurse faculty shortage. Four NH recipients have been funded to continue in their work in doctoral programs.

These are only a few of the changes occurring in NH and healthcare that provide opportunity for nurses to “make a difference” in the future of nursing. The ANA website www.nursingworld.org offers a summary of Health Care Reform with other national trends in nursing and healthcare.

And the opportunities and challenges continue. Healthcare reform will demand our attention on how to best meet the needs of our patients in these turbulent times. NHNA members throughout the state are a part of all these partnerships and new opportunities. Active participation in NHNA is a great way to meet other nurses who share your vision, values, and share being an advocate for nursing as part of an effective professional organization working to advance nursing’s agenda. I encourage all ‘not yet members’ to join — and, as our newest nurses enter the workforce, that we all mentor and support them — as it will take all of us together to direct our future and meet the challenges and opportunities ahead.
APRN Practice Receives National Recognition

Life Long Care of New London, a primary care NP-only practice owned by Kitty Kidder, APRN, FNP, has been officially recognized by the National Council on Quality Assurance (NCQA) as a Level 3 Primary Care Medical Home. Life Long Care is the first APRN-owned practice in the country to have earned this designation. Because of this achievement, NCQA has amended its national policy to make APRN-owned practices eligible for recognition.

The NCQA’s voluntary designation program is used to recognize physician practices as patient-centered medical homes, a development designed to promote comprehensive and coordinated care. The NCQA developed the criteria for the recognition program in conjunction with the AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association.

In the past the NDQA designation was open to physician-led practices as an assessment of quality on nine standards. Each standard has one to ten components which needed reports, screen shots, or some other method of “proof” determined by NCQA. One of the requirements, that every patient have a physician, effectively prohibited nurse-led primary care practices to achieve the designation. NCQA offers certification to physician practices at Levels 1, 2 and 3. The levels are based on the assessment score from 0 to 100. The higher the score, the higher the designation. An electronic medical record is required in order to achieve a Level 2 or Level 3. Life Long Care of New London scored 92 out of a possible 100 points for the Level 3 designation.

After learning about the standards, Kidder and her colleagues broke down the standards into tasks for everyone in her small office. Areas were identified that needed improvement. Kidder notes “we needed to document ‘barriers to learning’ and we chose to use the barriers of vision and hearing impairments as well as language preference. In a community where the dominant language that is spoken is English it was easy to mark the chart of those patients who had a different language preference. In order to create the report necessary for the NCQA survey, language preference needed to be marked on every chart. Since we have an electronic record in the office it simply involved opening the chart of every patient in the practice, opening social history and checking language preference then English. There was a standard for patient satisfaction, so we created a survey and the nurses handed out the survey to be completed at the end of the office visit.”

In preparing their application Kidder and colleagues followed the “Ginger Rogers” method of dance. According to Kidder “We need to dance twice as well while doing it backwards, in high heels and with a smile on our face! We were very concerned about being successful because we knew we would be judged on our ability to successfully comply with rules that were written with physician practices in mind and we knew that it held implications for NP’s of the future having the ability to apply for the NCQA designation.”

“Life Long Care strives to be an excellent medical home for all of its patients. This achievement and recognition is a beginning, not an end, to their organization, improvement and provision of excellent patient and family-centered care,” said Jeanne McAllister, director of the Center for Medical Home Improvement. “The NCQA application process requires an extraordinary amount of effort; smaller practices such as Life Long Care hold somewhat of a disadvantage since they do not have the administrative support of a large primary care network. Life Long Care met this challenge head on. Life Long Care has proven that smaller practices can achieve the highest quality results, and can transform into a model of primary care that all practices can, and should, emulate.”

Kidder noted “The NCQA Level 3 designation means that an NP-only office had competed with physician practices and passed all the requirements that any physician office would have to pass. The NP office has been found to provide the same level of care that a physician would provide. It also means that since an NP owned practice has been successful that there should be no reason why other NP practices could not apply for the same. It is further evidence that NP’s can provide quality primary care to patients and families.” LifeLong Care Inc employs three nurse practitioners and has been operating since 2002 in New London, NH.

KUDOS

Congratulations and best of success to nurse practitioner Laura Anderson, RN, ARNP, on the opening of her own practice. After obtaining her Master’s degree from Rivier College in Nashua in 2008, she has practiced as an APRN at Concord Hospital. Anderson Family Healthcare is associated with Wendy Wright, a nurse practitioner who has had her own practice for four years. Wright will continue to practice there for four days a week. The clinic, in Suite 201 at 10 Ferry St. in Concord, is accepting new patients. Anderson has a special interest in Alzheimer’s disease and adolescent care.

Thanks to nurses Cyndi Campbell and Jami Dion, Craig Evans, a 62 year old basketball referee at a Raymond High School game, was given a second chance. The off duty nurses along with an off duty EMT and the athletic trainer administered CPR with AED defibrillation when Evans lost consciousness while running up and down the court. Evans was transported to Exeter Hospital where he received a stent for a blocked coronary artery within 75 minutes of the arrest. Great team work!

Congratulations to Amy Thompson, RN, MSN, who recently received her Master’s of Science in Nursing with a focus in Nursing Informatics in December 2010 from Walden University. Thompson has a BSN from the University of Southern Maine and has practiced in the Emergency Department of Wentworth Douglas Hospital for the past 10 years. She is currently the ED Case Manager. Her capstone Master’s project was focused on Medication Reconciliation.

If you have a KUDO to announce, please send your information to every@nhnurses.org
A young woman presents herself at the clinic with a partial thickness burn to her leg. She states that she received the injury as a result of a motorcycle muffle coming to rest against her leg after it was parked for the better part of a day. She has months coordinating the 7-day trip for the medical team; this year they numbered nearly 30. Many had made the trip before and were back, eager to serve again. Months before this trip, the team is busy with preparations. Funds are raised, and enough supplies are collected to fill 42 large suitcases! The nursing students also construct a variety of health-related teaching plans specifically designed for use with the different ages, cultures, and languages of the people they will treat and teach each day.

A typical day begins well before dawn—it is a myth that roosters don’t crow until the sun rises! After a quick breakfast, the team packs the truck with the day’s supplies and boards the bumpy buses for the long journey to the English Institute in Monte Christi. The bus ride from the airport to Monte Christi was long and bumpy; on roads that could at times be questioned if they were in fact roads. The group arrived at the English Institute in Monte Christi—the site where the mission trip to the Dominican Republic began. The English Institute in Monte Christi is a rice batey (a company town set up for laborers). The clinic this day is not in New Hampshire, not even in the United States; this clinic is in a banana batey in the Dominican Republic. (Batey = company built village for laborers.) This mobile, makeshift clinic is sponsored by Orphanage Outreach, and staffed by a team assembled by nursing professors from Manchester Community College—physicians, PAs, nurses, nursing students, translators, as well as allied health professionals.

Day 1: Early morning on January 8, 2011, a group of 35 volunteers, set off for a medical mission trip to the Dominican Republic. We were armed with dozens of bags of donated medical supplies. Spirits were high as we headed to Boston Logan Airport. We arrived in Santiago early afternoon and loaded three buses for the long journey to the English Institute in Monte Christi, a city with a population of 26,000, on the northwest coast of the Dominican Republic. For those who had never been on a mission, it was a bit of a culture shock. The bus ride from the airport to Monte Christi was long and bumpy; on roads that could at times be questioned if they were in fact roads. The group arrived at the English Institute in Monte Christi—this is an orphanage outreach and now functions as classrooms for teaching English to kids. Our medical mission group stayed here.

Not Your Typical Clinic continued on page 5

Institute to a warm traditional Dominican meal of rice, beans, chicken, and fresh fruit.

Day 1: Sunday, our first official day in Monte Cristi, was a busy day of becoming acclimated to our surroundings and being educated to the Dominican culture. A large part of the day consisted of going through all of the supplies and arranging them by medication class, hygiene products, wound/bandage kits, glasses, infant supplies and education posters for the clinics.

Day 2: Monday, our first clinic day, we went to La Cruz, a rice batey (company town set up for laborers). The clinic was set up at “Club Caribe,” an old, run down country club. There were two buildings; one set up to be our pharmacy and the larger building was used for triage, education, a waiting area, and the area where the patients were seen by one of our two physicians or our OB nurse practitioner. Approximately 130 patients of all ages were seen throughout the day—many needing medication for pain relief. Multivitamins, antibiotics, and anti-fungal creams were frequently prescribed. The day went very well with few complications. By the end of the day, the team had a better understanding of what worked well and what needed to be improved upon for the days to come. Many of us had also learned some Spanish words or phrases to help us communicate!

Day 3: Tuesday, we traveled to Maguacu, which is a banana batey. This area was smaller in size and we had to set up our women’s health area in a different building altogether, a dirt field separating the two locations. The group was able to learn a little more about the Dominican culture, as our clinic was set up in the town discotheque, with our suitcase pharmacy located on the stage. As the day progressed, the locals tended to their roosters, displaying them with pride. In the Dominican, cock fighting is very common as a sporting pastime.

Day 4: Wednesday brought some new challenges. The trip to LaRecta, a rice batey, was about an hour from Monte Cristi, on roads that were at times barely passable. This would prove to be the longest day on the trip. For the first time, we were starting to see more of a Haitian population. This posed a new challenge for translation, with a majority

Getting There: Early morning on January 8, 2011, a group of 35 volunteers, made up primarily of Manchester Community College Nursing students, set off for a medical mission trip to the Dominican Republic. We were armed with dozen of bags of donated medical supplies. Spirits were high as we headed to Boston Logan Airport. We arrived in Santiago early afternoon and loaded three buses for the long journey to the English Institute in Monte Cristi, a city with a population of 26,000, on the northwest coast of the Dominican Republic. For those who had never been on a mission, it was a bit of a culture shock. The bus ride from the airport to Monte Christi was long and bumpy; on roads that could at times be questioned if they were in fact roads. The group arrived at the English Institute in Monte Cristi—this is an old hotel that has was purchased by Orphanage Outreach and now functions as classrooms for teaching English to kids. Our medical mission group stayed here.
TIDBITS

NURSES TOP RANKED

A Gallup survey of 1,037 people showed that 81% said that nurses had “high” or “very high” honesty and ethical standards, putting them at the top rank of the most trusted professionals for the 11th time since 1999. “It’s extremely gratifying to know that the public continues to hold the profession in such high esteem,” ANA President Karen Daley said, adding that the high regard for nurses puts them in a good position to play a key role in health care reform.

PINK NURSES GO VIRAL

A breast cancer awareness video, which features nurses and other staff of Oregon-based Providence St. Vincent Medical Center wearing pink gloves and dancing to the tune of a Jay Sean song, has become a viral hit. The “Pink Glove Dance” has had more than 12 million YouTube hits since it was posted almost a year ago, and prompted at least 80 similar recordings. Medline Industries, maker of the pink gloves, has donated $1 to the National Breast Cancer Foundation for every case of pink gloves sold.

FREE CE/COMMUNICATIONS TOOL KIT

The Agency for Healthcare Research and Quality (AHRQ)—part of DHHS, has developed a free online CE Nurse Communication Tool Kit to improve communication between healthcare professionals.

Communication between nurses and physicians can be challenging, especially when nurses are trained to be descriptive while doctors tend to cut to the chase. Poor information flow can result in prescribing and monitoring errors that can compromise patient safety. The Nurse Communication Toolkit teaches the principles of effective standardized communication and offers strategies for implementing assertive communication in any clinical setting. By using the SBAR method of communication—Situation, Background, Assessment, and Recommendation—nurses can ensure that physicians have the necessary information to make the most informed decisions about individual patients as efficiently and effectively as possible.

While the tool targets warfarin therapy in nursing homes, skills learned can be applied to any clinical setting and will help nurses overcome a variety of communication challenges. See www.chainonline.org/nursecommunicationtool

Not Your Typical Clinic continued from page 4

of the patients speaking Creole. Another issue was crowd control. With only two Creole translators, it was difficult to triage the patients, educate patients, and make sure they were sent to the proper practitioner. Despite the difficulties, it was a successful day. We worked late into the evening, finishing by flashlight, to ensure that everyone was seen.

Day 5: Thursday was our final day of clinic. We journeyed to the Banelino banana processing plant in Juliana. After all the hard work we had put into this mission trip, it was a bittersweet day. We had finally worked out most of the obstacles faced throughout the week and everyone who arrived at the clinic was seen. This was the first day we didn’t have to turn anyone away.

Final Day Off: To end our week in the Dominican, Friday was a relaxing day taking in the sites. We were treated to a buffet lunch with Dr. Garcia, a local doctor who manages healthcare issues in the bateys, and was instrumental in setting up our daily clinic sites. We were also given the opportunity to visit one of the orphanages run by Orphanage-Outreach. We had a few hours to spend at the Monte Cristi National Park, hiking up El Moro to observe the ocean or taking in the sun and waves from the beach. We also had time to reflect on our week-long experience. In the four days of running free clinics, we were able to treat nearly 700 men, women and children, provided medication, personal hygiene products, and health education for everyone. Poco a poco—little by little—we were able to make a difference.

FREE CE/COMMUNICATIONS TOOL KIT

The Agency for Healthcare Research and Quality (AHRQ)—part of DHHS, has developed a free online CE Nurse Communication Tool Kit to improve communication between healthcare professionals.

Communication between nurses and physicians can be challenging, especially when nurses are trained to be descriptive while doctors tend to cut to the chase. Poor information flow can result in prescribing and monitoring errors that can compromise patient safety. The Nurse Communication Toolkit teaches the principles of effective standardized communication and offers strategies for implementing assertive communication in any clinical setting. By using the SBAR method of communication—Situation, Background, Assessment, and Recommendation—nurses can ensure that physicians have the necessary information to make the most informed decisions about individual patients as efficiently and effectively as possible.

While the tool targets warfarin therapy in nursing homes, skills learned can be applied to any clinical setting and will help nurses overcome a variety of communication challenges. See www.chainonline.org/nursecommunicationtool
Fitness for Duty Includes Getting Your ZZZzs

by Debra Simmons, PhD(c), RN, CCNR, CCNS and Cindy Zolnierek, MSN, RN
Reprinted with permission from Texas Nursing Voice Jan-Mar 2010

Introduction
In 2006, Wisconsin registered nurse Julie Thao faced criminal prosecution for “neglect of a patient causing great bodily harm” following a medication error that resulted in a patient’s death. Nurse Thao had slept at the hospital the night before after a 16-hour shift. It was the July 4th holiday, and she had agreed to work a double shift (7:00 AM to 11:00 PM) the next day to be “lucky enough” not to suffer serious consequences from their mistakes. How does the fact that nurse Thao had worked a double shift the day before and slept at the hospital play into the error equation?

Nurses are frequently asked to “work over” to cover an unexpected absence of a co-worker or to cover a chronically sick or an ill family member. Nurses may not be aware that they are human and “to err is human.” But, there’s more...

Anatomy of an Error
An error is a deviation from the science of our world. We all are trained, regular nurses to the human anatomy, but most of us have not really considered the anatomy of an error and its consequences. It’s at that point that we ask, “How did this happen? I was so careful!” The obvious answer is that we are human and “to err is human.” But, there’s more...

Errors can be broken down into two types. Active errors occur by the person doing the activity, for example, when a nurse gives the patient a wrong medication. Latent errors occur farther away from the action, that is, away from the bedside. For example, a doctor may prescribe two medications stored in adjacent bins in the medication cart when a nurse gives the patient a wrong medication.

Errors can be as well-pre-filled syringes prevent dosage errors, programmed infusion pumps prevent certain infusion errors, and bar coding has prevented some identification errors. However, a lack of effective health care system can manifest these designs eliminate error? Though improvements have been made, nurses continue to be at the “sharp end” where latent errors become active. Therefore, the nurse often represents the final opportunity to prevent a latent error from becoming an active error—the last safety net so to speak.

Human Performance Factors
Humans are imperfect. Human factors confound performance and risk (for see sidebar, Some Human Factors Affecting Performance). Two of these factors involve our interaction with the environment, for example, “how we’re feeling when we’re faced with unfamiliar equipment, poor lighting in a patient’s room, exhaustion in evening shift, etc.”

Some Human Factors Affecting Performance

Distraction
Fatigue
Sleep deprivation
Lack of communication
Lack of knowledge/skills
Lack of feedback/Lack of resources

Fatigue as a Factor in Fitness for Duty
Fatigue is defined as “an overwhelming sense of tiredness, lack of energy, a feeling of exhaustion associated with impaired physical and/or cognitive functioning. Sleepiness and fatigue often co-exist.” Sleep deprivation is “the inability to achieve adequate quality sleep, we are able to replenish this sleep deficit.” When we don’t, our homeostasis or balance is upset and we become sleep deprived.

Sleep deprivation may result in:

- lapses in attention and inability to stay focused
- reduced motivation
- compromised problem-solving
- confusion or bewilderment
- irritability or hostility
- unusual lassitude or anxiety
- memory lapses (particularly in short-term memory)
- impaired communication
- faulty information processing and judgment
- diminished ability to detect and recognize the significance of subtle changes in a patient’s health
- diminished reaction time
- slowed information processing
- inability to deal with the unexpected
- indifference and loss of empathy

Sleep deprivation may result in:

Mood alteration, reduced performance, reduced motivation, increased safety risks, and physiological changes (Rogers, 2008). Federal regulators recognize the adverse effects of fatigue on safety and require the airline industry (along with trucking and nuclear industries) to directly manage fitness for duty of airline crew members for more than 11 hours. Crews comprising captains who had only had time for a four-hour nap between flights so was feeling a bit tired. Sound frightening? Would you board the plane?

What if you knew that in a safety study conducted by the National Transportation Safety Board (NTSB) of U.S. major carrier accidents from 1978 to 1990, it was concluded: Half the captains for whom data were available had been awake for more than 11 hours prior to their accidents. Half of the first officers had been awake for less than 24 hours prior to their accidents. First and second pilots whose time since awake was above the others made more errors overall and significantly more procedural and tactical decisions errors (1994).

How confident are you of the pilot’s fitness for duty? Insufficient sleep is associated with cognitive problems, mood alteration, reduced performance, reduced motivation, increased safety risks, and physiological changes (Rogers, 2009). Consider the design of the work environment, staffing and communication processes—has any health care system perfected these designs eliminate error? Though improvements have been made, nurses continue to be at the “sharp end” where latent errors become active. Therefore, the nurse often represents the final opportunity to prevent a latent error from becoming an active error—the last safety net so to speak.

Sleep/wake homeostasis is a second biological component of sleepiness and wakefulness during the day. It functions in response to light signals which stimulate the release of hormones such as cortisol in the morning light and melatonin in the evening. We respond with fluctuations in attentiveness during the day. Most of our experience with the greatest sleepiness in the early morning hours (2:00-4:00 AM) and a second sleepiness in the evening (9:00-11:00 PM). Circadian rhythms can only be shifted one to two hours in either direction and can be influenced by our sleeping and waking behaviors. For example, if we normally work early in the morning, but stay up late and sleep in over the weekend, we experience greater than usual sleepiness on Monday morning as our body adjusts to the change in sleep-wake cycles in the early morning. We’re better able to perform during the later hours of the day if we make the change in sleep-wake cycles systematically.
Why are nurses at risk for fatigue? There are a number of organizational and personal factors that contribute to nurse fatigue. The unpredictable nature of the health care environment—emergencies, fluctuating census patterns, changes in patient conditions, physician direction and changes to caring needs for nursing staff. Although organizations have strategies for anticipating patient care needs and scheduling nurses appropriately to meet those needs, it is often a "best guess" and must be adjusted. This creates stress. Staffing needs—some days more nurses than those scheduled will be needed, requiring nurses to work in addition to their scheduled and possible overtime. An organization that has vacancies faces the challenge of meeting needs, changes in meeting its staffing needs without requiring additional hours from nurses.

Characteristics of a 24-hour, 7-day-a-week operation also contribute to occupational risk for fatigue. Night shift hours predispose individuals to sleep deprivation due to their circadian rhythm and likely disruption in sleep during day shift. Twelve-hour shifts are popular with nurses, but they cause large shifts in the end of the work day, or at the completion of a few shifts in a row. On-call often interrupts sleep as well as requires nurses to work hours exceeding the recommended daily limit. As human beings, nurses will have personal factors affecting risk for fatigue. Nurses who report social duties and caretaking roles outside of work often report higher levels of stress both at work and at home. A nurse may be the caretaker for elderly family, young children, or ill patients. The nurse may have financial responsibilities—some days more nurses than scheduled will be needed, requiring nurses to work in addition to their scheduled and possible overtime. An organization that has vacancies faces the challenge of meeting needs, changes in meeting its staffing needs without requiring additional hours from nurses.

Individual Safety Practices

Despite the evidence, nurses are frequently faced with either voluntary or required work schedules that may place them at risk for fatigue. How can nurses protect themselves and their patients when they may be at risk for fatigue? A number of countermeasures, preventative and operational strategies, can assist in maintaining alertness and on-the-job performance. However, these strategies should be applied with caution—they do not eliminate the safety risks of working when fatigued.

A primary, preventative countermeasure is to minimize sleep loss by using days off to "catch up" or "stock up" in anticipation of sleep debt. Good sleep habits, or sleep hygiene (see inset), can improve sleep quality. However, despite the sleep deprivation, people can assimilate, are required to fully recover from a sleep deficit and sleep cannot be effectively "stored" to accommodate for a future lack of sleep.

Operational strategies include those things you can do while on the job to mitigate fatigue. Social interaction and conversation can assist in maintaining alertness. Physical exercise combats sleepiness, however may leave one feeling tired. Strategic use of caffeine can improve alertness. Nutritional snacks and planned breaks, including naps, can assist the nurse in maintaining energy (see inset). Evidence-Based Practice Recommendations).

The nurse has a primary duty to the patient. The nurse bears the ethical responsibility for the patient. This ethical responsibility includes ensuring personal fitness for duty when accepting an assignment. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/her patient that supersedes any facility policy or physician order. The nurse has a primary duty to his/she...
When Duty to Keep Patients Safe is Threatened by Fatigue...

Jennie began her day of scheduled on-call at 3:30 p.m. when her 8-hour OR shift concluded. After arriving home at 4:30 p.m., she had something to eat and then took a 2-hour nap. At 10:30 p.m., she was called in for a trauma. She completed two emergency cases that night and was particularly disturbed by one patient, a young woman who died during surgery. She returned home at 4:30 a.m. but had difficulty falling asleep. Feeling exhausted, she called the charge nurse at 5:00 a.m. to let her know that she was falling asleep. Feeling exhausted, she called the charge nurse told her she was expected to come in to work and coming on-call was no excuse for not to work after taking call that night. The charge nurse at 5:00 a.m. to let her know that she was not to work after taking call that night. The charge nurse told her she was expected to come in to work and coming on-call was no excuse for missing work. Despite grabbing a double Espresso on the way to work, Jennie found herself having difficulty staying awake while driving. When she arrived at work, she told her manager that she felt too tired to practice safely, could not accept the assignment, and requested safe harbor (completed the quick request form).

Jennie’s manager then met with her to see if they could collaborate and reach agreement on an acceptable assignment. Jennie thought that if she could use the sleep room until noon, she would be rested enough to assist with afternoon cases. The manager arranged for this and asked Jennie if she would withdraw her Safe Harbor request. Even though the immediate situation was remedied, Jennie elected to have the Nursing Peer Review Committee consider her request because scheduled shifts immediately following an on-call shift was not an unusual practice at her facility. She completed the comprehensive form, and gave it to her manager before going to the sleep room.

Jennie also voiced her concerns about fatigue, on-call, and scheduled shifts to the nurse representing perioperative services on the Nurse Staffing Committee so that they could evaluate the issue.

Directors of the BON had already composed a letter of specific concerns and public safety issues to the Governor’s office and was awaiting a reply at that time.

The Forum agenda then turned to reviewing the health related bills for this session to determine which we support or oppose. To effectively use our resources the NHNA prioritizes our plan for the session (Level 1 (action / verbal and written testimony required), Level 2 (Submission of written testimony only or a “card” indicating support or opposition) or Level 3 (Monitoring but taking no position at this time.) See sidebar list.

Level 1
CACR 005 Line item veto for Gov
Senate 417—Title protection bill—testimony update
HB 2—Proposed state budget—including cuts to BON

Level 2
H 16 Support—Electronic controlled prescription system
HB 58 Support—Repeal of CAH allowance for doctors/nurses to transfer critically ill via ambulance in absence of EMT
HB 71 /11l Support—Non-controlled pharmaceutical take-back programs
HB 93 Support—Adds APRN to document disability for crossbow permits
HB 156 Oppose—Reduces tobacco tax
HB 163 Need nurse on council if established
HB 191 Support—Implements audit report recs for Community Health System (Laurie Harding prime)
HB 199 Support—Streamlines procedures for screening panels
HB297 Oppose—Death with dignity (aka euthanasia bill)

HB 596 Support—Limit provider liability
SB 17 Support—Makes statements by care providers inadmissible as evidence in medical injury claims

Level 3
HB 75 Commission on bed bugs (group looking at other alternatives to a commission)
HB 107 Medical marijuana
HB 114 Eliminate screening panels
HB 168 Budget process
HB 523 Elder abuse
HB 562 Rule program for lead-safe practices
HB 591 Authority of state agencies to raise fees
HB 651 Study rising incidence of autism
HB 674 Health information exchange
HB 754 Prohibiting vaccinations in public schools
HB 889 Establish study committee to determine value of professional licensing practices—nurse participate in fact finding
SB 570 Screening panels
SB 983 Emergency obstetrical care

Alerts requesting testimony or calls to legislators will be sent to NHNA members. Nursing News readers are encouraged to track bills at the NH state website: www.gencourt.state.nh.us/bill_status. Click on ‘bill text’ to see its details.

Many thanks to all the volunteers named herein, along with site hosts: Linda von Reyn, Catherine Flores, Marilyn Ireland, Barbarajo Bockenhauer and Anita Pavlidis, and to the Granite State Distance Learning Network and IT support at each site for their essential help in providing and coordinating the technology for this event.

At the Town Hall forum in January (see pg 1 article) we promised to let people know just how much the Board would be adversely impacted—and how they could help.

Unfortunately at this writing we still do not have either answer. Specific figures have not been published—and hearings have not gone according to normal schedule.

We will publish an update on our website when more is known. www.nhnurses.org
Coalition Launches Website About Health Care Law

The Affordable Care Act is often in the news, but many people aren’t sure how the law affects them. That’s why the American Nurses Association recently joined with other leading national organizations to form the Health Care and You Coalition. The Coalition’s goal is to provide easy-to-understand information about the health care law to help Americans understand what the law means for them.

We’re pleased to announce the launch of the Coalition’s website, HealthCareAndYou.org. The website features information on the law in all 50 states and the District of Columbia, an interactive timeline of when different parts of the law take effect, and current health coverage options in all 50 states.

In the months and years ahead, HealthCareAndYou.org will be an up-to-date resource on the health care law. We hope you will visit often and encourage your members, colleagues and the public to do the same. You can also subscribe to updates on Twitter (@HCandYou) and YouTube (HCAndYou).

ANA Commends President’s Support for Accelerating State Health Program Waivers

The American Nurses Association (ANA) applauds President Obama’s support for a proposal that would provide states with flexibility to develop their own plans to ensure that their residents have access to affordable health insurance three years earlier than currently scheduled under the Affordable Care Act (ACA).

President Obama told state governors this week that he supports the bipartisan Empowering States to Innovate Act, which would allow states to apply for waivers from the Affordable Care Act (ACA) as early as 2014 to implement their own health care coverage programs. The ACA sets 2017 as the year that states could begin applying for waivers.

The waiver provision would give states the flexibility to implement their own innovative strategies for expanding health care coverage that would work best for their residents so long as their programs meet criteria, including covering at least as many of the state’s residents as the ACA would cover and ensuring no increase in the federal budget deficit.

ANA has long advocated that access to an affordable package of essential health services is a basic human right. ANA supports states’ efforts to design plans specific to their populations and institutions to move toward this goal, and agrees with President Obama’s willingness to promote adjustments to the ACA that still keep its core goals intact.

ANA continues its strong support of the ACA and is disappointed with efforts by the 112th Congress to repeal the law or roll back its provisions.

Red Cross Seeks Nurse Volunteers

The New Hampshire region of the American Red Cross is actively seeking nurse volunteers to assist in their routine and disaster operations. There is no charge for training, which can be arranged for nurses interested in participating. Newly licensed nurses may also volunteer. Colleen Fitzpatrick of the Great Bay Chapter noted that some of the nursing needs include:

§ A nurse or nurses who could help us with our annual review of Health Status Records submitted by all disaster volunteers (about 70). This can be accomplished electronically.

§ A nurse or nurses who could speak with any volunteers being deployed to a national disaster who may have red flags on their last minute Health Status. This can usually be accomplished by phone.

§ A nurse who can support our Disaster Action Team, who respond to local events like house fires. We frequently must replace medications lost in a fire, and having a nurse available by phone helps this process.

§ Nurses who might work in any shelter(s) opened for a local disaster. This requires very little actual treatment. The big job is doing on-site triage, to see if some residents need a medically better solution than a Red Cross shelter and a standard Red Cross cot.

Registered nurses or licensed practical nurses interested in volunteering should contact Fitzpatrick at colleen.fitzpatrick@comcast.net or 603-674-1993—or your local chapter:

Granite Chapter, volunteergc@nhredcross.org
603-225-6697 x222

Great Bay Chapter (Seacoast), Matthew Spaulding volunteergb@nhredcross.org 603-766-5440 x1008

Greater Manchester Chapter, Caela Goumas volunteergm@nhredcross.org 603-624-4307 x211

NH Gateway Chapter (Nashua and Souhegan Valley) Alex Brinckerhoff, volunteergw@nhredcross.org 603-889-6664 x224

NH West Chapter (Keene, Monadnock Region & Sullivan County), Amy Elkaliouby, volunteerrws@nhredcross.org 603-352-3210 x140

Related story—

ANA continues its strong support of the ACA and is disappointed with efforts by the 112th Congress to repeal the law or roll back its provisions.
Social networking such as use of Facebook, Twitter, and MySpace is becoming the norm in today’s world. There are, however, ethical and professional boundary issues emerging that potentially place the nurse at risk.

Many healthcare providers are using social networking systems including email to discuss patients, or even talk with patients. Text messaging patient information can indeed become a patient confidentiality and HIPAA violation, especially if messages are sent unencrypted. Text messages should not contain personal opinions about a patient, patient’s family, other healthcare providers, or care being provided.

Some nurses, however, use texting to network regarding needed patient care advice. Texting typically employs the use of abbreviated terms, some of which can easily be misinterpreted, similar to issues of “unsafe abbreviations.” While texting a patient’s condition to another healthcare provider in order to obtain suggestions for recommended treatment might be useful, a summary of the text may not become a part of the medical record. Just as with phone conversations, it is important that the medical record reflects the conversation. Without such information, should a lawsuit be filed, the ability to defend a case may be compromised. Additionally, if the actual texting is shown to the medical examiner, it will jury, “read” and “issuing” the message will not be one of professionalism, but one of hasty, casual, incomplete consultations, and one that may be interpreted as unconcerned, and/or disrespectful of the patient” (Baker, 2010, p. 5–6).

Adding patients or being added to a patient’s “my friends” list on Facebook or other social networking sites blurs the lines of professional boundaries. Posting pictures on web pages and networking sites can also place the nurse at risk. Nurses need to think about professional implications and the potential for discipline related to violations of standards of nursing conduct or practice (WAC 246-840-710).

Additionally, some employers as well as educational institutions are checking various social networking sites to locate more information about current and potential employees/students. According to a recent article published in American Nurse Today, “a recent Microsoft survey found that 70% of employers rejected job candidates after finding ‘unsuitable’ photos or ‘inappropriate comments’ (such as complaints about employers) on social networking sites used by applicants” (Trossman, 2010, p. 38).

These examples describe some of ways that we use technology and the hazards that can accompany these new tools, but this is certainly not an exhaustive list. These are emerging issues that employers, employees, care providers and patients are still navigating. There are not yet any definitive guidelines. To protect yourself and best serve your patients be thoughtful and cautious in your online and text communications.

References

You’re Up in “MySpace”

Social networking technology can obscure the patient/provider boundary. Social networking technology can often blur the lines between personal and professional interactions.

Professional boundaries exist in order to maintain a therapeutic or “curing” relationship between patient and caregiver. Patients are seeking the curative aspect of the care they receive from the providers that care for them. This includes the medical providers. Social networking technology can sometimes blur the lines between provider and patient. It is important to remember that social networking technology can be used to place the provider at risk.

Before you post, ask yourself if this is something that you would send in a letter or include in an article or educational assignment. Posting is really just another form of the written word and the same rules apply.

Distinctions between personal and professional contact become more difficult when social networking sites, blogs, and online dating services come into the mix. Is a patient a “friend” for the purpose of your social networking site? Are your comments about your professional life sufficiently obscured to avoid recognition by a patient? Are the terms you use to describe or identify yourself via email or on your social networking site giving the right impression? What about the image you are projecting on your profession? Does the fact that you are a student mean you have less responsibility for following the tenets of professional behavior?

Medical and nursing schools have begun to recognize that policies concerning internet use need to be developed and used as a teaching tool when discussing professional behavior. A study of the online behaviors of medical students published in the September 2009 issue of the Journal of the American Medical Association (JAMA) provides some initial research on web behaviors. Over 60% of the respondents to this report indicated that they would share unprofessional information online.

Not too long ago, patient contact was limited to work hours. Patients had the option of going to the emergency room when needed patient care advice. Texting typically employs the use of abbreviated terms, some of which can easily be misinterpreted, similar to issues of “unsafe abbreviations.” Texting typically employs the use of abbreviated terms, some of which can easily be misinterpreted, similar to issues of “unsafe abbreviations.”

Some of us will remember a time when communication was limited to ringing the dinner bell, using the telephone, or writing a letter. Conducting a literature review meant going to the library and using the card catalog. In your local library, taking copious notes, and waiting for access to that specific journal. Today, information technology has rendered our old communication systems obsolete, even nostalgic (When did you last receive a fax?).

While texting a patient’s condition to another healthcare provider in order to obtain suggestions for recommended treatment might be useful, a summary of the text may not become a part of the medical record. Just as with phone conversations, it is important that the medical record reflects the conversation. Without such information, should a lawsuit be filed, the ability to defend a case may be compromised. Additionally, if the actual texting is shown to the medical examiner, it will jury, “read” and “issuing” the message will not be one of professionalism, but one of hasty, casual, incomplete consultations, and one that may be interpreted as unconcerned and/or disrespectful of the patient” (Baker, 2010, p. 5–6).

Adding patients or being added to a patient’s “my friends” list on Facebook or other social networking sites blurs the lines of professional boundaries. Posting pictures on web pages and networking sites can also place the nurse at risk. Nurses need to think about professional implications and the potential for discipline related to violations of standards of nursing conduct or practice (WAC 246-840-710).

Additionally, some employers as well as educational institutions are checking various social networking sites to locate more information about current and potential employees/students. According to a recent article published in American Nurse Today, “a recent Microsoft survey found that 70% of employers rejected job candidates after finding ‘unsuitable’ photos or ‘inappropriate comments’ (such as complaints about employers) on social networking sites used by applicants” (Trossman, 2010, p. 38).

These examples describe some of ways that we use technology and the hazards that can accompany these new tools, but this is certainly not an exhaustive list. These are emerging issues that employers, employees, care providers and patients are still navigating. There are not yet any definitive guidelines. To protect yourself and best serve your patients be thoughtful and cautious in your online and text communications.

References

You’re Up in “MySpace”

Social networking technology can obscure the patient/provider boundary. Social networking technology can often blur the lines between personal and professional contact become more difficult when social networking sites, blogs, and online dating services come into the mix. Is a patient a “friend” for the purpose of your social networking site? Are your comments about your professional life sufficiently obscured to avoid recognition by a patient? Are the terms you use to describe or identify yourself via email or on your social networking site giving the right impression? What about the image you are projecting on your profession? Does the fact that you are a student mean you have less responsibility for following the tenets of professional behavior?

Medical and nursing schools have begun to recognize that policies concerning internet use need to be developed and used as a teaching tool when discussing professional behavior. A study of the online behaviors of medical students published in the September 2009 issue of the Journal of the American Medical Association (JAMA) provides some initial research on web behaviors. Over 60% of the respondents to this report indicated that they would share unprofessional information online.

Not too long ago, patient contact was limited to work hours. Patients had the option of going to the emergency room when needed patient care advice. Texting typically employs the use of abbreviated terms, some of which can easily be misinterpreted, similar to issues of “unsafe abbreviations.” Texting typically employs the use of abbreviated terms, some of which can easily be misinterpreted, similar to issues of “unsafe abbreviations.”

Some of us will remember a time when communication was limited to ringing the dinner bell, using the telephone, or writing a letter. Conducting a literature review meant going to the library and using the card catalog. In your local library, taking copious notes, and waiting for access to that specific journal. Today, information technology has rendered our old communication systems obsolete, even nostalgic (When did you last receive a fax?).

While texting a patient’s condition to another healthcare provider in order to obtain suggestions for recommended treatment might be useful, a summary of the text may not become a part of the medical record. Just as with phone conversations, it is important that the medical record reflects the conversation. Without such information, should a lawsuit be filed, the ability to defend a case may be compromised. Additionally, if the actual texting is shown to the medical examiner, it will jury, “read” and “issuing” the message will not be one of professionalism, but one of hasty, casual, incomplete consultations, and one that may be interpreted as unconcerned and/or disrespectful of the patient” (Baker, 2010, p. 5–6).

Adding patients or being added to a patient’s “my friends” list on Facebook or other social networking sites blurs the lines of professional boundaries. Posting pictures on web pages and networking sites can also place the nurse at risk. Nurses need to think about professional implications and the potential for discipline related to violations of standards of nursing conduct or practice (WAC 246-840-710).

Additionally, some employers as well as educational institutions are checking various social networking sites to locate more information about current and potential employees/students. According to a recent article published in American Nurse Today, “a recent Microsoft survey found that 70% of employers rejected job candidates after finding ‘unsuitable’ photos or ‘inappropriate comments’ (such as complaints about employers) on social networking sites used by applicants” (Trossman, 2010, p. 38).

These examples describe some of ways that we use technology and the hazards that can accompany these new tools, but this is certainly not an exhaustive list. These are emerging issues that employers, employees, care providers and patients are still navigating. There are not yet any definitive guidelines. To protect yourself and best serve your patients be thoughtful and cautious in your online and text communications.

References
NATIONAL NURSES WEEK
MAY 6-12, 2011

Celebrate with NHNA on May 11th
HOLIDAY INN - 172 N. Main St. Concord, NH

WOULD FLORENCE ‘FRIEND’ YOU ON FACEBOOK?
Social Media Meets Nursing Practice

Technology is creating new issues for the healthcare workplace. Join us for a look at both advantages and challenges.

12:00 p.m.  Registration and exhibit area open
LUNCH ...plus a little good old fashioned IN PERSON “social networking”!

1:00 - 2:15  Web 2.0 Tools...What You Need to Know  Sharon Sabol & Paul Ambrose
2:30 - 3:45  Social Media: Impact & Consequences on Healthcare Practice  Ronald Schneider, Jr., Esq.
4:00 - 5:15  Benefits, Barriers and Best Practices  Pamela Katz Ressler, RN, BSN, HNC
5:15        Wrap up

GOLD SPONSOR: Dartmouth-Hitchcock

SILVER SPONSORS: Elliot Health System

BRONZE SPONSORS: DEVINE MILLIMET

GREAT NURSES WEEK GIFT!
Buy tickets in blocks of 10. Distribute as rewards or use for raffle prizes!

EXHIBITOR OPPORTUNITIES STILL AVAILABLE
See www.NHNurses.org or call 603-225-3783

This continuing nursing education event is being submitted for approval to ANA-MAINE, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

Nurses Week Event 2010 REGISTRATION

NAME____________________________________ PHONE____________________
ADDRESS__________________________________________________________
CITY________________ ST____ ZIP__________
EMAIL__________________________
EMPLOYER/ SCHOOL________________________
[ ] $60  [ ] $50 for NHNA members, full time students, retirees

DISCOUNT CATEGORY:  [ ] NHNA MEMBER  [ ] STUDENT  [ ] RETIREE
FOR GROUPS OF 10+, CONTACT OUR OFFICE FOR A GROUP REGISTRATION FORM
[ ] Check enclosed payable to NHNA OR
[ ] Charge my [ ] VISA [ ] MasterCard [ ] Discover
Card Number__________________ EXP____/____ SEC____
Signature____________________ DATE____/____/____

MAIL: NHNA 210 N. STATE ST. 1-A CONCORD, NH 03301 FAX: 228-6672
OR REGISTER ONLINE AT WWW.NHNURSES.ORG
Why have professional organizations? Our present state of practice, research and education is due in large part to the environment of collaboration created by professional organizations. The evolving body of knowledge that defines practice is supported through membership organizations, be it specialty practice to umbrella organizations such as ANA, the efforts of those willing to “give back” shape your practice. Members may choose to engage by volunteer committee work, serving in elected office or simply by providing financial support.

What is the work of professional nursing associations? Three major categories emerge: professional development, growing/advancing the profession, and policy and advocacy. Let’s look at these categories more closely.

Professional development includes competency and leadership development through education, credentialing and socialization. Growing the profession includes establishing standards of practice, professional performance, standards for education, standards of administration/leadership, dedication to research, and dissemination of research findings. Advocacy and policy development include establishing government relations, legislative advocacy, and promoting a healthy, productive, and safe work environment. Now you may ask how membership in a professional organization accomplishes these things.

Huston (2006) writes nurses value membership because “it conveys professional status, a willingness to uphold the standards of the profession and a vested interest in the issues and concerns the professional association takes on for benefit of the members” (p. 467). Associations are created by the membership. Opportunities abound for leadership development, for collaboration across practice arenas in the form of task force work, and for development and growth of the profession by having a voice in practice standards, competency definition, and policy development. Membership allows nurses from all disciplines to come together to synthesize the knowledge and skills of various specialties; it creates a space where those outside the profession can look for answers to questions regarding policy development.

Research done by five specialty nursing associations found nurses identified the following three (3) main reasons for not joining a professional organization: family responsibilities, lack of time to participate, and lack of information about the association (White & Olson, 2004). Other findings indicate the typical age of members of most associations is the 40-60 year old age group. This falls in line with the White and Olson findings, where younger members find it difficult to participate in the traditional manner, such as attending meetings, holding office, or participating in committees and councils. Unfortunately, by choosing to wait to join until family responsibilities are less pressing, many nurses miss out in making their voices heard when it comes to practice and policy development. It is important for all nurses to support the work of a professional nursing association by becoming a member so professional development, growing/advancing the profession, and policy and advocacy work truly reflect what the majority of nurses see as important. The risk you take by not joining is leaving policy development to just a few.

ANA recently published the 2nd Edition of the Scope and Standards of Practice (2010). The 16 standards for practice and performance are listed with competency statements. ANA also re-issued and updated Nursing’s Social Policy Statement and the Code of Ethics for Nurses. These three foundation documents are key pieces of work that all nurses must know and embrace. The right to practice, the right to hold a license, the contract with the public (our reason to exist) is explained in these documents. The development of these documents is work completed by the professional associations. It is your membership fees and volunteer work that accomplishes this monumental work.

Membership in a professional organization offers the opportunity to have input into development of the scope and standards of practice. This work touches all our lives since this work is used to develop licensing laws and job descriptions. Membership reminds all of us what nursing is supposed to be about. “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through diagnosis and treatment of the human response, and advocacy in the care of individuals, families, communities, and populations.” (ANA, 2010).

References


Dr. Lucille C. Gambardella, APN-BC, CNE, ANEF
Reprinted with permission from The DNR Reporter, Nov-Jan, 2011

Author: Lucille received her BSN from Villanova University, MSN from Boston University and PhD from Columbia Pacific University. Dr. Gambardella has chaired the Department of Nursing at Wesley College and has served as Director of Graduate Programs since 1995. She is a former president of the Delaware Nurses Association and Delaware Board of Nursing. Her research interests include depression in women, the effects of deployment on marital discord, and leadership roles in nursing education. Lucille was inducted into the National League for Nursing’s Academy of Nurse Educators last year and is a certified nurse educator and certified clinical specialist in psychiatric/mental health nursing. In addition to her role as a nurse educator/leader, she has a private consulting practice, Positive Transitions, in Lewes, DE. Dr. Gambardella can be reached at gambar@wesley.edu.

Building a passion for political action

Historically, nursing and political strategy have not been partners in practice. However, in today’s healthcare environment, to engage or not engage in the political process, should not be a choice; it should be an expectation of sound professional wisdom. According to Nickitas, et al. (2011), “no longer can healthcare professionals be prepared solely for clinical practice...they must ready themselves to engage in the economic, political, and policy debates in the field.” This author is attempting in this article to motivate the reader to take action and recognize the relevance of political competence in the practice of professional nursing and acknowledge the true meaning of engagement in the political process.

Many of the readers out there can likely think back to their basic nursing preparation and recall little or no reference to politics in the curriculum plan as they became a nurse. Others, more recent graduates, might vaguely remember the subject being mentioned during a class in the senior professional seminar. Perhaps a comment was made about the importance of voting or paying attention to those bills in the legislature that might affect nursing practice. This brief reference to the relationship between nursing and political savvy is no longer sufficient as health care reform begins to unfold. Instead, a logical and coherent belief system that recognizes and engages nursing and politics as compatible PARTNERS in practice will better serve the nursing profession.

As early as 1982, Kalisch and Kalisch in their landmark text, Politics of Nursing, defined politics as the “authoritative allocation of scarce resources.” What a profound statement that is and it is even truer now than it was in 1982. One only needs to look at the economics of health care costs, the poor access to care, and the shortage of nurses and other health care personnel to affirm this statement.

A discussion about what engagement truly means seems appropriate here. Engagement to an obstetrics nurse (Stedman, 2011:10-15) means the fetus has entered the inlet in preparation for birth; in relationships, engagement means a promise or pledge of marriage between two people based on trust, love, and commitment; and in everyday life engagement can mean an appointment to meet someone (Webster, 2009) or a “state of being in gear.” That’s the “aha” definition for engagement in politics and political action: a state of being in gear. To be involved in the political process, the nurse must be in political gear! The question is how does the nurse get in gear? What steps does it take to create a passion for this concept called politics that is so foreign to most nurses? What will the outcome of being in gear be; what will it mean to the outcomes for the patients being cared for in the health care system across practice environments and for those in nursing education who are preparing the nurses of tomorrow?

Getting in gear involves a conscious effort to understand the impact of politics on the health care system in general, and on nursing practice specifically. (Practice here is defined as clinical practice, nursing education, nursing leadership and management, and nursing research) As a rule, politics plays a key role in all forms and levels of government including federal, state and local government. (Calatano, 2006). Further, politics is a complex interaction between public policy and constituent interests. Nurses, as constituents, should be interested in health care policy and all of its ramifications. One way of getting in gear is to read voraciously about political engagement in the health care system to improve access to care for the millions of patients in our country who did not have it. Not much has changed since 1982; millions still do not have access to care, states are still not consistent in allowing the full professional rights of advanced practice nurses in the health care system, and the exorbitant costs of health care have escalated rather than declined. It will take political change to implement health care reform that is inclusive of nursing. Accept the challenge; make political action a part of your professional nursing practice.

Politics is often linked with power, and power is not a word most nurses are comfortable demonstrating. On the other hand, feeling empowered is another matter. The nurse who feels empowered can overcome challenges, can make a difference in others and in systems, can create change, and can overcome the fear of having power and recognize it as a means to influence others. The ultimate example of this empowerment is the nurse who makes a decision to enter the political process and run for an elected office at the local, state or national level. The nurse legislator (in DE nurses should thank Senator Bethany Hall-Long) demonstrates her passion and commitment for contributing to the political process and chooses to sit at the table where major decisions that affect healthcare and nursing practice are made every day.

It is obvious that not every nurse will run for an elected office, but every nurse can decide to acknowledge the importance of political influence and incorporate the accompanying behaviors into professional action steps. Financial support of candidates who are working to improve health care and nursing practice is a first step. Offering to campaign and volunteering the many services needed to launch and run a campaign can be a valuable resource to candidates. Another way to use the expertise of a nurse in the political arena is to follow legislation that will impact health care and nursing practice. Using nursing knowledge to testify at hearings, to write letters of support or non-support of a bill, calling legislators to lobby for important changes in health care are all nursing actions that can make the ultimate difference in the success or failure of a bill friendly to nursing. For example, nurse-attorney Rebecca Walker who serves as the current President of the Board of Nursing fulfilled this role, but has taken it to the decision to run for elected office in the state house of representatives in November’s election.

The following statement by Senator Daniel Inouye, a true political friend of nursing, in the Kalisch text Politics of Nursing (1982) was indeed prophetic of the times we live in now. He stated:

“...nurses must begin to truly act as professionals and as a result demand the rights and responsibilities due their professional expertise. It is our nursing profession that must take the leadership and identify and then modify those aspects of the law that discriminate against them. It is they who must care enough about their patients to become politically active.”

This quote by Inouye referenced the need for advanced practice nurses of all kind to become an integral part of the health care system to improve access to care for the millions of patients in our country who did not have it. Not much has changed since 1982; millions still do not have access to care, states are still not consistent in allowing the full professional rights of advanced practice nurses in the health care system, and the exorbitant costs of health care have escalated rather than declined. It will take political change to implement health care reform that is inclusive of nursing. Accept the challenge; make political action a part of your professional nursing practice.

References

The film highlights many different research studies with favorable outcomes when the extraordinary power of the mind-body connection is embraced. At Duke University Medical Center, Tammy was 26 weeks pregnant when her water broke. Duke offers Tammy daily guided imagery sessions aimed at controlling her stress level knowing that stress in an uncomplicated pregnancy can induce labor and in a healthy person can suppress the immune system. By treating her mind, Tammy’s stress level is lowered and best possible outcomes are likely to improve, and they do. This is one of many examples highlighted where the use of integrative (alternative, complementary, holistic, etc) medicine is used to cross the mind body chasm.

Part two explores the physician patient relationship, and the dehumanizing of patients in a technologically advanced healthcare system. This neglected “softer side of medicine” is being taught at Drexel University School of Medicine using actors to role play with medical students in the discussion of difficult conversations. Such as, informing a mother that her child’s fight with cancer is coming to an end when there is nothing else modern medicine can do. Drexel recognizes the inadequacy of the current model where physicians spend an average of six minutes with each patient and are “so enamored of technology and specialization” that they have lost sight of the individual. The individual that we learn in part one of this film has the power to heal themselves if guided so. Drexel recognizes the tendency for seasoned physicians to replace optimism with cynicism.

Part one of this film explores the mind-body connection in this new era of medicine, by going inside hospitals, clinics, research centers and academic centers to explore new ways of knowing about the influence our body has on our mind and vice versa. The filmmakers uncover the paradigm shift on the medical horizon from patient to person: the whole person, including the mind. Allopathic medicine has always used feeling terms such as “hope”, “worry”, and “broken hearted” in relation to the patient’s experience which suggests an understanding that the mind and body have a relationship of paramount importance. Why then doesn’t the current medical model treat the mind and body as one, or at least treat the mind concurrently when treating the body?

While probing into our current healthcare system to give science an embrace (leaving the patient in need of one!), it is asserted that “science can inform medicine...but it can never explain it all”, and the human condition is in direct relationship to healing. Part two goes on with several vignettes of patients whose failure or success in the healing process was directly related to their relationship with their own healing; guided or misguided as it was, by modern healthcare. It wraps up with the notion that “caring is at the root of the physician patient relationship and in the absence of curing, healing is still taking place that involves caring.”

At this writing this film is five years old – and we still have not reached that horizon. Arthur Kleinmen, MD at Harvard University states “There is no reason we can’t be as humanly sophisticated as we are technologically sophisticated” and I agree. I do criticize the film for embarking on the physician patient relationship in part two and excluding nursing and the other disciplines. The film doesn’t have the cinematography, bells and whistles of other nationally released big screen documentaries. It forgives any red carpet aspirations and puts the spotlight on the patient, which is where it belongs.

3 out of 5 boxes of popcorn

This film is not rated. Directed by Mufle Meyer

Available on DVD

References


Research: Hospital-acquired infections increased lengths of stay by an average of 19.2 days and added $43,000 in costs, according to an Agency for Healthcare Research and Quality study based on 2007 data. The death rate for patients with an HAIs was six times higher than for patients without an infection, the study showed.

Reflection: An entrepreneur would be very successful if they invented a device that could wash and dry dirty hands without the need for providers to stop and think about it.

Research: The number of Americans who have used at least one prescription drug in the past month increased from 43.5% to 48.3% within the past 10 years, a CDC survey found. In the survey period of 2007 and 2008, one in five Americans used at least one prescription drug in the previous month. Use of prescription drugs increased with age.

Reflection: The need for Medication Reconciliation is more important now than ever before, as is the need for nurses to educate patients about their medications.

Research: In the past decade, 10 states, including Arizona, Kansas and Maryland, had significant reductions in fruit and vegetable consumption, and no state overall was able to meet the goals of Healthy People 2010 to improve healthy food intake among Americans, according to a CDC report. The report found that in 2009, 67.5% of adults ate fewer than two servings of fruit a day and 73.7% ate fewer than three servings of vegetables. However, a Consumer Reports survey found that nine out of 10 Americans said their diets are at least somewhat healthy and 34% deemed them "very" or "extremely" healthy.

Reflection: How do you define healthy? And what ever happened to “An apple a day…….”?

Research: U.S. researchers found that 85% of 6,000 public restroom users last month washed their hands as opposed to only 77% in 2007. The study also showed higher rates for women than men, with only 7% of them skipping hand washing compared with 23% in men.

Leadership is not determined by the titles one holds, but by the actions one takes on a daily basis. Sanborn stresses the importance of the small things people do that positively influence the environment in which they work. She simplifies the ways in which someone can become a leader, so that the reader can understand and apply leadership concepts to his or her life. This book is an inspiration for anyone seeking greatness in their careers or lives.

The two following books were reviewed by Alex Armitage, BSc (Hons), MSc., RN, a certified Clinical Nurse Leader, specializing in bringing evidence-based practice to bedside to improve patient care, patient outcomes and institutional viability.

Family Violence and Nursing Practice

Nurses frequently encounter battered women, abused children and other victims of family violence who place nurses in a unique position to identify and prevent familial abuse. This newly revised second edition of Family Violence and Nursing Practice provides a comprehensive and nursing-focused resource for violence and abuse within a family.

Family Violence and Nursing Practice is divided into three broad sections: theoretical background of familial violence and its long-term implications for the survivor; types of familial abuse laid out in separate chapters with in depth discussion and information angled at nursing practice; and the legal, ethical and moral perspectives on familial abuse. The information is presented comprehensively and clearly, resulting in a resource which is informative, comprehensive and easy to read for the clinician. The statistical data provided in each chapter underscores the salient aspects of the different types of violence being discussed in a meaningful way. It pleased me that the discussions around each type of abuse are specifically applicable to the practicing nurse.

I found this book to be well written, very thorough and up to date. This book allows a deep understanding of abuse within the family context. It integrates violence theory, long-term biological implications of abuse, and types of abuse clearly. Nurses need the skills to react to the situations they are in the nursing profession.

Critical Care: A New Nurse Faces Death Life and Everything in Between

Nursing is a profession of stories, of people and their lives, of trials and tribulations and, often, of suffering and death. We have all listened and garnered our stories which we will never forget. We have all had our transcendent moments with patients and their families. This is one of the foundations of the nursing practice.

Critical Care: A New Nurse Faces Death Life and Everything in Between chronicles MS Brown’s first year as a nurse in medical oncology. She vibrantly brings to life the struggles and triumphs of patients and the nurses who care for them. She describes the impact a good nurse makes to patients who are vulnerable, or in pain. In some instances, Brown makes clear, is listening to the fears a patient and family face and offering whatever comfort is possible in the face of not having real answers to their most pressing questions. These journeys are vividly described through the fresh eyes of a new nurse.

Critical Care: A New Nurse Faces Death Life and Everything in Between is a clear reminder as to why we entered the profession of nursing and the capacious impact that we have on each person which crosses our path. Ms Brown’s voice through this book is clear and resonant, and her skill at writing makes this book a joy to read. I found that the sincerity and clarity with which each story is presented sets this book apart from many in this genre.
The New Kid on the Block

Sue Fetzer, RN, PhD

My husband says that my occasional stubborn nature (see http://www.aacn.nche.edu/DNP/DNPPositionStatement.htm) seemed as the DNP train was leaving the station! So it was with much consternation that I agreed to attend the 2011 Doctoral Education conference held recently. I went with my opinion that the DNP was a bad idea with little evidence of a positive impact on the profession or health care.

I attended the conference presentations with such titles as “Advancing Practice through DNP Capstone Projects,” “Preparing New Faculty to Teach in the New Paradigm,” and “The DNP as Transformational Leader.” I talked to others about the role, about the educational curricula and about the use of the DNP in practice. I learned about the challenges of program development, key elements to consider and the stumbling blocks. I changed my opinion. It was an epiphany. I got it!

For the past 50 plus years, nursing has been producing new knowledge through research. Just think about the practices that have taken up to 20 years to get these interventions out of academia and into nursing practice. And, I would conjure, if this stubborn “German-Polack” can welcome the DNP offers individuals the opportunity to be “real nurses.” The DNP offers an opportunity to transform practice by leading systems reform and implementing evidence-based practice. They will be master’s prepared nurses who will remain in practice to transform practice by leading systems reform and implementing evidence-based practice. They will be nursing educators who take the role of educator to new PhD students, but instead of focusing on knowledge development they will become experts in knowledge utilization. The DNP will be “BRUTE,” but just as rigorous course of study. The DNP will not replace the PhD, but complement and become a colleague with the PhD. The potential for synergy is palpable, scholars working together to produce results not obtainable by each alone.

Many advanced practice nurses and future APRNs have heard about the 2015 resolution. The American Association of Colleges of Nursing has suggested that the terminal degree for APRNs should be a doctorate. Many systems must be in place before the profession can meet this goal, and it is unlikely it will be a mandate in place on January 1, 2015. However, the DNP offers individuals and professions away to improve practice and patient outcomes. If this stubborn “German-Polack” can welcome and promote the new kid on the block, I hope you will too!

Definition of a “Real Nurse”

Becky Graner, MS, RN

Reprinted with permission from the North Dakota Prairie Rose, Nov. 2010

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

Diagnosis and treatment of the diversity of human responses is accomplished by the use of the nursing process assessment, diagnosis, outcomes identification, planning, implementation, evaluation. This method of problem solving is supported by the nursing scope and standards of practice and standards of professional performance. Essentially, the scope and standards are the basis for how we do things. They show how we behave or have. The values rest in nursing ethics and we answer to the public we serve. Our social policy statement defines our social contract, the reason we get to be a “real nurse.”

For too long nursing has been measured and defined by what we do, sometimes by what we know, and rarely by how we behave. Just take a look at the popularity of the “nurse” TV shows. Nurses depicted in these programs are shown stealing drugs, leaving patients to take care of personal problems, or as help less busy following orders to advocate for patients. All these characters need to do to redeem themselves is to be able to flawlessly start an IV, give a shot, or perform some other technique that has been deemed what real nurses do. Never mind, that while performing complex skills, the nurses portrayed in many of these shows fail miserably to uphold the standards of professional performance or the code of ethics for nurses.

ANA recently published the 2nd edition of Nursing Scope and Standards of Practice. This work covers the sixteen (16) standards by which nurses are measured. Nurses typically know the first six (6) standards by heart, the next ten (10) standards however, tend to be less well known and in the world of “doing” the standards at the popularity of the “nurse” TV shows.

News and professional sources are full of evidence that violence in the health care workplace is increasing. One form of nurse to nurse violence that often goes unrecognized described as “disparaging the competence of one’s colleagues” (Thomas, 2009). Every time a nurse makes a comment that devalues another nurse’s practice this behavior violates the nursing code of ethics and the standards of professional performance. Sadly, this behavior is so common it has become part of our culture. This behavior is why the practice of eating your young continues, it is why the older nurse is set to the side, it is why we often hear nurses who have moved from the bedside to practice in academics, administration and research bemoan their bedside colleagues. Bullying flows the opposite way as well when supervisors interrogate staff, administrators dismiss concerns, or educators take the role of evaluator to the extreme of being judge. These behaviors constitute failure to meet the standards of professional performance and nursing’s code of ethics. Without looking too hard, there seems to be a good example of a bad example in every direction one gazes.

Standard 14 is Professional Practice Evaluation. This standard speaks to the nurse’s ability “to evaluate his or her own nursing practice and the professional practice of others about the role, about the educational curricula and about the use of the DNP in practice. I learned about the challenges of program development, key elements to consider and the stumbling blocks. I changed my opinion. It was an epiphany. I got it!

For the past 50 plus years, nursing has been producing new knowledge through research. Just think about the practices that have taken up to 20 years to get these interventions out of academia and into nursing practice. And, I would conjure, if this stubborn “German-Polack” can welcome and promote the new kid on the block, I hope you will too!

Definition of a “Real Nurse”

Becky Graner, MS, RN

Reprinted with permission from the North Dakota Prairie Rose, Nov. 2010

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

Diagnosis and treatment of the diversity of human responses is accomplished by the use of the nursing process assessment, diagnosis, outcomes identification, planning, implementation, evaluation. This method of problem solving is supported by the nursing scope and standards of practice and standards of professional performance. Essentially, the scope and standards are the basis for how we do things. They show how we behave or have. The values rest in nursing ethics and we answer to the public we serve. Our social policy statement defines our social contract, the reason we get to be a “real nurse.”

For too long nursing has been measured and defined by what we do, sometimes by what we know, and rarely by how we behave. Just take a look at the popularity of the “nurse” TV shows. Nurses depicted in these programs are shown stealing drugs, leaving patients to take care of personal problems, or as help less busy following orders to advocate for patients. All these characters need to do to redeem themselves is to be able to flawlessly start an IV, give a shot, or perform some other technique that has been deemed what real nurses do. Never mind, that while performing complex skills, the nurses portrayed in many of these shows fail miserably to uphold the standards of professional performance or the code of ethics for nurses.

ANA recently published the 2nd edition of Nursing Scope and Standards of Practice. This work covers the sixteen (16) standards by which nurses are measured. Nurses typically know the first six (6) standards by heart, the next ten (10) standards however, tend to be less well known and in the world of “doing” the standards at the popularity of the “nurse” TV shows.

News and professional sources are full of evidence that violence in the health care workplace is increasing. One form of nurse to nurse violence that often goes unrecognized described as “disparaging the competence of one’s colleagues” (Thomas, 2009). Every time a nurse makes a comment that devalues another nurse’s practice this behavior violates the nursing code of ethics and the standards of professional performance. Sadly, this behavior is so common it has become part of our culture. This behavior is why the practice of eating your young continues, it is why the older nurse is set to the side, it is why we often hear nurses who have moved from the bedside to practice in academics, administration and research bemoan their bedside colleagues. Bullying flows the opposite way as well when supervisors interrogate staff, administrators dismiss concerns, or educators take the role of evaluator to the extreme of being judge. These behaviors constitute failure to meet the standards of professional performance and nursing’s code of ethics. Without looking too hard, there seems to be a good example of a bad example in every direction one gazes.

Standard 14 is Professional Practice Evaluation. This standard speaks to the nurse’s ability “to evaluate his or her own nursing practice and the professional practice of others about the role, about the educational curricula and about the use of the DNP in practice. I learned about the challenges of program development, key elements to consider and the stumbling blocks. I changed my opinion. It was an epiphany. I got it!

For the past 50 plus years, nursing has been producing new knowledge through research. Just think about the practices of 33 years ago (I was a new grad) and the practices of today. As a new grad, I was using betadine for Foley catheter care q shift. We put 100 units of heparin into IV Hep locks q shift and after every IV med.; some shifts that meant over 1,000 units of heparin per patient! We kept MI patients in bed for 3 days, and fed them like infants for the first 24 hours so their heart was not stressed. We placed patients in Trendelenburg position (head down, feet up) any time their BP dropped. We gave milk to patients with ulcers every hour (the “Sippy” diet). And every patient with a NG tube was usually positioned flat in bed. All of these past practices have been shown to be ineffective and even hazardous to patients. All of these practices resulted in negative patient outcomes. It was the PhD nurses researchers developing the new knowledge that provided evidence for best practices. But it has not been enough that the nursing profession has developed new knowledge. It has taken up to 20 years to get these interventions out of academia and into nursing practice. And, I would conjure, that some nurses (and physicians) are still turning patients upside down in Trendelenburg. Shame!

The problem in nursing has been that new knowledge has not been easily and quickly moved into practice. We know that many nurses (up to 80%) have not read a nursing journal in the past 3 years. If nursing knowledge doubles every 18 months (a conservative estimate), then these nurses will not have read the new knowledge and therefore, outdated practice. We need scholars to move knowledge into practice. This is the reason nursing needs new DNP and PhD prepared nurses. The focus of the PhD is to prepare nurses as scholars to produce new knowledge to advance the profession. The focus of the DNP is to prepare nurses as scholars to translate and implement new knowledge into practice.

The DNP movement picked up steam, with a lot of new programs have been proposed, developed and implemented. In fact there are currently 131 educational institutions in the US offering the DNP degree with another 161 planned. Nationwide there are more DNP students (n = 5,165) than there are PhD (n=1,477) students. The American Association of Colleges of Nursing (AACN) in 2004 issued a position statement making 12 recommendations for implementation of the DNP (Doctorate of Nursing Practice) was not in the profession’s best interest. It seemed, at the time, a way to water down doctoral education. After all, I had worked really hard to get my PHD, and it wasn't supposed to be easy. Plus, I thought, the DNP meant the end of scholarship. And why did practice require a doctorate?

The nursing profession now recognizes that the DNP is to prepare nurses as scholars to produce new knowledge into practice.
We welcome new & reinstalled members

Laurie Anderson Nashua, NH Robin Phillips Manchester, NH
Elizabeth Green Plainfield, NH Heidi Coen Contoocook, NH
Jennifer Anifant Manchester, NH Lisa Powers Manchester, NH
Susan Hamilton Merrimack, NH Cynthia Coughlin Keene, NH
Pamela Bannan Merrimack, NH Lori Profta Piermont, NH
Donna Holt Derry, NH Patrick Crowley Hampton, NH
Eva Barger Manchester, NH Maria Schaufela Hanover, NH
Katherine MacAlister Portsmouth, NH Anne Marie Durant Concord, NH
Amy Becker Concord, NH Jean Ten Haken Grantham, NH
Kathleen Maiorano Grantham, NH Donnal Lee Elliott-McCabe Nashua, NH
Catherine Bernosky-Flores Osipee, NH Jennifer Theriault Seabrook, NH
Sarah Marshall Newmarket, NH Rae Louise Frazer Monroe, NH
Carol Carilli Wolfeboro, NH Lisa Therrien Alstead, NH
Sonja Martinson Fairlee, VT Jeanne Gilman North Chelmsford, MA
Maria Cassidy Pike, NH Trili Timm Chichester, NH
Jessica Pelletier Gorham, NH Amy Girard Manchester, NH
Nancy Clayman Nashua, NH Donna Woods Amherst, NH

MEMBERSHIP Check One ☑️ Consider our ‘Painless Pay Plan’ monthly options!

☐ NHNA Membership $125/yr or ☐ $10.92/mo (State only - no ANA benefits or voting rights)
☐ ANA Membership $183/yr (Membership in ANA only - no NHNA voting rights or ability to hold office)

DUAL ANA & NHNA MEMBERSHIP (Full benefits and privileges of both organizations)

☐ Full Membership $249/yr or ☐ $21.25/mo (Licensed RN only - employed full or part time)
☐ Reduced Membership $124.50/yr or ☐ $10.87/mo (New RN Graduates; students in full time RN educational advancement program; or RN’s not employed)

☐ Special Membership $62.25/yr (Retired or Disabled RN’s)

New Hampshire Nurses’ Association
WWW.NHNURSES.ORG

The Importance of Professional Membership

National statistics show that some 80% of the nearly three million RNs in the U.S. still do not belong to any professional nursing organization.

The American Nurses Association (ANA), along with over 80 specialty nursing organizations, serves a vital role in advancing the role of nursing and health care. ANA in particular (which represents nurses across all specialties) works to develop policies, set standards, advocate in government and private settings, provide education, maintain the Code of Ethics for Nurses and shape the future of the profession.

At the state level, ANA affiliate associations are:
• Key in protecting the Nurse Practice Acts of each state—and elevating the standards for nursing;
• Instrumental in advancing the rights of advanced practice nurses;
• The voice for nurses at the state legislature;
• Providers of quality continuing education & networking opportunities;
• Strong advocates for the interests of nurses in the workplace.

So for those who think—“All of this work is being done anyway—why should I belong?”...

Professional associations are member supported non-profit organizations. Members allow associations to accomplish what needs to be done. Member dues provide the necessary funding for operations to continue and expand. Member volunteers provide the human resources, guidance and expertise to the work to be done and move the profession forward.

With the present day shortage of healthcare providers, especially nurses, workplace concerns and increasing distress over access to care for our patients, nurses need to be more involved with healthcare policy decisions. Although nursing continues to be ranked at the top of “most trusted profession” polls, a 2009 Gallup survey entitled “Nursing Leadership from Bedside to Boardroom” showed that nursing could and should be much more influential in many areas. (See full article in this issue and on the NHNA website: www.nhnurses.org)

There is strength in numbers. Greater numbers of association members
• Give more power and credibility to the association when speaking in front of Congress and other regulatory bodies;
• Provide funds for associations to do its work on behalf of the profession;
• Put nursing in a position to direct health care policy versus reacting to it.

PLUS—membership gives you:
• A voice in the decisions being made for the profession;
• The opportunity to receive various discounts and tangible benefits;
• Certification opportunities at discounted rates;
• Free or discounted continuing education;
• Access to important ‘members only’ information;
• Volunteer opportunities which provide leadership experience;
• Opportunities to interact with nursing colleagues statewide or nationally.

So please—if you are not yet part of any professional nursing association—or your membership has lapsed—take a moment to join now.
You see them everywhere—nurses, doctors and medical technicians in scrubs or lab coats. They shop in them, take buses and trains in them, go to restaurants in them, and wear them home. What you can’t see on these garments are the bacteria that could kill you.

Dirty scrubs spread bacteria to patients in the hospital and allow hospital superbugs to escape into public places such as restaurants. Some hospitals now prohibit wearing scrubs outside the building, partly in response to the rapid increase in an infection called “C. diff.” A national hospital survey released last November warns that Clostridium difficile (C. diff) infections are sickening nearly half a million people a year in the U.S., more than six times previous estimates.

The problem is that some medical personnel wear the same unlaundered uniforms to work day after day. They start their shift already carrying germs such as C.diff, drug-resistant enterococcus or staphylococcus. Doctors’ lab coats are probably the dirtiest. At the University of Maryland, 65% of medical personnel confess they change their lab coat less than once a week, though they know it’s contaminated. Fifteen percent admit they change it less than once a month. Superbugs such as staph can live on these polyester coats for up to 56 days.

Dirty uniforms endanger patients? Absolutely. Health-care workers habitually touch their own uniforms. Studies confirm that the more bacteria found on surfaces touched often by doctors and nurses, the higher the risk that these bacteria will be carried to the patient and cause infection.

Until about 20 years ago, nearly all hospitals laundered scrubs for their staff. A few hospitals are returning to that policy. St. Mary’s Health Center in St. Louis, Mo., reduced infections after cesarean births by more than 50% by giving all caregivers hospital-laundered scrubs, as well as requiring them to wear two layers of gloves. Monroe Hospital in Bloomington, Ind., which has a near-zero rate of hospital-acquired infections, provides laundered scrubs for all staff and prohibits them from wearing scrubs outside the building. Stamford Hospital in Connecticut recently banned wearing scrubs outside the hospital.

Across the pond, a British study found that one-third of medical personnel did not launder their uniforms before coming to work. One British surgeon who specializes in hip and knee replacements reduced postoperative infections by two-thirds at her hospital by protecting patients from contaminated uniforms. Before approaching any patient’s bed, nurses put on disposable, clear plastic aprons that were pulled off rolls like dry cleaning bags. Each one costs a nickel.

In response to this evidence and public outrage over infections, the cash-strapped British National Health Service is providing nurses with hospital-laundered “smart scrubs.” The smart design includes short sleeves, because long sleeves spread germs from patient to patient.

In a hospital, C. diff contaminates virtually every surface. It spreads when traces of an infected person’s feces get in another person’s mouth. Patients who touch objects in their room and then eat without washing their hands unknowingly swallow the germ. Many otherwise healthy patients who go into the hospital for elective surgery, such as hip replacement, have contracted C. diff and died.

Outside the hospital, C. diff is also difficult to control. It isn’t killed by laundry detergents or most cleaners. Researchers at Case Western Reserve and the Cleveland Veterans Administration Medical Center found that even after routine cleaning, 78% of surfaces still had C. diff. Only scrubbing with bleach removed it. That’s not the kind of cleaning restaurants are prepared to do after serving hospital workers.

Imagine sliding into a restaurant booth after a nurse has left the germ on the table or seat. You could easily pick it up on your hands and then swallow it with your sandwich. Hospitals should provide workers with clean uniforms and prohibit wearing them in public.

Ms. McCaughey, former lieutenant governor of New York state, is a fellow at the Hudson Institute and chair of the Committee to Reduce Infection Deaths.
NY Henry House Settlement Nurse
Frances W. Field, 95, died in Lebanon, January 27, 2011. A native of Ohio, a yearlong battle with osteomyelitis at age 12 inspired Fran’s life-long involvement with nursing. She graduated from Vassar College in 1936 and, after receiving a Master’s in nursing from Case Western Reserve and worked for the Henry Street Settlement House in New York City as a public health nurse. After raising a family she practiced as a public health nurse in Connecticut and then as the director of the local agency. In 1987, she accepted a job at Mary Hitchcock Hospital as its first discharge planner. She later went on to work at Dartmouth Medical School, bringing her community health perspective to the curriculum as the first nurse hired to the Medical School faculty. She helped found Hospice of the Upper Valley.

Head Nurse
Patricia (Minotti) Curless, 77, of Bradford died December 17, 2010. A native of Massachusetts, she received her nursing diploma at New England Deaconess Hospital. After practicing nursing in Georgia and Massachusetts she relocated to New Hampshire. She was an office nurse for Dr. Hayes at the Concord Clinic; served as a head nurse at New London Hospital and McKerley Nursing Home in Concord. Most recently, she owned and operated Medical Records Service.

School Nurse
Jane (Hayden) Morrill, R.N., 77, of Nashua, died February 3, 2011. She was a graduate of Notre Dame Hospital Records Service. She started her nursing career as a school nurse in Newton, MA and became the school nurse at the Nottingham West Elementary School and the Nashua School System. Until the age of 80 she taught nursing skills assistant program.

School Nurse
Judith Ann Shaw, 66, of Laconia died February 2, 2011. A native of Los Angeles, CA and most of her life, she held a nursing diploma and a bachelor’s degree in psychology. She practiced as a school nurse in Laconia, NH in a nursing assistant program.

School Nurse
Ann Louise Murdoch, 71, died January 24, 2011 after a long illness. A Manchester, NH native she went on to nursing school in California. Returning to New Hampshire she practiced for over 42 years at the New Hampshire Hospital in Concord, retiring in 2002.

NY Henry House Settlement Nurse
Frances W. Field, 95, died in Lebanon, January 27, 2011. A native of Ohio, a yearlong battle with osteomyelitis at age 12 inspired Fran’s life-long involvement with nursing. She graduated from Vassar College in 1936 and, after receiving a Master’s in nursing from Case Western Reserve and worked for the Henry Street Settlement House in New York City as a public health nurse. After raising a family she practiced as a public health nurse in Connecticut and then as the director of the local agency. In 1987, she accepted a job at Mary Hitchcock Hospital as its first discharge planner. She later went on to work at Dartmouth Medical School, bringing her community health perspective to the curriculum as the first nurse hired to the Medical School faculty. She helped found Hospice of the Upper Valley.

Head Nurse
Patricia (Minotti) Curless, 77, of Bradford died December 17, 2010. A native of Massachusetts, she received her nursing diploma at New England Deaconess Hospital. After practicing nursing in Georgia and Massachusetts she relocated to New Hampshire. She was an office nurse for Dr. Hayes at the Concord Clinic; served as a head nurse at New London Hospital and McKerley Nursing Home in Concord. Most recently, she owned and operated Medical Records Service.

School Nurse
Jane (Hayden) Morrill, R.N., 77, of Nashua, died February 3, 2011. She was a graduate of Notre Dame Hospital Records Service. She started her nursing career as a school nurse in Newton, MA and became the school nurse at the Nottingham West Elementary School and the Nashua School System. Until the age of 80 she taught nursing skills assistant program.

School Nurse
Judith Ann Shaw, 66, of Laconia died February 2, 2011. A native of Los Angeles, CA and most of her life, she held a nursing diploma and a bachelor’s degree in psychology. She practiced as a school nurse in Laconia, NH in a nursing assistant program.

School Nurse
Ann Louise Murdoch, 71, died January 24, 2011 after a long illness. A Manchester, NH native she went on to nursing school in California. Returning to New Hampshire she practiced for over 42 years at the New Hampshire Hospital in Concord, retiring in 2002.