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NURSING NEWS

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In Dedication

September 11 marks the 10th anniversary of one of the greatest assaults on democracy in recent history. Most of us recall vividly where we were when the World Trade Towers toppled, the Pentagon was pierced and the ground in Pennsylvania was charred. This issue of the NHNN is dedicated to the families and friends of those who were lost. It is also dedicated to those women and men who protect our freedoms every day, the members of the Armed Forces. As a memorial, the News asked the military nurses of New Hampshire to tell us their story, two are printed below. ***To all who have served and are serving, the nurses of New Hampshire thank you!***

Col. (Ret) Priscilla Merrill RN, Northwood, NH

I entered the USAF Nurse Corps on graduating from Medical College of Virginia with my BSN in 1982. I was a Navy brat and was so proud of my Dad, a Korean War and Vietnam Test Pilot. I hadn't planned on the military at all until a Recruiter asked me to be in charge of getting a group of nursing students together for a dinner and orientation program. I found the travel opportunities and education plus internship enticing. I was commissioned with dad pinning on my "butterbars" right after graduation. I was a second lieutenant and RN on the same day!

I had a training course in the dead heat of Texas in August! (MIMSO, Military Indoctrination for Medical Service Officers) I immediately was *twitterpated* with hot foreign pilots in flight suits! We learned basics, marching, protocol, how to wear uniform, field medicine and so much more in a 2 week crash course. From there, off to my 6 month internship at Wright Patterson in Dayton, OHIO. This program was a major deciding factor for me in joining the Air Force. You go to a major medical center for intense training in all nursing areas so that you were not "green" when you arrived to your first duty station. It allowed you to try everything and get very proficient at skills you couldn't find elsewhere.

From there, off to Pease, my first duty assignment. We had "Dream Sheets" and Pease was NOT in my top 10 but fell in love with Portsmouth and know it was meant to be. A favorite assignment was instructing at TOP STAR at Travis AFB in Sacramento. This course was intense immersion for 2 weeks in specialty and trauma medicine. I have yet to see the education I received paralleled in the civilian world and the opportunities are endless for travel and nursing niches.

Another favorite memory for me was gathering in a room of one of our Health Service Corps members (Veterinarian in "real life") who happened to be a gourmet chef! He had about 15 of us in his tiny room for a phenomenal Christmas feast 1990. Tears were shed over missing our families but together we persevered and formed lasting deep friendships.

From there, I had many assignments and after my kids were born, went into the reserves and was called to Desert Shield/Desert Storm Stateside in Louisiana. I left my infant son and 3 year old behind with less than 24 [hours] notice! I was IMA (Individual Mobilzation Augmentee) and we cared for the families and elders and pregnant women left behind for 7 mos.

You form such strong camaraderie in the military and I loved serving my Country as my Dad before me did. I loved my career and happily retired in 2002 as serving 22 years. I am so grateful for those proud young people who continue to serve!

Lieut. (Ret) Kathleen M. Sherman, RN, BSN

Upon graduating Adelphi University with our BSN, my best friend and I decided to join the Navy. My friend's brother, a Marine, encouraged us to do so, saying it would be an experience of a lifetime. And he was so right!

I served four years active duty in the military as a Navy Nurse Corps Officer, and the remaining 16 years as a reservist. My active duty time was served at Naval Medical Center San Diego, and the remaining reserve time in Hawaii and Bethesda, Maryland. I was recalled for Desert Storm, and Operation Enduring Freedom and Iraqi Freedom, both times assigned stateside at military medical centers as backfill.

Being a nurse is a very rewarding profession, but serving as a Navy nurse allows you to serve others in uniform, military retirees and their families, and your country, all at the same time. It is both professionally and personally rewarding. Being a Navy nurse allowed for many opportunities to educate, lead and shape health care policy within the military health care system. My most favorite part of the job was instructing Hospital Corpsmen on how to provide quality patient care. And sharing equal status with the medical team was very significant in building strong and respectful peer-to-peer relationships.

I received retirement orders from the U.S. Navy Reserves in 2005. When I left the Navy, I felt like I was leaving part of my family! I can now proudly say my new career is serving our Veterans while working as a Health Promotion Disease Prevention Program Manager at the Manchester Veterans Administration Medical Center. I feel like I have come full circle in my federal career, and enjoying my new journey immensely!

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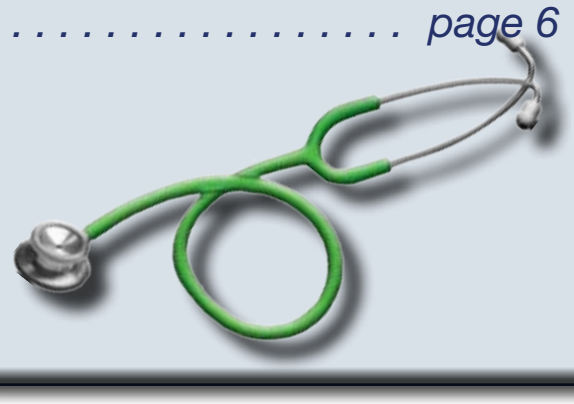

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VISION STATEMENT

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 healthcare 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 promote the health status of individuals, families and communities. We have an obligation to initiate legislative strategies to improve the quality of health and the delivery of health care services while promoting quality practice environments that advocate for the economic and general welfare of nurses.

Adopted: 5/80
Revised: 1991
Revised: 12/4/97

Letter from the President

Anita Pavlidis, MS, RN

VOICE & VISIBILITY:

As one of my colleagues and former President of NHNA used to say, we need to have our voices heard and make our presence known. It is a good thing to remember especially in times of change and turmoil.

Envision how things would be if the voice and visibility of nursing were commensurate with the size and importance of the nursing profession.

A survey conducted by the Robert Wood Johnson Foundation found nursing ranked higher than physicians as being trustworthy, honest and ethical. However, the surveys don't tell if the public ranks the work of nursing highly or even if the public knows anything about the knowledge, judgment and expertise that go into nursing.

Gallup surveyed more than 1,500 thought leaders from insurance, corporate, health services, government and industry, as well as university faculty. The first-of-its-kind survey found that an overwhelming majority of opinion leaders say **nurses should have more influence in many areas**, including reducing medical errors, increasing the quality of care, promoting wellness, improving efficiency and reducing costs. A clear majority say that nurses should have more influence than they do now on health policy, planning and management.

But when asked how much influence various professions and groups are likely to have in health reform, opinion leaders put nurses behind government, insurance and pharmaceutical executives, and many others. These opinion leaders see real barriers to nursing leadership (RWJ).

Robert Wood Johnson surveyed healthcare opinion leaders asking the question:

What, if anything, do you think could be done to ensure that nurses take on more leadership in improving health status and delivering healthcare services in the United States today?

Responses included the following:

Make your voice heard/increase input (RWJ)

- Opinion Leaders have a high degree of trust and confidence in nurses as an information source, behind doctors.
- Nurses are ranked as having the least amount of influence on future healthcare reform compared to other stakeholders, behind patients and doctors.
- An overwhelming majority feel that nurses should have more influence than they do now across a variety of topics within planning, policy, and management of health systems and services.
- Opinion leaders feel that nurses' primary influence is in reducing medical errors, quality care outcomes, and coordinating the patient journey.
- Several major barriers to nursing contributions are identified, with a majority responding that nurses are not perceived as key decision makers.
- Removing these barriers centers around increasing the voice of nurses, expectations and accountability, improving perceptions of nursing among others, and improving the selection and training of nurses.

We need a stronger model for developing and grooming nurse leaders. "Education, mentoring programs, better incentives, modeling and replacing ourselves really is the responsibility of leadership," asserts Anne Evans, CNO of Lutheran Hospital in Wheat Ridge, Colorado. In keeping with her belief, Lutheran Hospital has instituted formal succession planning with the help of the Colorado Center for Nursing Excellence.

Nursing needs a voice. The staff nurse needs to share their vision with leadership and gain a voice at the local, state and national level. Shared governance, nursing practice councils and involvement at upper levels in appropriate decision-making all work to create high-level presence. "The whole idea of vertical communication is critical, and it starts with the staff nurse and goes all the way up to the Board member," says Emily Weigel, nursing education coordinator at Boulder Community Hospital in Boulder, Colorado. To address vertical communication, Boulder Community created an innovative program that involves every employee in the hospital. Called "Getting the Board on Board," it assigns board members to patient rounds and selects nurses to attend board meetings.

Nursing needs to work together and use the power of our numbers to lead through the uncertainty that surrounds health care today. If you are not currently a member of NHNA, I encourage you to join now, to be part of the change, and be the ***voice and visibility*** of the profession. If you are already a member, I challenge you to step up to the plate, seek, and serve with the excellent leadership skills you already possess.

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Kudos

Nicole Connors, BS, RN, and Cindy Spencer, BS, RN, CCRN, of Wentworth Douglass Hospital presented a paper: "Let the Data Do the Driving: Informing Clinical Decision-Making in the Community Hospital" during the International Stroke Conference in Los Angeles.

Cathy Danforth, RN, MS, CNL, received a post-master's certificate from the University of Colorado-Denver in Health Information Management/Exchange preparing her provide support to the initation of Electronic Medical Records. Danforth practices at Wentworth Douglass.

June Fabre, MBA, RN-BC, of Smart Healthcare in Amherst, NH, was awarded Chapter Member of the Year by the New England Association of the National Speakers Association (NSA), the leading organization of professional speakers.

June Fabre

Dr. Susan Fetzer, PhD, RN, was recently promoted to the rank of professor by the University of New Hampshire. Fetzer, a nurse educator for the past 21 years, is the first member of the nursing faculty to be promoted to a full professor rank in the department's 45 year history.

Celeste Kidder, a diabetes educator at Concord Hospital, was recently awarded the McBean Little award at the annual Granite State Diabetes educator meeting. For the past 10 years Kidder has served as a diabetic educator. Kidder is past president of the Granite State Diabetes organization.

Sean Lyon, an FNP practicing in primary care at Life Long Care in New London, is the 2011 Nurse Practitioner of the Year.

Melissa Nelson, RN, an oncology nurse with the Norris Cotton Cancer Center at New London Hospital, has recently been inducted into the Epsilon Tau Chapter of the Sigma Theta Tau International (STTI) Honor Society of Nursing. "New London Hospital is very fortunate to have a nurse as accomplished and compassionate as Melissa on our team," said Trish Sweezey, RN, Chief Nursing Officer.

Melissa Nelson

Linda Reed, ARNP, received the 2011 Lifetime of Service award from the New Hampshire Nurse Practitioner Association. Reed was selected for her outstanding and long term exemplary commitment to NHNPA.

Stacey Savage, RN, BSN, was elected NH Emergency Nurses Association President Elect to assume the position January 1, 2102. Savage is the Nurse Manager of the Wentworth-Douglass Hospital Emergency Department.

Janet C. Stocker, RN, MS, NP-S, AOCNS, is this year's recipient of the Oncology Nurse Excellence award from the Oncology Nurse-APN/PA. Stocker is an oncology adult nurse practitioner and a clinical nurse specialist at Wentworth-Douglass Hospital.

New Hampshire Nurse Receives National Award

Colin Richards

The 2011 Emergency Nurses Association Nurse Manager Award will be presented to Colin Richards, BSN, RN, at the Emergency Nurses Association Annual Conference and Awards ceremony in Tampa, Florida on Thursday, September 22, 2011. Richards has been the nurse manager of Emergency Services at the Memorial Hospital since 2008. In nominating him, Mary Vigeant MSN ARNP, an acute care Emergency Services provider noted that Colin "sets an energetic and positive tone, not only for Emergency Room staff and employees throughout the hospital–but as evidenced by his winning this prestigious award–for nurses nation-wide." The nomination was supported by the entire staff of the Hospital's Emergency Department and cited him for significantly improving staff morale; assisting department personnel to develop and adopt winning problem-solving strategies; mentoring other RNs; and using his considerable skills and teaching abilities to introduce the highest skill levels for resuscitation, intravenous therapies, medication administration, and care of patients with traumatic injuries.

"He is an extraordinary mentor who has effectively aligned the pillars of the Memorial's strategic plan with the Clinical Ladder expectations and opportunities of our RNs. He has personally achieved multiple certifications (ENPC, TNCC, ACLS, ATLS, PALS, NRP) and works hard to ensure that nursing staff keep up to date with their own skill sets and protocols," said Ethnee Garner, VP of Nursing.

Richards, who is also responsible for the Hospital's Oncology/Infusion Center, has helped identify winning strategies that made it possible for the Emergency Department to purchase a small ultrasound unit. Garner further states that Colin "…continues to work diligently to put systems in place that improve fiscal responsibility, accountability, and growth." "A shining example of Richard's abilities as a leader who works effectively with others, include his efforts to work with local mental health resources to meet patient needs. As a result, he has introduced telepsychiatry services in the ED to bolster local Mental Health resources," said Garner.

Research & Reflection

Research
A study presented at the Society for Healthcare Epidemiology of America meeting found that a nurse-led catheter-removal protocol, which involves a device-specific charting module and documentation, helped reduce catheter use by 32% and catheter-associated urinary tract infections by 45%. The Agency for Healthcare Research and Quality's 2010 State Snapshots report found five states–New Hampshire, Minnesota, Maine, Massachusetts and Rhode Island–made the biggest gains in improving health care quality last year.

Reflection: Let's hear it for NH nurses!

Research
About 40% of mobile phones belonging to patients and their visitors contained pathogens compared with 21% of phones owned by medical staff, according to a Turkish study in the American Journal of Infection Control. The study of 200 phones also found that several phones that belonged to patients tested positive for drug-resistant pathogens, but none belonging to staffers did.

Reflection: How would your phone test if it was swabbed?

Research
A review found "no proof that falls in hospital are, in fact, preventable. And if not, they should not be categorized as a preventable occurrence and the burden shouldn't be borne by hospitals," according to the co-author of a study in the Journal of the American Academy of Orthopedic Surgeons. One of the studies that researchers reviewed suggests that comprehensive prevention programs don't reduce falls among patients during typical hospital stays but are effective in long-term care.

Reflection: While some falls are preventable, just ask a night nurse who is at high risk.

Research
The World Health Organization's new patient safety envoy says the chances of dying in a hospital because of a care-related error are one in 300, while a passenger's risk of death in a plane crash is one in 10 million. According to the agency, seven out of 100 hospitalized patients in developed countries and 10 out of 100 in developing countries contract health care-associated infections.

Reflection: With all of our health care technology, we don't do much better than those without.

Legal Nurse Consultant Certificate Program Opens in Concord

NHTI, Concord's Community College has announced an on-site certificate program for nurses interested in the role of the Legal Nurse Consultant (LNC). LNCs are professional nurses with both clinical expertise and training in the law who can provide expertise to both the healthcare and legal professions. The LNC, under the supervision of an attorney, assists with cases involving healthcare issues, such as medical malpractice, personal injury, product liability or workers' compensation. Activities can include interviewing clients; screening cases for merit; analyzing and summarizing medical records and other evidence; researching and evaluating healthcare literature; assisting in preparation for an evaluation of depositions; identifying, locating, screening and consulting medical experts; and preparing exhibits for settlement hearings or trials. LNC's also can be called upon as expert witnesses.

The new program, a first in New Hampshire, will use the combined resources of the NHTI Paralegal program and the Center for Nursing Professional Development. The certificate, awarded by the American Association of Legal Nurse Consultants, is approved and recognized by the American Bar Association. For more information contact NHTI's Paralegal Studies Department at (603) 271-7104.

New Hampshire Nurse Focuses on ED Psychiatric Patients

Sara Barr Gilbert, RN, CEN, MACP, SANE-A

When I attended my first national emergency nurses' conference in 2008, I was hoping to learn how other ED nurses managed psychiatric patients. I spoke to a nurse from the Midwest who told me that suicidal patients were allowed to smoke outside, unattended. A Florida nurse worked in a department in which psychiatric patients were routinely denied meals, in an attempt to dissuade them from returning. Another nurse complained that there were "sixteen suicidal patients being boarded" in her emergency department when she left for the conference. "What do I do if they are still there when I get back?" she asked.

Having spent the first half of my career working in the mental health field, I came home from Minneapolis knowing I'd like to educate my fellow nurses about managing psychiatric patients. I thought that "strategies" being used to manage this population were extreme: lenient and punitive, with no clear understanding of underlying diagnoses or symptoms. Patients were not being routinely reassessed for suicidality, anxiety and agitation. In many cases, a "hands off" approach was taken unless the patient became aggressive. Without an understanding of psychiatric diagnosis, it is very easy to escalate an anxious patient to the point of aggression, putting staff and themselves at risk of injury.

The message I wanted to convey to ED nurses was that psychiatric patients do not need to be "fixed." As nurses, we are inherent "fixers" and we become frustrated when patients engage in behaviors that are unhealthy. However, psychiatric patients often have chronic mental health illnesses that cannot be resolved during an ED visit. Instead, we need to be focusing on managing the symptoms of an acute exacerbation of their illness–much the same as we do for medical patients.

When a patient presents with an exacerbation of COPD, we assess, intervene and then evaluate our intervention. If the patient's condition deteriorates as a result of our intervention, we use a different approach. However, when we intervene with psychiatric patients, we seldom evaluate the effectiveness of the strategy. If the patient deteriorates, e.g. behavioral symptoms worsen, we tend to blame the patient–and continue to use the same strategy.

It is not only ED nurses that struggle with this population. Med-surg nurses often confront patients with chronic, co-morbid psychiatric issues that complicate treatment. In some cases, patients develop symptoms of mental health issues (e.g. depression, anxiety) while hospitalized after a traumatic injury or life-threatening illness. Without an understanding of psychiatric diagnoses, staff may inadvertently minimize the impact mental health issues have on medical illness.

Medical illnesses and mental health issues are similar to the "heart and lungs." Although they are distinct entities, the function–or dysfunction–of either will inevitably affect the other. As mental health resources dwindle, medical providers need to become smarter about identifying, assessing and managing psychiatric issues to prevent relapse of medical issues, noncompliance and readmissions. Also, the Joint Commission has recently advised hospitals of the need to provide more effective assessment of medical patients who may be at risk of suicide.

Since 2008, I have been actively involved in educating medical care givers about the care psychiatric patients receive. The information has been well-received by ED nurses, clinic staff, acute care nurses and EMS personnel. Implementation is fairly simple, and the strategies are effective in managing the symptoms of acute exacerbations of psychiatric illness. Dartmouth-Hitchcock Clinic-Keene has developed a mental health competency for its staff, based on my article from *Advanced Emergency Nursing Journal,* **Psychiatric Crash Cart: Treatment Strategies for the Emergency Department** (2009). I am excited to be presenting at two national conferences this fall for the Emergency Nurses Association and the American Psychiatric Nurses Association. I am fortunate to be on St. Anselm's continuing education schedule for November, with a lecture geared towards managing medical/psychiatric patients.

It's been rewarding to see changes in the management techniques used by nurses when working with this venerable population. The strategies are simple, effective and therapeutic. Initial assessment, symptom management and monitoring are critical in order for mental health disorders, as well as medical illnesses, to be successfully treated.

Perinatal Nurses Offer Free Continuing Education

Nurses can update their knowledge of the complications of pregnancy, neonatal care, pediatrics and sexually transmitted diseases by accessing the March of Dimes website. The site lists over 15 focused modules providing continuing education for perinatal nurses. The newest module provides a sound foundation of knowledge and understanding for nurses who work with bereaved families. "The goal is that that all families who experience the tragedy of losing a baby are cared for sensitively and expertly by a professional nurse who understands," said Denise Côté-Arsenault, PhD, RNC, FNAP, author of the course material.

The March of Dimes has CE provider status through the New York State Nurses Association with certificates provided upon completion. For more information:

http://www.marchofdimes.com/professionals/education.html

Saint Anselm Opens New Program

Saint Anselm College Department of Nursing has announced that 12 students have been admitted to their new RN-to-BSN program. Using a hybrid model, classes are delivered partially online and partially on campus. Face to face meetings are held twice per course with the remainder of the program online. RNs with associate degrees in nursing who would like to complete their BSN degree can attend full or part time. Depending on prior course work, those who attend full-time can complete the program in 18 months. Call Rosemary Theroux, PhD, Program Director, at 603-641-7334 for information.

Students Attend Health Camp

Memorial Hospital nurses, **Shauna Ross,** MSN, CMSRN, and **Val Skolnick**, RN, demonstrate the technique of "orange injection" as seventh and eighth grade students observe, during the 8th Annual Health Camp coordinated by the Mt. Washington Valley Career to School Partnership. The weeklong activities were coordinated by **Marta Ramsey**, RN, of The Memorial Hospital. Students learned to draw blood, perform EKGs, BCLS, and watching their own wrist placed in a cast, and were then invited to eat pizza. Also participating in the educational activities were White Mountain Community College, North Conway Ambulance Services, Saco River Medical Group, SOLO Wilderness Medicine, Mineral Springs Care and Rehabilitation Center, and Conway Village Fire Department.

During Health Camp week, campers practice injecting oranges under direction of Shauna Ross, MSN, CMSRN, and Val Skolnick, RN.

Depression in Home Healthcare Patients A Public Health Problem

Janet E. Smith, MBA, MSN, RN
Instructor, LaSalle University School of Nursing and Health Sciences, Philadelphia, PA
Hospice/Palliative Care Nurse, Moorestown Visiting Nurse Association, Moorestown, NJ

Introduction
Depression is a public health problem for home healthcare patients. It is estimated that 13.5% of newly admitted home healthcare patients meet the criteria for Major Depressive Disorder and of those only 22% are treated (National Institutes of Mental Health, 2010). Although depression is a treatable condition, the failure to recognize and treat it leads to greater morbidity and mortality physically and psychologically (Brown, Raue, Roos, Sheeran, & Bruce, 2010). Home healthcare nurses may often disregard a patient's symptoms of depression, either because of time constraints or because of lack of education on appropriate assessment and interventions. A quote from a home healthcare nurse participant in a research study exemplifies this.

"I saw her eight times while she was on service before she committed suicide. She was such a sweet, nice lady; but she was depressed. It was evident each time I visited and it seemed to get worse. And it seemed she had dementia. The aides all commented about it. I talked to her; tried to joke while I was dealing with her diabetes and wound care. It didn't work. We didn't do anything for her depression. We did not assess or treat it. It was as though it became hidden behind a veil; hidden by our focus on her physical disease…" (Cabin, 2009, p. 171).

This article addresses assessment of depression in home healthcare patients, use of the Outcome Assessment and Information Set-C (OASIS-C) and education of home healthcare clinicians.

Assessment for Depression
Since most patients receiving home healthcare are homebound, they are frequently dependent on healthcare providers who come to their home. Often, healthcare providers, families and even patients believe that depression is part of aging and results from the many losses of older adulthood, such as deaths, decreased functionality or moving to a new living situation. Therefore, it is important that healthcare providers are educated about depression as a treatable medical illness (Arean & Cook, 2002; Brown, Raue, Roos, Sheeran, & Bruce, 2010). Two of the roles of the home healthcare nurse are assessment and early intervention to prevent complications. Assessment of mental status and symptoms of depression are equally important as this is correct assessment of physical health symptoms. Researchers surveying and observing home healthcare nurses on field visits (Brown, Raue, Roos, Sheeran, & Bruce, 2010) found a need for education on depression recognition and assessment instruments. Additionally, they observed that nurses often relied on observational skills, rather than direct questioning to assess depression. Nurses also expressed concern about their ability to assess suicidal ideation. While observational skills can serve the nurse well in other areas of home assessment, direct questioning is necessary to assess evidence of depression and suicidality. Brown, Raue, Roos, Sheeran, and Bruce (2010) provided two educational sessions to home healthcare agencies on assessment of depression and suicide. Following the educational sessions, nurses in the education group were more confident of their assessment abilities, as compared to a matched control group.

Outcomes and Assessment Information Set-C
With the onset of use of Outcomes and Assessment Information Set-C (OASIS-C) in January, 2010, Medicare gave credence to the importance of assessing for depression. All Medicare-certified home health agencies are required to use this assessment instrument at the start of care and resumption of care (home care resumed after a hospital stay). One of the new areas included in OASIS-C (CMS, 2010) is the requirement that patients be screened for depression using a standardized screening tool. The instrument specified, although not required to be used, is the Patient Health Questionnaire (PHQ)-2. The PHQ-2 is a two question, well researched screening tool for geriatric depression (Corson, Gerrity & Dobscha, 2004; Lowe, Kroenke, & Grafe, 2005; Li, Friedman, Conwell & Fiscella, 2007), intended for use in primary care offices.

The PHQ-2 includes the two "gateway" symptoms of depression delineated in the Diagnostic and Statistical Manual IV TR (American Psychiatric Association, 2000). These are depressed mood and decreased interest in all or almost all activities. At least one of these symptoms must be present to meet diagnostic criteria for major depressive disorder (American Psychiatric Association, 2000). If either is present, then the second question (CMS, 2010) on the PHQ-2 about the number of days in the past two weeks that symptoms were present is posed (0-1 day, 2-6 days, 7-11 days or 12-14days). The total possible score for the PHQ-2 is 0 to 6 based on the number of days each symptom is present. The score is 1 if present for 2 to 6 days; score is 2 if present for 7 to 11 days and score is 3 if present for 12 to 14 days out of the last two weeks (Sheeran, Reilly & Raue, 2010).

Since the PHQ-2 was designed and investigated for use in primary care practices, research is needed on the effectiveness of use in the home care setting. In primary care a score of 3 identified 87% of depressed patients (Lowe, Kroenke, & Grafe, 2005; Li, Friedman, Conwell & Fiscella, 2007). Sheeran, Reilly and Raue (2010) recommend that home healthcare patients with a score of 3 are referred for further evaluation. However, each home health agency may have to determine the appropriate cutoff score and agency policy for referral. Agencies employing or contracting with a psychiatric nurse or psychiatric advanced practice nurse will be able to further assess these patients at home as part of the home health plan of care.

Conclusion
Depression in home healthcare patients is a serious issue, and one that is treatable. Once educated, home healthcare clinicians are in an excellent position to assess for and recognize symptoms of depression. The OASIS-C is a helpful screening instrument to assist clinicians to assess for symptoms of depression. It is important that the assessment is utilized to dialogue with the primary care provider to develop the plan of care that is most beneficial to the physical and mental health of the patient.

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Walker Retires as Board of Nursing Exec


Margaret Walker

Dr. Margaret Walker retired from the Board of Nursing effective July 1, 2011. Walker had served as the Executive Director of the Board and the "face and voice" of the regulatory agency for 8 years. As the Executive Director she was responsible for overseeing the daily operations of the Board staff including licensure and educational program approval for RNs, APRNs, LPNs, and LNAs. The programs implemented by Walker forever changed the practice of nursing in New Hampshire. During her tenure the State engaged in the Interstate Compact, allowing New Hampshire licensed nurses to practice in over 20 other states without a reciprocity application. Background checks of new licensees were initiated. The Nurse Practice Act was revised and the Joint Practice Council dissolved. Walker was responsible for stewarding the successful medication nurse certification program for LNAs and was a strong advocate of continuing LNA education. "Days of Discussion" became a way the volunteer Board of Directors heard constituents. Walker handled sensitive difficulties with aplomb including the forced closure of two nursing programs in the state. With Walker's leadership "teach-outs" were coordinated allowing students to complete their education. Walker was frequently found in the legislative office building providing testimony on nursing and health related issues.

When she accepted the Executive Director position in 2003, Walker was no stranger to New Hampshire nursing. After receiving her LPN education at the Technical College in Portsmouth, Walker returned to school within 2 years and obtained her associate's degree from the New Hampshire Technical Institute in Concord. Within 5 years she was back in school and completed the RN to BS program at the University of New Hampshire. During these early years Walker practiced as the Director of Nursing for NH Kidney Center and Seacoast Dialysis. Her interest in management prompted her return to school once again to Plymouth State College where she received her Master's in Business Administration. Four educational institutions in New Hampshire can claim Walker as an alumnus! For the next three years she served as the Director of the McKerley Healthcare Center in Bedford. While at McKerley she took on oversight of nursing assistant education. In 1991 Walker became a state employee and provided oversight and monitoring of regulatory compliance of providers receiving Medicare/Medicaid benefits in New Hampshire. She joined the Board of Nursing in 1999 as a Program Specialist over nursing assistant licensure. When she accepted the Executive Director position of the Board of Nursing, Walker again returned to school, and completed her Ed.D. from the University of Phoenix in 2007.

Walker's resignation, while a surprise to many, was due in part to changes in the NH retirement system enacted by the Legislature this year. However, Walker is not rocking on her front porch and knitting sweaters quite yet. After a month without an Executive Director, and only one nurse on the Board's staff, Walker was appointed to an "Interim Director" part-time position as a search for a new executive director is undertaken. The new director will have big shoes to fill.

Nurses Part of Award Winning Teams

Cheshire Medical Center / Dartmouth-Hitchcock Keene recently presented the 2011 Annual Chairman's Awards to two teams involved in continuous quality improvement work: the Centering Pregnancy and the IntelliDose implementation teams.

The Centering Pregnancy model of prenatal care includes healthcare assessment, education and support, provided in a group setting, and facilitated by a credentialed healthcare provider and co-facilitator. The Centering Pregnancy team identified the model of care and developed the program. Members of the Centering Pregnancy team recognized were: Jessica Densmore, RN, CNM; Linda Hakala, RN; Amanda Houle, PsyD; Rebecca Pratt, RN; and Felicia Robinson, RN, CNM.

IntelliDose, a computer-based physician order entry system used to manage medical records for oncology patients, focuses on the specific details of drug administration and tracking, and other physician-ordered medications and testing. Research shows that the IntelliDose online system supports patient safety by providing physicians and other care providers with quick access to up-to-date patient information.

Members of the IntelliDose team are: Steve Larmon, MD; Peter Malloy; Denis Fortier, RPh; Patrick Skeffington, PharmD, MS; John Genovese, RPh; Jennifer Michelson, RN, BSN; Beverly Griffin, RN, ONS; Sarah Whicker, RN, ONS; Sara Sargent, RN; Val Collins, RN; Kevin Forrest; Bob Meyer; Ray Howland; Tim Ahern; Steve Fisher; Cindy Dotlich; Marie Young; Scott Wyman; and Lyn Elkind.

IntelliDose Team, L to R: Jennifer Michelson, Tim Ahern, Marie Young, Sarah Whicker, Peter Malloy, Sara Sargent, Steve Fisher, Val Collins, Beverly Griffin RN ONS, Lyn Elkind, and Steve Larmon

Centering Pregnancy Team, L to R: Jessica Densmore CNM, Rebecca Pratt RN, Felicia Robinson RN, CNM, Linda Hakala RN, and Amanda Houle

SNHMC Re-designated a Magnet Facility

The nursing staff of Southern New Hampshire Medical Center (SNHMC) was delighted to receive a call from Lois Kercher, PhD, RN, a member of the Executive Committee of the American Nurses Credentialing Center (ANCC) Magnet Commission on August 16. As Kercher announced the Commission had voted unanimously to re-designate SNHMC as a Magnet facility, cheers and clapping drowned her congratulatory remarks. SNHMC's re-designation places it among only 382 US hospitals allowed to put the elite Magnet logo on the website.

The Magnet Recognition Program was developed by the American Nurses Credentialing Center (ANCC) to recognize health care organizations that provide nursing excellence. The program also provides a vehicle for disseminating successful nursing practices and strategies.

SNHMC submitted a 400 page re-designation application on October 1, 2010. Three nurse appraisers completed a site visit to the facility from June 15 thru 17th, 2011 to clarify, verify and amplify the information in the application. The documentation and appraisers report was voted on by the members of the ANCC Magnet Commission.

In informing the SNHMC staff of the positive findings of the Commission and bestowing Magnet status Dr. Kercher noted that there were only three Magnet facilities in New Hampshire. However SNHMC was the first to achieve re-designation under new standards established by ANCC in 2010. There was agreement in the crowd when Kercher quipped that Magnet re-designation was even more challenging to obtain with the new standards than the initial designation as intense scrutiny is placed on quality outcomes, evidence based practice, innovation and interdisciplinary care.

In thanking the ANCC, Vice-President of Patient Services, Colette Tilton, RN APRN noted that the effort to achieve re-designation was a system wide effort to achieve the level of excellence necessary to retain the prestigious designation.

Attention NHNA Members: Call For Scholarship Applications

NHNA is committed to supporting the educational advancement of nurses in New Hampshire. This year we are offering three, $1,000 scholarships to NHNA members enrolled in degree programs to continue their nursing education.

One award each will be available to an RN pursuing a Bachelor's /BSN; one pursuing a Master's in nursing, and one working toward a PhD or DNP.

Interested candidates should **download the application** form from our website and submit along with a 500 word essay on their educational goals and why they are deserving of the award; current resume; proof of acceptance into an accredited degree program, and an endorsement letter from a peer or faculty member.

Submission deadline: November 10, 2011 to be reviewed by our Nursing Practice Commission during November and awarded in December to the applicants selected.

Mail to NHNA 210 N. State St. 1-A, Concord, NH 03301; email to office@nhnurses.org, or fax to 603-228-6672.

50 States United for Healthy Air – A Broad Perspective on Protecting Health

Editor's Note: Kathleen Craig, RN, MSN attended ANA Environmental Lobby Days in May as a representative of NHNA. Kathy is the director of the Birthing Pavilion at DHMC and an NHNA member. Her report of the activities follows.

Washington, D.C. Doctors, nurses, tribal leaders, clergy, social justice advocates, and community leaders from all 50 states convened in Washington, D.C. May 2-4, 2011 to meet with Obama administration officials and lobby legislators on Capitol Hill. The message was very simple: All Americans have a right to breathe clean, healthy air. More than 150 individuals lobbied in response to changes being considered to a wide range of health protection standards by the U.S. Environmental Protection Agency (EPA).

Citizens across the country are routinely exposed to harmful levels of toxic air pollution from industrial sources such as power plants, cement plants, and incinerators. This pollution robs people in affected communities of their lives, their health, and their ability to raise their children safely. May is recognized as "National Asthma and Allergy Awareness Month," so it was opportune time for groups with an interest in promoting population and environmental health to converge in response to political pressures to eliminate current protections offered by the Clean Air Act.

Calling themselves *50 States United for Healthy Air,* the group included representatives from the American Nurses Association, Earthjustice, the Hip Hop Caucus, Interfaith Power & Light, National Council of Churches, and Physicians for Social Responsibility. Members of the group focused discussion on crucial health protections that are currently under attack by well-financed industry groups, including:

- A proposal in March that set the first ever federal regulations on mercury and other toxic air pollution from power plants;
- Strong, health-based protections for cement plant pollution, finalized in August 2010, saving an estimated 2,500 lives every year;
- A proposal to regulate harmful coal ash dumps and landfills;
- A rule finalized in February that limits toxic air pollution from thousands of boilers and incinerators located in communities across the country;
- A January 2010 standard that is anticipated to be final by July that would limit ozone pollution–commonly referred to as smog–in cities and towns across the country.

Despite the demonstrated benefits of these health protections–tens of thousands of lives saved every year, major reductions in asthma, heart disease, respiratory ailments, cancer and other illnesses, and billions of dollars in healthcare savings for the American public–industrial polluters are influencing Congress to delay or even block these health protections from taking effect.

"From its earliest days, the nursing profession has understood the importance of a clean, healthy environment to human health," remarked ANA President Karen A. Daley, PhD, MPH, RN, FAAN. "After all, it was Florence Nightingale who established as the first rule of nursing, 'Keep the air within as pure as the air without.' The purity and safety of our air in many communities is at risk. Mounting scientific evidence indicates that the human body is becoming a reservoir for the toxic chemicals found in the air, water, food, household products, and even in products commonly used in the provision of health care. That is why ANA is proud to help convene the 50 States for Healthy Air, to protect our environment, and its impact on human health."

The three day event included training for effective lobbying, individual meetings with representatives and Capitol Hill staffers, including Charlie Bass, round table discussion with members of President's Obama's administration, and a meeting with Lisa Jackson, head of the EPA. Participants presented case studies and asked the federal government to continue to protect individuals and communities from health effects of pollution by legislating for the future.

The Legislative Year in Review

The Title "Nurse" Means Something in NH Thanks to Your Nursing Association
Judith Joy, RN, PhD
Chairperson, Government Affairs Commission, NHNA

The Government Affairs Commission (GAC) of the NH Nurses' Association (NHNA) has had an incredibly busy year because of and perhaps in spite of the intense focus on the financial crisis and budgetary issues. Early in the legislative year election results revealed that the budget was going to be forged on the basis of cutting spending (no new taxes??–question marks explained later) and that many of the legislators elected to shape our State's fiscal future were novices with a platform of conservative to reactionary values. Reactionary would seem an extreme statement were it not for the NHNA Policy Day meeting with a legislator who pronounced licensure of nurses an unnecessary invasion of the State into our personal business. More later.

The financial crisis that we are all experiencing was, in part, a cause of a significant win for the nurses of NH. The health care community has often used less expensive providers in certain roles. Considering cost of care is a reasonable objective that we should all support unless it threatens the quality and safety of care. Earlier articles in Nursing News detailed how your Association uncovered issues related to the use of the title nurse when the worker was not, in fact, a nurse. As a result the **NHNA, through legislators supportive of nursing, advanced legislation to protect the title "nurse" and Senate Bill 53 became law this June**. Health care workers who are not prepared according to standards set to protect the public (and the reputation of nursing as a profession) can no longer call themselves nurses nor can they be called nurses by their employers.

Directly related to the NH State government budget crisis were actions taken by the State to reduce the cost of operating state agencies, i.e., the Board of Nursing (BON). As you may know, and is detailed further in this newsletter, the NH BON is self supporting by state law: It is required to levy fees to support its operation. In spite of this detail the State required the BON to reduce staff by four positions as a cost saving measure. The NHNA challenged this action directly with state authorities but were not able to prevent the staffing cuts. The NHNA responded by requesting and receiving a letter from the BON detailing the impact of those budget cuts.

As Dr. Susan Fetzer makes clear in her article elsewhere in this newsletter, this action by the State of NH amounts to a special new tax on NH nurses which we cannot permit. As a result, the NHNA has requested that the BON undertake rulemaking, an action that is within the authority of the BON, to reduce licensure fees for NH nurses to no more than the required 125% of the operating cost of the BON. To be clear, the NHNA wishes to support the BON in its efforts to maintain full and effective discharge of its duties. We prefer that the State of NH restore the budget and staff of the BON to its previous level and we continue to work with the BON and our resources to achieve that goal. In the meantime we will take actions necessary to protect the nurses of NH from shouldering the burden of NH State government unfairly.

Although these were the big issues we addressed this legislative year, they were not our only activities. The GAC begins each year with a Town Hall meeting where issues of concern for nurses are raised. We continue, as bills are introduced, by ranking bills to efficiently focus our efforts. The following is a summary of other significant legislative issues we addressed on your behalf this year.

- **HB 1 & 2 The Budget**–In addition to the BON issue, the NHNA released a position statement regarding the adverse impact of this budget on behalf of the membership that was published in major NH newspapers.

- **HB 58–Inter-facility transfers of critical access hospital patients with a single provider.** The NHNA successfully supported various specialty nursing groups in this legislation. It repeals an allowance for certain providers (MD, RN or PA) to ride alone in the back of an ambulance while transporting a critically ill patient. After much discussion, the NH Hospital Association, the Emergency Nurses' Association, NHNA and the NH Department of Safety, (Division of Fire Standards and Training, Emergency Planning Medical Services) came together and agreed that having only one clinician in the back of the ambulance was unsafe practice for the patient, the clinician and the hospital, especially considering current emergency law requires two paramedics be in the back of an ambulance with a critically ill patient.

- **HB 71–Drug take back programs.** The NHNA successfully supported this effort toward uniform and safe disposal of drugs to increase community safety. This bill allows New Hampshire communities and private entities in conjunction with law enforcement officers to establish controlled and non-controlled pharmaceutical drug take-back programs for disposal. (See announcement elsewhere in this edition for an October initiative in NH).

- **HB 93–Crossbow documentation by nurse practitioner.** The NHNA successfully supported the NH Nurse Practitioner Association in this effort that adds an advanced practice registered nurse to the persons who may complete the medical documentation for a person with a disability applying for a crossbow permit with the fish and game department. As more NP-led primary care practices are established, it is important that our laws and regulations grant practice authority to the fullest extent of the APRN scope of practice.

- **HB 156–Reducing Tobacco Tax.** The NHNA successfully opposed passage of this bill. Encouraging smoking by reducing the price of tobacco products is not beneficial for the health of NH residents. This bill was another element suggesting radical conservative values that appear to ignore long-term consequences of legislative actions.

- **HB 163–Establishing a medical sharps advisory council.** Although this legislation was not passed, it was a successful effort. Health and Human Services oversight voluntarily agreed to establish this council. The NHNA will continue to monitor to insure that nurses are represented as planned.

- **House Bill 191–Outcome measures in mental health.** NHNA successfully supported this bill that implements recommendations of the Office of Legislative Budget Assistant's audit of the NH community health system. It clarifies eligibility and requires all state contracts to have outcome measures. It also addresses the growing problem of uncompensated care delivered to individuals who present for mental health service by clarifying that clinical interventions cannot be denied but enables the agencies to prioritize care for this group of clients based on a thorough clinical assessment. This enables community mental health agencies to stretch their increasingly scarce resources a bit further while providing care to needy individuals.

- **House Bill 199–Amends RDA 519-B:4,11 facilitating process of medical screening panels. Retained in House Judiciary Committee.** NHNA was unsuccessful in supporting this legislation to passage but is hopeful for future passage when reported out of the Judiciary Committee. NHNA supported development of medical screening panels in NH. The panels were developed in the 1970's in response to claims driving insurance costs up. Panels-comprised of a retired judge or person with judicial experience, health care provider and an attorney were impaneled to weed out weak suits. Medical screening panels have been an effective deterrent to lawsuits without merit (which have had the effect of increasing insurance costs). They have been criticized for requiring too much preparation and therefore deterring suits that may have merit but are brought by claimants without financial means. This legislation may streamline the process.

- **HB 422–Prohibiting vaccinations in public schools.** The NHNA joined the NH School Nurses Association in successfully opposing this bill. Currently vaccination clinics in schools are strictly on a voluntary basis.

Looking at movies from...

Outside the Popcorn Box

I Am Because We Are (2008)

Reviewer: Sandra McBournie, RN, MEd. is the Program Coordinator for the Center for Nursing Professional Development and Faculty member at NHTI, a member of the NHNA Commission on Continuing Education, and movie lover. Movies reviewed in this column are considered with enhancement of the nursing profession and practice in mind–and a little bit of thinking "outside the box." For more reviews by Sandra or to comment: www.outsidethepopcornbox.blogspot.com

The question for the cynic is why not? If you are an international celebrity and entertainer like Madonna, why not make a documentary film about your interest in helping a suffering African country after some tabloid controversy about your private adoption? *Why not* try to change a perhaps cemented image (remember the Girlie Show World Tour days?) with a show of compassion and caring while the camera spotlights a sick African infant dying in your arms? *Why not* use your celebrity influence to turn heads, and hopefully dollars, towards a million or so orphans? The answer is beautifully depicted in **"I Am Because We Are."**

You become weary about the entertainer's motives when the self-narrated film starts out with too many sentences beginning with "I." Realizing after all she is not just the narrator but the writer and producer, but for once not the star, she does answer some questions posed by the tabloids that her fans (myself included) may have been wondering about. Such as: *"Why Malawi?–Why now?"* But for those answers you will have to watch it yourself. This documentary is not about Madonna, and nor shall this review be.

The film spotlights the sub-Saharan country of Malawi–one of the poorest nations in the world with a population of about 12 million, where more than one-twelfth of its citizens are orphaned children who lost their parents to AIDS. In exploring the impact of such a large number of parentless children, heart-wrenching personal stories of loss are revealed. Stories are complete with names of victims; pictures and video of overflowing orphanages, hospitals and juvenile prisons that go on like an extended *Save the Children* ad. Your attention is starting to wane when applicable words of wisdom from well-known experts in their field are interjected. Nobel Prize Laureate Archbishop Desmond Tutu says "You don't have to be rich to be good, generous and compassionate," and from President Bill Clinton: "What we have in common is as important as our interesting differences."

I appreciated the inclusion of the tumultuous history of Malawi (independent from Britain since 1964 followed by a dictatorship) as an answer to the question–*"How did they get this way?"* The complex answer to *"Why is it staying this way?"*–comes in vignettes on extreme poverty, hunger, corruption, violence, lack of education, destructive spiritual rituals, superstition, genital mutilation and a general lack of hope. It would be interesting to watch this film and count just how many times the word *desperate* is used.

It feels like the filmmakers are ultimately hoping that the viewer will take a look in the mirror, asserting that all people "want to cling to what is familiar even though they know it is holding them back," and that this cycle of behavior is embedded in citizens not just in Malawi, but around the world. To prove their point, we see visual global images of war, vicious religious ritual, drug use and more. With this premise, the film moves beyond pulling heartstrings and into pushing buttons. And, having one's buttons pushed is what turns audiences on, provokes thought and action. Bingo-they did it!

So the film starts as a story about the AIDS / orphan epidemic in Malawi and ends as a story about world problems and world solutions. By looking at the globe through the lens of Malawi, the viewer realizes that the film's over arching message of *hope and determination* is contagious. In seeing, caring about, and helping Malawi, we may just help ourselves. Only the creative genius of a person like Madonna could spin that so poignantly.

I recommend this film to healthcare providers not just because the cinematography alone is stunning, but for those that have a global and humanitarian interest, it does communicate many of society's most challenging issues. I recommend it to all others simply for its look in the mirror philosophy and the potential as a proper remedy for any problem, not just in Malawi but in any country, city, home, or hospital room.

Reviewer Rating: 3.5 out of 5 Boxes of Popcorn
Written, produced and narrated by: Madonna
Directed by: Nathan Rissman
Available: Entire film can be watched on Hulu and You Tube, also available on DVD

"Because You Should... It's for Your Own Good."

Anne Howe, RN, BSN,MSN, RN-BC
Director of Nursing, NH Veteran's Home
NHNA Director at Large

I used to recoil at those words. They seem to be the words of my mother and the collective wisdom of mothers everywhere throughout time. Ironically, as much as I bristle internally when I hear these words, in many instances, I have come to listen and take action.

I remember my mother always saying, "you should eat vegetables" and "you should get eight hours of sleep–preferably at least two before midnight" …"it's for your own good"… Turns out that these "shoulds" really are "for my own good"–as validated by scientific evidence. I eat lots of vegetables and I get a good night's sleep most nights.

Recently at our monthly Board meeting for New Hampshire Nurses' Association (NHNA), we were each asked to share the main reason we joined our State's nursing organization. Several of us rather sheepishly admitted, "because you should." We were somewhat embarrassed by this intuitive gut reaction rather than a thoughtful articulate answer.

Upon reflection, I "should" belong to NHNA because all nurses are leaders and, as a good leader, I need to stay informed of pertinent professional issues. *And supporting NHNA truly IS "for my own good"–in many direct and indirect ways.*

NHNA informs me about the future of nursing and the recommendations of the Institute of Medicine (IOM) report that will affect me both as a nurse and a consumer of health care. NHNA's quarterly publication, *New Hampshire Nursing News*, quickly summarizes the current issues in the state. It is a trusted source for bringing awareness of pending legislation and national initiatives that will affect my nursing practice in New Hampshire. It offers clinical research I might not see elsewhere; shares viewpoints that get me thinking, and recognizes the accomplishments of nursing colleagues around the state.

As an ANA-NHNA member I also get lots of emailed information between Nursing News issues. *The optional ANA 'Smart Briefs' system in particular, scans all US publications for nursing related news; provides a synopsis and links to the full stories.*

Just one of the many tangible benefits with full ANA-NHNA membership is a significant discount on ANCC certification and recertification. Actively volunteering two years of service to NHNA during a certification period fulfills one category of your Professional Development requirement. Accepted volunteer activities include board of directors, committees, editorial boards, review boards and task forces. NHNA provides many opportunities for this type of service which requires your specialty expertise! *(See our Call for Nominations in this issue).*

NHNA's Commission on Government Affairs is a dedicated group working *"for my own good"* by bird dogging legislation and providing advocacy and voice for me. (See their legislative summary in this issue).

Our Commission on Nursing Practice is diligently focused on issues *"for my own good"*–that affect workplace practice (currently nurse delegation to medical assistants) and the educational advancement of nurses to keep pace with 'Future of Nursing' goals.

The hard working volunteers of NHNA's Commission on Continuing Education review and approve a large percentage of the CE provided in our state–by large hospital entities or individuals–ensuring compliance with ANCC guidelines for quality education–*"for my own good."*

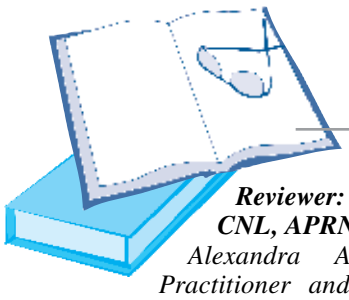
Our Organizational & Membership Affairs Commission, along with NHNA staff, creates our own programs and events to provide quality educational and networking experiences. In striving to reach more NH nurses and increase statewide interaction, they have begun to utilize videoconference technology at convenient regional locations. In the coming year they plan to add a variety of webinar programs–also *"for my own good."*

The NHNA Board itself, which directs the organizational mission and therefore oversees the aforementioned work groups, is constantly looking out for the good of all NH nurses. *We've considered going with the slogan:* ***"we've got your back"****–which is used by some other state nursing associations.*

Being a nurse is a source of personal pride to me. ANA and its' state level constituents–including NHNA–have helped our profession to evolve into the number one most trusted profession by the public; they impact our work practices and standards.

NHNA provides an opportunity for me to give back to the profession I love.

When YOU become a member, you will be supporting the profession and fulfilling your obligation of all nurses to be represented and informed–*because you should… and it IS for your own good.*



On the Bookshelf

Reviewer: Alex Armitage, MSc., CNL, APRN

Alexandra Armitage is a Nurse Practitioner and Clinical Nurse Leader who has specializing in bringing evidence-based practice to the bedside to improve patient care, patient outcomes and institutional viability. Alex has spent time both in Africa and in Taiwan, nursing across cultural barriers and understanding role of societal perceptions in healthcare.

The Nurse's Social Media Advantage–Robert Frasier, Sigma Theta Tau International (2011)
Paperback, 225 pages

I like this book. I like this book because it has information which is actually useful.

The Nurse's Social Media Advantage is a small book which is very well written and very well organized. These three factors alone make it attractive as an easy read. I must caution you up front that the layout of the book is black and white type with purple accents and illustrations. The purple accenting makes the book a little quirky, perhaps even chintzy. On reading I realized very quickly how effective the use of the third color, purple, is to making this book understandable and user friendly. Headings are highlighted, tips are clear, and quotes are easy to find. Organization–nice.

In dealing conceptually with the Internet, Mr. Fraser has covered an enormous topic. He focuses the reader on moving from understanding the platform which is being used, to utilizing and ultimately benefiting from this platform. Chapter 1 discusses the Internet and chapter 2 the basics of social media. Not new material for many of us, but very necessary for some. Basics–nice.

Chapter 3 is the common sense chapter outlining some boundaries which will keep you out of trouble. At first I thought that most of this discussion is quite self-evident, but on remembering the numerous incidents of nurses getting themselves into deep trouble on Facebook and other social media platforms, perhaps this is not so obvious after all. Cautionary–nice.

"The Internet is the world's largest library. It's just that all the books are on the floor" John Allen Paulos (p.83). Putting a little time in the trenches working through chapters 4 and 5 allows you to become an expert user. You decide what information you see and how you see it. This reduces the overwhelming quantity of information which is available on-line to something which is both manageable and relevant to your needs. At this point you control the Internet and the Internet does not control you. Expertise–nice.

Now this is where I find that *The Nurse's Social Media Advantage* gets really interesting, moving beyond controlling information streams to becoming part of the information stream. The last five chapters, a good half of the book, become personal. The book diverges from the functional aspect of managing the Internet to showing how a nurse can professionally network, share health information and participate in on-line communities. There are discussions on building an on-line reputation (described as just as important as wearing deodorant) and how to share your personal knowledge and identifying your target audience. The beauty of the Internet is that sharing of information can be as simple as sharing a comment on a topic or it can be exponentially more than that. Nurses are teachers, each of us have skills and life experience that can benefit others. Engaging other nurses and engaging the public in such informative discussions is a core value in nursing practice. Personal, relevant, uplifting–nice.

This is a book that I believe everyone should have on their desk. At the very least it will simplify your daily dealings with the Internet. But it could also allow you to shine through the ether that we are all so desperately connected to each day–the Internet.

Rx Drug Take-Back Initiative

October 29, 2011 10:00 AM-2:00 PM

The DEA has scheduled another National Prescription Drug Take Back Day to provide a venue for persons who want to dispose of unwanted and unused prescription drugs. Events held in Sept. 2010 and April 2011 included **4,000 participating agencies and collected more than 309 tons of pills!**

At press time we do not have the list of NH collection locations. By the time you see this, that information should be posted at: **www.deadiversion.usdoj.gov/drug_disposal/takeback/index.html ***

This initiative addresses a vital public health and safety issue. More than seven million Americans abuse prescription drugs, according to a 2009 national survey on drug use and health by the Substance Abuse and Mental Health Services Administration. Each day, approximately, 2,500 teens use prescription drugs to get high for the first time according to the Partnership for a Drug Free America. Studies show that a majority of abused prescription drugs are obtained from family, friends, and the home medicine cabinet.

Four days after last fall's Take-Back Day, Congress passed legislation amending the Controlled Substances Act to allow the DEA to develop a process for people to safely dispose of their prescription drugs. President Obama signed the Safe and Secure Drug Disposal Act of 2010 last October. Until another process is in place, the DEA will continue to hold Take Back Days every six months.

* For questions contact 628-7411 ext. 171 or 134.

LAST CALL

MED SURG CERTIFICATION PREP
Nov. 5-6, 2011
Concord - NH Hospital

INSTRUCTOR: Karen Tollick RN, BSN, MSN-C

Clinical Development Educator, Southern NH Medical Center

Ms. Tollick has been in nursing for 33 years - in England and the U.S. - gaining a wealth of experience in ICU, PACU, Orthopedics and Emergency medicine. Karen has been educating nurses for 19 of those years in staff development and clinical faculty capacities - including teaching both critical care and MS prep courses at SNHMC. She has also taught for AWHONN, AACN and through St. Anselm's College of Continuing Education.
Karen's teaching style is creative, enlightening and entertaining.
You will leave recharged and ready to be certified!

If you are considering taking the Med-Surg certification exam through either ANCC or AMSN, you'll want to attend this Invaluable session - offered at very special rates!
Also a great intensive for any nurse contemplating a specialty change to Med-Surg.

Fee includes materials; continental breakfast and lunch.

Day 1	Day 2
8:00 A.M TO 4:30 P.M.	**8:00 A.M TO 4:30 P.M.**
Multisystem Issues	Cardiac Issues
Endocrine / GI Issues	Pulmonary Issues
Musculoskelatal Issues	GU / Renal Issues
Neurological Issues	Professional Nursing:
Hematological /	Standards;
Immunological Issues	Legal & Ethical Issues
	Test taking tips

This continuing nursing education activity has been submitted for approval to ANA-MAINE, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
Note: **CNE credit cannot be granted** for those already certified in Med-Surg Nursing or taking this purely as a refresher course.

REGISTER ONLINE AT
www.NHNurses.org or with this form

Name_____
Address_____
City_____ST_____Zip_____
Phone_____
Email_____
Employer _____

[ ] NHNA Member * **$195**
[ ] Non-member **$250**
[ ] Check enclosed for $_____ - or -
[ ] Charge to my : [ ] Visa [ ] MC [ ] Discover
Card #_____
Exp date: _____/_____ Sec. code_____
Signature_____
* Member Number:_____

CANCELLATION POLICY:
Refunds minus **$25 administrative fee** for cancellation after **8/1**
NO REFUNDS FOR CANCELLATION less than 2 weeks prior to a session. Another attendee may be substituted.
NHNA reserves the right to cancel for low enrollment in which case full refunds will be made.

MAIL TO:
NHNA 210 N. State St. Suite 1-A Concord, NH 03301
Credit card registrations may be faxed to: 603-228-6672

WEEKEND IMMERSION in NURSING INFORMATICS
October 29-30, 2011
Catholic Medical Center - Manchester, NH
Registration deadline passed - call about available space.
Details at **www.NHNurses.org** Phone: **603-225-3783**

LAST CALL

Fall Convention & Annual Meeting

Harnessing the Power of Nursing

~ Communicating with Confidence ~

October 26, 2011 8:00-4:30 SERESC * - 29 Commerce Dr. Bedford, NH

ANNUAL MEMBERSHIP MEETING - 8:00 a.m. NHNA members are encouraged to attend even if unable to stay for the conference.

Donna Cardillo, RN is the Career Guru for Nurses. She is the Dear Donna columnist at Nursing Spectrum magazine and the former Healthcare Careers Expert at Monster.com. Donna is also an "Expert Blogger" at DoctorOz.com, the first and only nurse blogging there. She is an author, thought leader, humorist, and legendary cut-up.

KEYNOTE: Nurse Power! ***Communicating Your Value, Promoting Your Worth***

This uplifting program is designed to remind nurses of their own greatness and empower them for future success. It's guaranteed to make nurses feel good and proud about who they are, what they do, and how they contribute to healthcare. Get ready to be pumped up, turned on, and super-charged with Nurse Power! ™

ENDNOTE: Nursing ***- The Future is Ours!***

Nursing and healthcare stand at the precipice of radical change. A unique opportunity presents itself for us to take on a larger and more pivotal role in healthcare beyond anything that most of us could have ever imagined. As this new role takes shape, nurses will need to change their way of seeing themselves, their profession, and their capabilities. It's time to stop whining and start owning our power!

11:00 - 12:15 CONCURRENT SESSION CHOICES

A **DOCUMENTATION and Malpractice Prevention** **Wendy Wright, MS, APRN, FNP, FAANP - Wright & Associates**
Nurses are performing more services and working with more patients. The number of malpractice claims made against health care professionals is on the rise. Healthcare professionals must take all possible steps to avoid being at the receiving end of a malpractice claim; including improved documentation.

B **MEET or TWEET : MULTI GENERATIONAL COMMUNICATIONS** **Paula Johnson, RN, BSN, MPA - Dartmouth Hitchcock**
There is currently a wider age range represented in the workforce than ever before. Learn how these multiple generations working as peers communicate, give and receive feedback, and view work-life balance.

C **NURSING ACROSS CULTURES: Effective Healthcare Communications** **Lynn Clowes, NH Minority Health Coalition**
This workshop will examine health disparities by race, language, and culture; lay out both components of and resources to support effective communication across cultures. Attendees will be encouraged to participate in a lively discussion.

1:15 - 2:30 CONCURRENT SESSION CHOICES

D **CONFIDENT COMMUNICATIONS for Creating Positive Workplaces** **Beth Boynton RN, MS**
Speaking up assertively is essential for providing quality care and having rewarding careers. Yet this requires behavioral changes that are much more complicated than meet the eye. This interactive workshop will explore the practice of assertiveness in the context of real-world nursing challenges.

E **DEALING WITH DIFFICULT PEOPLE** **Jack Agati, Encouraging Concepts Associates**
What do you do when basic 'conflict resolution' efforts are ineffective? Jack presents a two-fold program which provides a practical approach that works!

This continuing nursing education activity was submitted for approval by ANA-MAINE, an accredited approver of the American Nurses Credentialing Center's Commission on Accreditation.

*** Venue directions at: www.SERESC.net/directions.php**

CANCELLATION POLICY: Refunds minus **$25 administrative fee** for cancellation after 9/1 **NO REFUNDS FOR CANCELLATION less than 2 weeks prior to the event. Another attendee may be substituted.**

MANY THANKS to our SILVER SPONSORS:

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WRIGHT **JOHNSON** **CLOWES** **BOYNTON** **AGATI**

CALL 225-3783 IF YOU ARE TRYING TO REGISTER AFTER OCT. 20

NHNA

www.NHNurses.org

REGISTER ONLINE or MAIL THIS FORM to: 210 N. State St. 1-A Concord, NH 03301 FAX 603- 228-6672

Name_____ Phone_____
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[ ] Check enclosed OR : [ ] Charge my : [ ] Visa [ ] MC [ ] Discover
Card #_____
Exp date: _____/_____ Sec. code_____ (3 digits on reverse of card)
Signature_____ Date____/____/____

CONFERENCE - including food & materials

[ ] Member *	$125
[ ] Non-member	$150
[ ] Retiree **OR**	
[ ] FULL TIME Student	$ 75

* Member number _____

CIRCLE CONCURRENT WORKSHOP PREFERENCES:

Block 1: A B C Block 2: D E

[ ] ATTENDING ANNUAL MEMBER MEETING ONLY

NHNA
NEW HAMPSHIRE NURSES ASSOCIATION

ATTENTION: NHNA MEMBERS *and 'NOT YET' MEMBERS...*

Take an active role in shaping your Association!

Run for NHNA Board office or one of our Commissions / Committees!

Election ballot being assembled - deadline Nov. 4, 2011

Complete and submit the **INTENT to SERVE** form at www.nhnurses.org

Call for NOMINATIONS

NOTE: AS VOTED BY MEMBERSHIP LAST YEAR, THE 2011 ELECTION WILL BE CONDUCTED ELECTRONICALLY - MAKE SURE WE HAVE YOUR EMAIL ADDRESS! ***If you are not getting regular email notices, we probably don't.***
Send that to office@nhnurses.org - PAPER BALLOTS AVAILABLE FOR MEMBERS WITHOUT COMPUTER ACCESS

NHNA BOARD of DIRECTORS - establishes policies/ procedures for the transaction of business, coordination of Association activities and operation, and assumes responsibility for fiscal solvency of the organization. Composition of the Board: five officers - President, President Elect, Immediate Past President, Secretary and Treasurer; three Directors at Large (including one 'recent graduate'), plus four Chairs of the Commissions below. On the ballot this year: **President Elect** (commits to assuming President & Past President roles for 1 yr each); **Treasurer;** and 2 **Directors at Large**. Position descriptions available on our website..

CONTINUING EDUCATION Commission: (two year term)

- Administers the peer review process and grants ANCC approval for CE activities submitted by providers.
- Acts as consultant / resource to NHNA members on matters of accreditation, credentialing & standards.
- Enhances the professional development of NH nurses by ensuring the quality of CE activities.

GOVERNMENTAL AFFAIRS Commission: (two year term)

- Serves as the "voice of nursing" when it comes to the NH legislative and health policy arena.
- Conducts an annual Town Hall Forum to help determine focus of legislative efforts for the coming session.
- Conducts annual Health Policy Days to educate nurses students on the NH legislative process and how best to be heard.

NURSING PRACTICE Commission - (two year term) Develops programs & activities related to:

- Educational & delivery systems for practice; economics of practice & health care; rights and responsibilities of nurses
- Promotion of both ANA Standards & Code for nurses
- Develops most 'white papers' and policy statements of the Association.

ORGANIZATIONAL & MEMBERSHIP AFFAIRS Commission (two year term)

- Works to develop and implement activities that promote organizational viability; build membership and expand benefits
  - Subcommittees: **Program Planning** (help to develop CE events, interactive video conferences and webinars); **Bylaws, Finance, and Nominating**

DELEGATES to ANA House of Delegates (Full ANA –NHNA membership required)

- Represents NHNA at the bi-annual national House of Delegates as one of four NH delegates (next HOD - June 2012)
- Studies national agenda issues in advance; caucuses with NH delegation and votes on behalf of NHNA members
- *Four year term allows participation in two 'House' cycles.*

In My Opinion

NHNA is Advocating for the Board of Nursing

Sue Fetzer

Sue Fetzer

My parents had two children; my brother is four years younger. Even though we are from the same gene pool, we couldn't be more different. He is a dirty-blond, blue eyed, tall, Democrat. I am brown haired, brown eyed, a not-so-tall Republican. He loves politics, can strike up a conversation with anyone, anytime, and is fearless when it comes to going places and doing things, often without gas in his truck or a wallet or license in his pocket. I am black and white, prefer the company of friends, and like to plan my day. Although I must admit, on occasion I do travel when the E {empty} light is on in the car. Despite our differences, we have a love of travel, a love of vegetables, and enjoy the freedom of a motorcycle ride. Since we were teenagers, my brother would race dirt motorcycles, and I would pack the lunch, fill the truck with gas, and bring along enough supplies to "patch" him up if he crashed. After all, we are siblings.

In some respects the New Hampshire Nurses Association and the Board of Nursing are siblings, from the same gene pool. The NHNA was organized over a hundred years ago, at the time for the sole purpose of protecting nurses' rights through licensure. The Board of Nursing was the product of those foremothers' efforts. Yet, while created of some of the same nursing "genes," the purpose of the Board of Nursing is to protect the public. As a public entity, it reports to the Department of Health & Human Services of the State of New Hampshire. The Board is a political entity; the Governor appoints and the Executive Committee votes on the members of the Board of Nursing. Conversely, the big sister, NHNA is driven by its membership, both Democrats and Republicans, and perhaps some in the Tea Party.

Like siblings, the NHNA and BON are good friends and allies. The history of the relationship between the BON and the NHNA, *unlike the horror stories of other states,* has been supportive and collegial, advocating when needed for each other's rights. The recent budget cuts and deliberations in the Concord State House have threatened the future of the Board of Nursing. As noted in the summer issue of *Nursing News*, the Board cut four staff positions. In this issue of the *News* you will read the retirement of their Executive Director. It is these actions that stirred the sibling protective ire of NHNA.

The actions taken by NHNA, on behalf of the nurses of New Hampshire, represented a desire to look out for our sister. As a public agency, documents can be requested under the "Freedom of Information Act." In a June 2011 letter, NHNA formally requested the budget figures of the Board of Nursing. The response of the Board is printed here. Clearly, the expense budget of the Board reflects less than half of the collected revenues. The excess revenues, your license fees, have been deposited in the New Hampshire general fund! The epitome of a Nurse Tax! (See In My Opinion, May, 2011) In learning this information, leaders of NHNA spoke of their concerns at the July meeting of the Board of Nursing.

Acting in its capacity to advocate for the nurses of New Hampshire and remove the State's greedy hands from the Board of Nursing's budget, NHNA has sent a formal request to the Board seeking an immediate decrease in licensure fees. A copy of this request is also printed herein. The Board has 30 days to respond to the request, and we are certain they will be prompt.

To an outsider, these actions by NHNA may seem confrontational and adversarial. Be sure they are not. I repeatedly admonish my brother to let me know when he goes out of the country, to wear his helmet, and put gas in the truck. It is done with sisterly concern. As the older sister, NHNA wants a strong Board of Nursing and will be relentless in advocating on the Board's behalf and bequest. After all, we are the family of nursing in New Hampshire.

STATE OF NEW HAMPSHIRE
NEW HAMPSHIRE BOARD OF NURSING
21 S FRUIT ST STE. 16
CONCORD NH 03301-2431

Webpage: http://www.state.nh.us/nursing

TDD Access: Relay NH 1-800-735-2964

Nursing 603-271-2323 **Nurse Asst.** 603-271-6282

June 22, 2011

Robert E. Dunn, Jr.
Devine Millimet Attorneys at Law
43 N. Main Street
Concord, NH 03301

Dear Attorney Dunn,

Pursuant to your request RSA 91-A, the board offers the following answers to your questions:

1. Four part time employees received notice of layoff as their positions were eliminated.

2. The layoffs have impacted the following job descriptions: Assistant Director-Education, Criminal background check clerk, and receptionist. These jobs have been reassigned internally and the impact of the layoff has not been measured to date.

3. The amount of licensure fees collected by the Board of Nursing for Nursing in FY 2011, as of June 22, 2011, is $1,278,871.

4. The total operational costs for Nursing in FY 2011, as of June 22, 2011, are $615,044.

5. The board is reviewing the need to reduce fees and will place this issue on the board's strategic planning session scheduled for September 15, 2011.

6. A copy of the layoff directive is attached as requested.

Please contact the board if you require additional information related to this request.

For the Board,

Margaret J. Walker

Margaret J. Walker, Ed.D., RN
Executive Director

NEW HAMPSHIRE NURSES' ASSOCIATION
210 N. State St. Suite 1-A, Concord, NH 03301
PHONE: (603) 225-3783
FAX: (603) 228-6672
EMAIL: office@nhnurses.org
WEBSITE: www.NHNurses.org

August 31, 2011

NH State Board of Nursing
c/o Margaret J. Walker, Ed.D., RN, Interim Director
21 South Fruit St. – Suite 16
Concord, NH 03301

Dear Dr. Walker,

On behalf of the New Hampshire Nurses' Association and the nurses of our State, we are submitting the enclosed request for rulemaking by the Board of Nursing to reduce current licensing fees.

In delivering this request, we wish to acknowledge the long and collaborative relationship between our organizations, and emphasize that this is done as much in support of the Board as an essential entity, as it is for the nurses of New Hampshire.

We understand, in light of this year's fiscal crisis, the desire on the part of the State of New Hampshire to increase revenue sources by whatever means possible. However, since the Board of Nursing is required by statute to be self-supporting, reducing staff and compromising BON function is not a legitimate means for the state to achieve that purpose. In this case, reduction of Board budget and staff in order to increase the BON contribution to the state's general fund [from 125% of operations to over 200%] - without a commensurate reduction in fees - amounts to a special tax on nurses: a situation which we simply cannot ignore.

Please understand that our sincere preference would be for the State of New Hampshire to restore the BON budget and staff to previous levels. As that does not appear to be an option, the New Hampshire Nurses' Association is pursuing the rulemaking request as a less than desired alternative.

Sincerely,

Anita Pavlidis

Anita Pavlidis, RN, MS
NHNA Board President

New Hampshire's Association for Registered Nurses
Established in 1906
A Constituent Member of the American Nurses Association

Allow Natural Death: Could These Three Words Change the Way We Care for Elders at the End of Life?

Submitted by: Robin Gordon Taft, RN, BS, MS
RG Taft Consulting

As most healthcare professionals on the frontline already know, hospitals have become environments where medical intervention is meted out to those who are elderly and approaching the end of life. The indignities of noxious and often painful treatments such as feeding tubes, catheters, and testing with no therapeutic goal, make comfort impossible. Tremendous suffering accompanies this approach to advanced aging and death. The current medical model denies dignity and peace to those who are trying to die in the setting of rising costs and diminishing resources. Institutions that are expected to prolong life, do so within complex systems that disallow an acknowledgement of the value of those precious last days, weeks, and months of an elderly person's life. There must be a better way to pass through this final stage of life.

With the airing of a Sixty Minutes segment entitled "The Cost of Dying," in November of 2009, the American public is also becoming aware of the cost and suffering attached to death in an acute care setting. Articles appear with increasing frequency in the popular media, emphasizing the high cost of the medicalization of the end of life for our frail elders. Nurses are strategically placed to advocate for patients and families who struggle to understand this clinical approach to their loved ones pending death. The Code of Ethics for Nurses states; "Nurses have invaluable experience, knowledge, and insight into care at the end of life and should be actively involved in related research, education, practice and policy development." Awareness of the use of the Allow Natural Death (AND) designation is one means to improving the care of frail elders at the end of life.

WHAT IS AND?
Allow Natural Death, or AND, is a formal designation that has replaced the DNR (Do Not Resuscitate) order in a growing number of facilities throughout the US. AND is a model of care that acknowledges aging and death as a natural part of life; one that foregoes aggressive technologies that treat aging as if it were a disease necessitating treatment towards cure. The words themselves reflect the intention of allowing a more natural response to approaching death, but there is a much deeper meaning here. AND places the highest value on providing kinder and gentler care to frail elders in the short term– even if it means that life will be shortened when the emphasis is on quality of life rather than quantity.

Frail elders are often found in acute care settings that are designed to administer sophisticated and aggressive care with the goal of healing and prolonging life. This may be inappropriate for those elders moving closer to the time of death. Emergency rooms, hospitals, and nursing homes are not governed by practices that enhance care of the dying. Often clinical practice denies dignity and peace to those who are trying to die while staff is obligated to uphold policies and procedures that must maintain patient safety at all cost. Curative plans of care have, at times, necessitated restraints be used to guarantee the continuation of certain therapies e.g.; IV access, feeding tubes, catheters, etc. By not acknowledging the impending death of these persons we are unable to provide care that brings value to the end of a long life.

WHY NOW?
The Allow Natural Death (AND) designation carries with it the promise of changing the way we care for frail elders at the end of life. There are sufficient drivers of this change to create a sense of urgency for this approach. More individuals are demanding a voice in their own care. Approximately eight in ten persons express a desire to die peacefully and, preferably, at home surrounded by loved ones. Advanced Directives with Living Wills have not afforded sufficient control of the dying process. The numbers of Americans over the age of 85 will triple by 2050 with approximately 20% diagnosed with Alzheimer's Dementia. Resources are insufficient to fill this growing need for complex care. Medicare costs are impossible to sustain at current levels. Bernardine Healy M.D., past CEO of the American Red Cross and head of the National Institute for Health, predicts a "Healthcare Armageddon." Urgency has been established. AND will assist those who seek to diminish reliance on the medical model of healthcare as it seeks instead to promote comfort, dignity and relationship at the end of a long life.

ORIGINS OF AND
The basic concept of allowing natural death is not a new one. (In fact, there was no ability to do otherwise until the advent of antibiotics in the 1930's) Before the widespread use of antibiotics, it was said that "Pneumonia is the old person's friend." Death, in those days, often came to a frail elder at home and within days or weeks of an infection in a body already weakened by years of near normal functioning. Since the 1960's, when life expectancy was only 60 years, Americans continue to live longer and stronger thanks to the growth of medications and treatments that have stretched life expectancy to a current level approaching eighty years.

Adherents to the Hospice philosophy have always advocated the principles of AND without consciously naming them. The founder of the modern day hospice was Dame Cicely Saunders, a nurse and social worker, who was motivated by her own observations of the unfortunate experience of one of her patient's death in a hospital. Today hospice patients will benefit from caregivers who "honor wishes to withhold or withdraw life prolonging treatment…," according to the goals of the National Hospice and Palliative Care Organization.

Many books have been written that expound on the concepts of dying in a more natural way. Scott and Helen Nearing, proponents of a more natural lifestyle, sought a complete divorce from medical management at the time of Scott's death in 1983. They wrote extensively on their pursuit of a simple life and of Scott's purposeful death at the age of 100, following five weeks of self imposed starvation. Numerous authors have been moved to share their insights, after watching the experience of a loved one who has died in hospital. AND's basic tenets are supported by the writings of Ira Byock, past president of the American Academy of Hospice and Palliative Medicine; Stephen Kiernan, VT healthcare author, and Dennis McCollough, medical ethicist. These authors advocate a lessening of medicalization while humanizing and maintaining the dignity of our dying elders.

During the 1990's, The Reverend Chuck Meyer and his successor, Amy Donahue-Adams formalized processes at end of life at Round Rock Medical Center in Texas by introducing the Allow Natural Death order as an alternative to DNR (Do Not Resuscitate). Facilities in Texas, Florida, Minnesota and California have replaced the Do Not Resuscitate (DNR) order with AND, or added AND to the patient's choices for care. Attention to AND is spreading as answers are sought to questions regarding the best use of scarce resources and how care is restricted.

WHAT NEXT?
The change to AND is an opportunity to simplify the language used for planning the end of life. The language of clinical practice is not readily understood by most of those who are expected to share decision making at the best of times, and less so in the midst of a health crisis. The perceived meaning of the DNR has been skewed as Americans maintain inappropriate optimism regarding resuscitation outcomes. Conversely, some families view the DNR concept as condemning their loved one to death. The option to AND necessitates conversation between providers, patients and family members that define desired goals of care at the end of life. AND enhances the possibility that preferred outcomes will be achieved. For our patients, AND means the legacy of a peaceful and dignified death for their loved ones to recall, rather than prolonged and futile suffering at the end of a life well lived.

WHAT CAN NURSES DO?

1) Use the words "Allow Natural Death" when talking with patients and families about their wishes for the end of life. Ask them to speak to one another about what this means to them. In LaCrosse, Wisconsin, specially trained nurses spend time with families doing exactly this and have made their facility the lowest spending in the US during the last two years of life.

2) Ask your facility to provide education to nursing staff who seek to provide quality end of life care. As our population ages, we will see more elders on the frontline who need the care we bring to this meaningful time in the life of a family. Be ready to assist families by providing practical information in language they can understand.

3) Take care of yourself. In 2006, Betty Farrell, RN, PhD, FAAN, published findings re: "Understanding Moral Distress of Nurses Witnessing Futile Care." Clearly, this work is highly emotional and demanding. Find others on the frontline of health care who will assure you that you are not alone. Seek the counsel of clergy and spiritual advisors who are prepared to listen to your experience of grief and frustration.

4) Advocate for research that will continue to illuminate the most effective ways to assist families in achieving their desired experience at the end of life.

In Memory of Our Colleagues

Red Cross Nurse


Patricia Rugg

Patricia Jean Rugg, 52, died May 4, 2011, after a courageous battle with cancer. A native of Rhode Island she graduated from nursing school in New Jersey in 1978 and had been a New Hampshire resident since 1985. She practiced nursing at the American Red Cross up until the time of her death. She specialized in phlebotomy collection and was well known by all her donors.

Office Nurse

Bette J. (Peterson) Bourque, 62, died May 13, 2011, at the Community Hospice House in Merrimack. Known to friends as "Pete," she received her diploma in nursing from Mary Hitchcock Memorial Hospital in Hanover in 1970. A Manchester native she practiced at Notre Dame Hospital and Elliot Hospital. Before her retirement she was an office nurse with Family Physicians of Manchester.

Psychiatric Director


Mary Lougee

Mary Lougee, 73, of Bow, died May 21, 2011 after a brief illness. A Concord native, she graduated from the New Hampshire Hospital School of Nursing in 1958 and then from New England College in 1974. Lougee practiced at the New Hampshire Hospital from 1958 to 1997 when she retired as Director of Nursing for Psychiatric Nursing Home Services. In addition to her psychiatric specialty she was a founding member of the Bow Rescue squad which she volunteered with for 20 years and served, until recently on the Ambulance oversight committee for the town of Bow. She was also a CPR Instructor Trainer. Part of her volunteer work included working to restore and identify the unmarked graves at New Hampshire Hospital. She was as a member of the New Hampshire Hospital School of Nursing Alumni Association; American Nurses Association; New Hampshire Nurses Association; National Association Directors of Nursing Administration for Long Term Care; New Hampshire Association of Directors of Nursing Administration for Long Term Care; the Long Term Care Forum; as well as Sigma Theta Tau National Nursing Honor Society, Epsilon Tau Chapter.

Pediatric Nurse

Jean M. (Farrow) Reynolds, 78, of Portsmouth, died May 24, 2011. Born in Vermont she received her nursing diploma from Worcester (Massachusetts) Hahnemann Hospital in 1954 and practiced for 35 years at Portsmouth Hospital in the pediatrics unit.

PACU Nurse

Andrea S. Murray, 49, of New Durham, passed away May 24, 2011 following a courageous battle with cancer. Born in Frankfurt, Germany, she moved to the Unites States in 1984. In 1989 she started as a Certified Nurses Aid at Huggins Hospital and attended the New Hampshire Technical Institute in Concord where she earned her Associate's Degree in Nursing. For several years she was employed in the PACU and Surgical Department and is remembered as having a wonderful bedside manner and a true love for nursing. Donations in her memory may be made to the Andrea Murray Nursing Scholarship Fund, c/o TD Bank North, PO Box 549, Wolfeboro Falls, NH.

Maine Native

Geraldine (Dionne) Dufresne, 95, died May 27, 2011 following a lengthy illness. A native of Maine she practiced as a RN in the Manchester, NH area prior to her retirement.

Massachusetts Native

Barbara J. Craigie, 62, died May 29, 2011, at home after a brief illness. Born in Massachusetts she resided in Manchester for many years. Prior to her retirement, she practiced at the Elliot Hospital for 23 years as a RN.

First MDS Coordinator


Phyllis Byrnes

Phyllis D. (Plourde) Byrnes, RNC, 60, of Manchester died June 3rd, 2011 after a year-long battle with cancer. A varied career in health care she was a radiological technician, radiation therapist and then earned LPN licensure. Byrnes received her associate's degree in nursing at New Hampshire Technical College. She held a bachelor's degree in education and prior to her illness was thinking of pursuing her master's degree and began classes in medical law. As the assistant director of nursing at Hanover Hill Health Care Center, she became the first certified MDS coordinator in NH.

Navy Lieutenant


Sandy Lange

Sandy A. (Sauer) Lange, 67, died June 5, 2011. A New York native she graduated from Villanova University in 1965 with a degree in nursing. She moved to California and joined the U. S. Navy as a Lieutenant. She was stationed in Oakland, CA during the Vietnam War. She later moved to New Mexico where she worked as a Nurse Practitioner for the Navajo Health Service. After moving to Vermont she taught at Oxbow Vocational Center for the health occupation program. She was employed as a charge nurse at Cottage Hospital in Woodsville, NH for many years. After retirement she moved to Portsmouth, NH

St. Anselm Grad

Dr. Dorothy desMarais Lempenau, 94, died June 15, 2011. A native of Connecticut she received her BSN from St. Anselm College and began her career at Elliot Hospital. She held advanced nursing degrees from Boston University and Kansas State University. She retired as the director of Asbury Hospital School of Nursing in Salina, Kansas, in the 1970s.

Cadet Nurse


Genevieve Jensen

Genevieve (Malisheski) Jensen, 86, died of breast cancer on June 24, 2011 in Bedford, NH. Born in Pennsylvania during WWII she worked in the War Department from 1942-1944 in both Washington, D.C. and Philadelphia, PA. In 1944, she attended Bellevue Hospital School of Nursing as a United States Cadet Nurse and after graduation as a registered nurse, served at Winter V.A. Hospital in Topeka, Kansas. Her nursing career included positions at Belleview Hospital in New York City, Queens General in Jamaica, N.Y. and Massapequa General in Sisford, N.Y. She retired from nursing after 22 years at Mount Carmel Nursing Home in Manchester, N.H.

Weare Native

Dorothy M. (Chandler) "Dot" Wilson, 93, of Concord, died June 26, 2011. A Weare native she practiced in private duty nurse and later as a registered nurse at Concord Hospital for 38 years.

RNFA

Phebe Gulick-Leonard, 49, died July 5, 2011, at her home in New Durham. After attending Curry College, she earned her associate's degree in nursing at Manchester Community College. An operating room nurse she obtained her First Assist Certification through Arizona State University. Phebe passionately loved nursing and assisting with multiple surgical specialties. For 15 years she practiced at Franklin Regional Hospital as an operating room nurse, primarily with Dr. Murakami, her dear friend and mentor, providing her with a wealth of surgical experience. Moving to New Durham led to a 10 year OR nursing career at Wentworth Douglass Hospital. Donations to either the Franklin Hospital Auxiliary Scholarship Program or Wentworth-Douglass Hospital Health Foundation/Nursing Scholarships are suggested.

USAF Nurse Corps


Rena Willis

Rena Willis, 82, of Gilford, passed peacefully early in the morning of July 7, 2011 at home under hospice care, after a brief battle with cancer. She received her diploma in nursing, attending the Laconia School of Nursing from 1947 to 1950. Her nearly 50-year nursing career included practicing from 1950 to 1953 at Lakes Region General Hospital; 1953-1957 in the USAF Nurse Corps, serving between the Mitchell Air Force Base in Long Island, N.Y., and Wiesbaden, Germany, with the 71st 100th USAF Hospital. She then returned to Lakes Regional and practiced in Maternity and Orthopedics from 1957 to 1998.

Dover Visiting Nurse


Susan Sears

Susan Babel Sears, 63, of Aurora, Colo., formerly of Dover, N.H., passed away July 8, 2011. A native of Manchester, N.H. she received her nursing degree in 1975 from Prince George's Community College in Maryland. After graduation she practiced nursing at various hospitals on the East coast, including Wentworth-Douglass Hospital in Dover, N.H.; then as a visiting nurse for Oyster River Home Health in Durham, N.H. from 1979 until she retired in 1983. After moving to Colorado in 2001 she continued to help out voluntarily in the Denver/Aurora community in a nursing capacity through health fairs and advocacy programs.

Occupational Health Nurse

Hellen G. (Blanchard) Sullivan, 93, of Nashua, passed away on July 16, 2011. Born in Codroy Valley, Newfoundland she was the eleventh of twelve children. Hellen relocated with her family to Burlington, CT in 1924, where she attended a one room little red school house for eight years before graduating from high School in 1936. Hellen then went on to attend Nashua Memorial School of Nursing, graduating in 1941 with her nursing diploma. During WWII, she worked as the Charge Nurse for Remington Arms Inc., and General Electric Co. setting up their health facilities in Lowell, MA. After several years of private duty nursing in Nashua, Hellen returned to Occupational Health Nursing in 1952 at Improved Pulp Paper Machinery Co. now know as Ingersoll Rand, where she worked until her retirement in 1979. She was a member of the NH, NE and American Occupational Health Association, and became the first Nationally Certified Occupational Health Nurse in the State of NH. During her career, Hellen instituted many Health & Safety Programs, was a Red Cross and CPR Instructor, and had many articles published in the National Occupational Health and the Association of the Blind Magazines. She also assisted with the curriculum at St. Anselm College. She was a member of the Catholic Nurses Association, the American Nurses Association, and the Memorial Hospital Nurses Alumni. After her retirement she stayed active with the Ingersoll Rand Retirees Assoc. and continued to do volunteer nursing care.

Elliot Hospital Alum


Ruth Hill

Ruth Evelyn (Kimball) Hill, 91, a lifelong Pembroke resident, died July 16, 2011 after a brief period of failing health. A graduate of the Elliot Hospital School of Nursing she had also earned numerous college credits. Ruth's practice included the Elliot Hospital, Concord Hospital and McKerley Nursing Home in Concord. She was a life member of the Elliot Hospital Nursing Alumnae Association.

In Memory continued on page 16

In Memory continued from page 15

Nurse Anesthetist

Carmeline Khazei

Carmeline Victoria (Picardi) Khazei, 77, died July 16, 2011 in Manchester. Born in Pennsylvania she graduated with a diploma in nursing from the Mercy Hospital in Pittsburgh, Pa. in 1955. In 1959 she received her degree as a nurse anesthetist from Mercy Hospital. In New Hampshire, Carmeline continued nursing as a certified registered nurse anesthetist. She practiced in a variety of nursing areas. For a while she worked the night shift so she could be with her children during the day. She worked as a visiting nurse and in the psychiatric unit caring for the mentally challenged and distressed. She loved children and also worked as a school nurse at Peter Woodbury School in Bedford, and with disadvantaged youth at a youth development center in Manchester.

Psychotherapist and Nurse Educator

Denise Connors

Dr. Denise Donnell Connors died at home on July 17, 2011, after a long illness. Born in Pittsburgh, Pa., she graduated in 1966 from St. Francis Hospital School of Nursing in Pittsburg. She continued her studies at Duquesne University and Boston College, where she received master's degrees in both community health and psychiatric mental health nursing. In 1986, she earned a doctorate of sociology from Brandeis University with a focus on the sociology of health and illness.

Dr. Connor's nursing career spanned a period of 40 years. It included working in intensive care at both St. Francis Hospital in Pittsburgh and the New England Deaconess Hospital in Boston; as a nursing instructor with the Boston Public Schools practical nursing program; and as a nursing professor at Fitchburg State College and the nursing faculties of the University of New Hampshire and the University of Southern Maine. In recent years, she practiced as a psychotherapist in group practices in Portsmouth and Durham, N.H. Most recently, she was a staff nurse at the Portsmouth Regional Hospital Behavioral Health Unit.

Littleton Native

Martha (Williams) Crossett, 90, passed away on July 18th, 2011. A native of Littleton, NH Born in Littleton, N.H., she attended the Brightlook Hospital School of Nursing (Vermont), earning her registered nurse diploma in 1941. She practiced for over 30 years at Littleton Hospital. Upon retirement, she continued caring for patients at the Morrison Nursing Home in Whitefield for several years.

Berlin Native

Jeannette Morneau Pinette, 87, of Berlin, NH, passed away July 20, 2011. A Berlin native she attended the St. Louis Hospital School of Nursing to receive her registered nurse diploma. She practiced at the Androscoggin Valley Hospital in Berlin.

Introduced Polio Vaccine

Amy Lang Brown, 91, died July 21, 2011, after a fall at her Center Harbor home. A native of Laconia she received her diploma in nursing from the Laconia Hospital School of Nursing, class of 1942. The beginning of her career involved private duty nursing for many Lakes Region clients. From 1951 to 1977, she served the children of the area as school nurse covering the school districts for the Center Harbor, Meredith, Sandwich, Moultonborough, Effingham, Freedom, Holderness and Ashland. She was instrumental in introducing the polio vaccine to the local schoolchildren during the polio crisis of the early 1950s– a group now known as Polio Pioneers. One of her life missions was to assist the needy and as school nurse she often delivered food and/or clothing to many such families in the area. She was a member of the New Hampshire and National Education associations, the Lakes Region and New Hampshire Retired Teachers associations, the American School Nurses' Association.

LPN in Geriatrics

Cynthia A. Robie, 83, of Hill, died July 23, 2011, at her home with her family after a battle with cancer. A native of New Hampshire she practiced as an LPN at the Merrimack County Nursing Home for 32 years.

Psychiatric Nurse

Ruth Kurtz

Ruth A. (Shepard) Kurtz, 74, York Beach, Maine, died July 26, 2011. A native of Franklin, New Hampshire she attended Simmons College and Boston University and trained at the New Hampshire State Hospital in Concord. She practiced in Massachusetts, Maine, and in New Hampshire at Franklin Regional Hospital. Her specialty was psychiatric nursing. Later, she was a member of the Nurses Club at York Hospital.

Victim of Auto Accident

Doris (Lavoie) Gardner, 69, died July 27, 2011, a passenger in an automobile accident on Interstate 95 in North Hampton. She was a nurse at Catholic Medical Center in Manchester for many years.

Nursed in France and Germany

Mary Celene (Blanchard) McDonnell, 92, of Concord, died July 28, 2011 in Laconia. A native of Massachusetts she attended the Memorial Hospital School of Nursing (Concord Hospital) and graduated in 1943 with a diploma in nursing. Soon after graduating she joined the US Army Nursing Corp and was commissioned as a 2nd lieutenant. In 1944 she served in the European Theatre of Operations in field hospitals treating wounded soldiers. She served in several European countries including France and Germany before her discharge with the rank of First Lieutenant in 1945. She was awarded several medals and campaign ribbons. After her services she returned to practice at the New Hampshire State Hospital for over 20 years. In 1974 she obtained a Bachelor of Arts Degree from New England College. She practiced as a staff nurse in the forensic unit. Prior to her retirement she was the Head of Admissions.

Notre Dame Grad

Rita Denis

Rita Issoire Denis, 87, died July 30, 2011 following a brief illness. A New Hampshire native she was a 1948 graduate of the Notre Dame Hospital School of Nursing. She practiced at the Notre Dame and later Catholic Medical Center before retiring after 45 years with the hospital. She worked and volunteered for over 10 years at the Bishop Peterson House and was a proud member of the Nightingales.

Margaret Pillsbury Grad

Helena Reid

Helena Alice (Parkhurst) Reid, died August 1, 2011 after a long period of declining health. Born in Manchester, NH, she attended the Margaret Pillsbury School of Nursing in Concord, NH. She lived most of her life in Manchester and Nashua, NH practicing as a pediatric nurse, including private duty for several years in Boston, MA and office nursing.

Elliot Hospital Grad

Marjorie J. (Knox) Croteau, 85, died August 5, 2011, after a period of failing health. A Massachusetts native she was a long time resident of New Hampshire. She obtained her LPN diploma from the Elliot Hospital School of Nursing and practiced at the Elliot Hospital and the Sacred Heart Hospital for many years.

St. Joes Grad

Mary Caron

Mary (Lapinskas) Caron, 87, passed away Tuesday, August 9, 2011. Born in Nashua, NH she received her diploma in nursing from the St. Joseph Hospital School of Nursing in Nashua, NH. She practiced at St. Joseph Hospital and then relocated to Massachusetts where she was a surgical nurse.

ANA Mourns the Passing of a National Nursing Leader

Luther Christman

A national leader and active in the American Nurses Association, **Dr. Luther Parmalee Christman**, died June 7, 2011 in Nashville, TN at the age of 96. Dr. Christman was a tireless and articulate advocate for nurses and nursing throughout his career serving as an inspirational role model for male nurses in a career choice with few men at the beginning of his career. His influence helped open the field to men who were interested in nursing as an occupation.

Christman graduated from the Pennsylvania Hospital School of Nursing for Men in 1939, and was married the same year. He was called a pervert when requesting maternity experience. He was refused admission to the Army Nurse Corps in World War II, and entry to two university nursing programs simply because he was a man. He went on to receive a baccalaureate from Temple University in 1948. He received an Ed.M. in Clinical Psychology from the Philadelphia Psychoanalytic Institute. In 1953, he became Director of Nursing at Yankton State Hospital, Yankton, South Dakota. Some of his suggestions for changes in nursing education and practice arose from his experiences at the hospital. He was a proponent of practicing nurses teaching nursing students, or the teacher-practitioner role. He encouraged the use of administrative assistants for office management and non-nursing tasks to allow more time for patient care for nurses. He was a strong advocate of primary nursing, or the presence of a primary nurse who would care for a single patient throughout their stay.

In 1956, he took a position with the Michigan Department of Mental Health. He was responsible for the development of the nursing programs in the state hospitals in Michigan and in the state's training schools for the mentally retarded. In 1963, he accepted a position as associate professor of psychiatric nursing at the University of Michigan, Ann Arbor. He earned his Ph.D. in Sociology and Anthropology at Michigan State University. He became dean of the nursing school and director of nursing at Vanderbilt University in 1967. The first male to assume the role of dean in the United States. There, he worked to rebuild the school, acquiring substantial funding, developing nursing as an applied science and introducing the practitioner-teacher model.

In 1972, he became the first dean of the Rush University College of Nursing and vice president for nursing affairs at Rush-Presbyterian-St. Luke's Medical Center. With strong administrative support, he moved to implement all the components for his plan for nursing, which would come to be known as the Rush Model for Nursing. The plan included the integration of practice, education and research; a quality assurance program; unit decentralization; levels of practice; primary nursing; the practitioner-teacher role; and a self-governing professional staff organization. Programs offering the clinical doctorate, doctor of nursing degree (entry level) and the combined PhD–DNSc were initiated. Christman helped establish the National Male Nurse Association in 1974, which became the American Assembly for Men in Nursing in 1981. He was a strong supporter for the recruitment of male nurses, believing that diversity could make the nursing profession stronger. A gift from the John L. and Helen Kellogg Foundation in 1979 funded at Rush the first National Center for Excellence in Nursing in the United States.

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When Patients Die and Nurses Grieve: Understanding the Grieving Process of Nurses After the Death of a Patient

Submitted by: Ute Schmidt, M.Ed., Board Certified Chaplain (APC) Certified Pastoral Educator (ACPE) Director of Spiritual Care and Clinical Pastoral Education Fletcher Allen Health Care Burlington, VT

After 390 days of being hospitalized, Mr. L. died in the Intensive Care Unit of a large medical center. It had been a long and difficult journey for Mr. L and his nurses. Mr. L was morbidly obese, suffering from diabetes, respiratory problems and multiple organ failures.

When the nurses on the medical surgical floor learned about his death, they felt relief. But many of the RNs also expressed sadness and regret. They had tried so hard to get him well, and yet all efforts to move him out of the hospital to a long-term care facility had failed. Mr. L fit the image of the difficult patient, the one who is non-compliant and at times aggressive and moody. The nurses struggled with liking him. Yet they cared for him with compassion and dignity.

Now that he had died, the nurses felt that they needed to do something to find closure for themselves and to honor the humanity of the patient. They decided to gather for a brief memorial service in the hospital chapel. A group of 12 nurses and their manager came together for a 30-minute service led by the hospital chaplain. She invited them to share their memories of the patient, the struggles, the moments of satisfaction and even joy. The nurses were able to effectively express a whole range of emotions that this patient invoked in them. The structure of the service and the comfort of the chapel assisted the RNs in entering a process of healthy grieving.

The way the nurses dealt with their grief in this situation is not typical. It is well-known that registered nurses provide compassionate end-of-life care and bereavement support to adult and pediatric patients and their families. In many cases, nurses form special relationships with terminally ill patients and their families that go beyond the traditional professional role of taking care of the patient's physical needs. Nurses grieve the loss of their patient on a personal level, especially (a) when the relationship was based on mutuality and reciprocity, (b) when this was an initial death early in one's career; (c) when coping strategies include spirituality and caring rituals; and (d) when the understanding of professionalism requires compartmentalization (Gerow, 2010).

When a patient dies, many nurses may not have the opportunity to take care of their own needs for closure and for processing feelings. The impact of death on families has been well-researched in numerous publications, while the grieving process of nurses and other health care providers has remained largely unexamined.

Findings of a few research projects assert that the grieving process for nurses is significantly different than the families' journey through grief. Nurses can play conflicting roles. They are supposed to remain strong and supportive for the families, while being affected by the loss of a person that they cared intimately for (Gerow 2010). As a result of this conflict, nurses often practice coping behaviors such as avoidance and compartmentalization of the experience. This can lead to burnout, physical, emotional and spiritual problems such as decreasing morale and motivation to continue caring for ill people (Gerow, Ruggles, Brunelli). Most nurses interviewed in various studies reported unresolved grief issues that manifest in recurring memories of the dying condition, fatigue, moodiness and difficulty concentrating.

The spiritual dimension of grief was the focus in a study by Shinbara and Olson, who advocate for spiritual coping strategies as helpful and healthy for nurses. Otherwise, they assert the experience of multiple patient losses can lead to spiritual burdening, to a faith crisis, spiritual pain and the questioning of meaning (Ewing & Carter, 2004; Rushton, 2004).

Nurses who utilized their nursing colleagues to recall positive memories of the patient felt more supported. They were able to re-orient themselves toward caring for new patients and to integrate the grieving experience into their clinical practice, increasing their ability to be compassionate (Brunelli, 2005).

Reviewing the literature and reflecting upon my experiences as a chaplain working with nurses has made it quite clear that addressing the grief of nurses after the loss of a patient is crucial for continued professional functioning and satisfaction on the job.

Even though the grieving process of nurses might be different than that of family members, there are similarities. Generally, grieving means to feel sorrow and pain (Merriam-Webster's Online Dictionary, 2004). The grieving process of releasing and working through emotional experiences of shock, denial, anger, depression, bargaining, blaming and sadness is a journey of reconciling and finding peace within oneself. A nurse will reach a place of acceptance and adjust to a changed reality when given the space to freely express all different emotions. It is work—grief work, as Sigmund Freud stated a long time ago. Grieving involves remembering, working through emotions and integrating the experience into your life (Pisarski, 1982).

In her article "The Grieving Process for Nurses," Tina Brunelli, RN, suggested that nurses first need to speak up about their hurt and grief. Further, hospital nursing leaders are asked to respond by providing space, time and trained personnel such as Employee Assistance counselors or professional chaplains for grief support groups that invite the multidisciplinary team. Grieving in community has a long tradition in all cultures, and it may help break down professional barriers. When physicians, nurses, social workers, chaplains and other providers share their grief together, they may discover similarities that can lead to more effective collaboration and more holistic and compassionate care for the patients.

Other writers, like Gerow, advocate for developing a comprehensive understanding of the grieving and coping process for nurses, including the significant influence of spiritual worldviews. Nursing faculty, administrators and leaders can provide better learning opportunities and supportive practice environments in which the professional nurse can grow and change within life's journey (Gerow, 2010).

In addition, memorial services have proven to be an effective tool for caregiver's coping process, as Brunelli pointed out. This corresponds with my experience as a chaplain who has coordinated special non-denominational services for caregivers and families to honor the lives of patients who died during the past year. These services have provided a structure to remember and celebrate in community as well as being part of a larger reality. The receptions after the services invite fellowship; sharing of stories over food and drink. This custom is as old as the Jewish-Christian text from Ecclesiastes 3: "There is a time for everything under the heavens, a time to mourn and a time to laugh," and it assists with the adjustment to a new reality. It may result in less burnout and more happy, caring nurses who will stay in the field because they, too, feel cared for by their employers.

In their research on the role of spirituality in coping, Shinbara and Olson found that a large percentage of nurses are connected to spirituality through such avenues as worship, prayer, meditation or self-reflection. Spirituality is understood as making meaning out of one's experiences and feeling a connection to something larger than oneself. Similar to the findings around grief, education on spirituality is predominantly provided around the patients' spiritual needs.

Many nurses collaborate with chaplains in their institutions to meet the needs of patients and families. Some findings show that spiritual care providers are being utilized to provide education on spirituality and loss, and to offer support to the nursing staff. That has been true in my experience as a hospital chaplain. Once I had established trusting relationships with the RNs on one oncology unit, they would call me when they felt sad about the loss of a patient or when they needed an informal debriefing, a blessing or a special healing service.

Faith and spirituality in their many forms can be healthy ways of coping with grief. For nurses who may not want to attend group sessions or attend memorial services, the practice of focusing on the three "G" principle might be an alternative: be grateful for the gift of working with the patient, allow for grief over the loss, and find ways of letting go (Shinbara, Olson, 2010 and Carlsen, et al. 2005). This may include some well-known self-care strategies such as listening to music, taking a bath, scheduling a massage, exercising, going for walks, hugging, spending time alone in nature or with friends and family, and writing a letter or journal (Ruggles, 2011). Nurses need to give themselves permission to grieve and let go in their own ways. I join Brunelli in quoting Reese, who wrote (1996), "It's only human to hurt, to cry, to grieve, when a person who's influenced you in some way has died. Please cry with your patients and their families; it is okay for you to grieve, too," and to ask for support.

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Christman retired in 1987. In a long and distinguished career, he had published many scholarly works and participated as an active member and officer of numerous organizations. He was especially devoted to Sigma Theta Tau and its International Center for Nursing Scholarship. He received, in 1981, the Edith Moore Copeland Founders Award for Creativity, and the first Lifetime Distinguished Achievement Award given by the honorary society in 1991. In 2004, Christman was inducted into the American Nurses Association's Hall of Fame. In 2007, the American Nurses Association established the Luther Christman Award. The American Assembly for Men in Nursing began awarding its own Luther Christman Award in 1975 to people who have helped further the cause of men in nursing.

His outspoken views on the field of nursing were enlightening and influential, not only in America, but all over the world. He lectured in Turkey, Japan and Sweden among other places. Christman was an advocate for improving professional nursing practice and elevating the educational level of the nursing profession throughout his 65-year career. Luther Christman, a white, Anglo-Saxon, Protestant, heterosexual family man, had none of the attributes normally associated with discrimination. Yet he encountered gender discrimination because he was a man in a woman's profession. As a retired, sprightly 90 year-old, he reviewed books for the American Journal of Nursing, was president of the American Assembly for Men in Nursing and was a provocative advocate for his vision of nursing.

It's Never Too Late for Education

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Lynn B. Clutter, PhDc, RN, CNS, CNE

Ginger Clutter

My mother in law passed away several years ago. We miss her. She was a Registered Nurse and an Oklahoma Nurses Association member until her dying day. I want to set forth her life as an example. She has been an inspiration for learning to those in her family and hopefully to you now. If you or one you know has a desire to pursue further education, I hope that my mother in law will be an inspiration. Perhaps this is the time to go for it!

For Ginger Clutter, it was never too late to learn. She valued education for herself and others. Indeed she had a long history of learning. After graduating from high school, she earned her Bachelors and Masters degree from the University of Illinois, Urbana. While there, she had a graduate teaching assistantship from 1946 to 1951 in the Department of Spanish and Italian. During that time she continued learning. In my opinion, a good teacher is a good learner. She was a good learner and did well in school.

She completed all the coursework for her PhD, so she liked to say she was an "ABD," that is, "all but dissertation." In 1945, she had married, in 1950 their first of four children was born, and in 1951 my father in law received his master's degree. This launched what she called, "the nomad life of a Petroleum Geologist." The point I'd like to make about these family transitions is that education often involves change. Flexibility is needed. Plans change. Family transitions are often at the root of educational changes. Although Ginger decided to stop her PhD work, her education was life long. Her education did, however, change from foreground to background.

Education was not the "end all" for Ginger Clutter. It is nice to know that when life moved a different direction, she embraced the change. Education should enhance one's life. The process may sometimes be complex, but the end result can be wonderful. Ginger Clutter knew the balance of when to study and when to stop.

Living in Billings, MT, Ginger taught Spanish at Rocky Mountain College. In 1965, the family–now of six–moved to Tripoli, Libya. There Ginger taught English to Libyan oil company employees at the Language Training Center. Moving again in 1974, the family transferred to London, England where Ginger worked at the American School in London. In the United States, Tripoli, and London. Ginger was academically involved and also taught her children the value of education. Returning to the United States and Tulsa, Oklahoma in 1979, Ginger lived near her nurse-daughter, Wendy Clutter Van Matre, ARNP, MS, CEN and her nurse-daughter-in-law, me.

Several years prior to the dawning of her sixth decade marked her status as a student nurse in at Tulsa Junior College (currently Tulsa Community College). Ginger not only became a Registered Nurse, but enjoyed a decade of RN service with the American Red Cross. She started nursing on night shift in NICU because she wanted to work with babies. She also worked at Methodist Manor for several years in support of their church. What a wonder! To have a late-life career and enjoy years of work is something of great value. Her investment in further education as an RN was well rewarded. It was satisfying and fulfilling for her in many ways.

But employment was not all. For twenty years, Ginger Clutter was active in service and leadership with the Registered Nurse Community Volunteers. The purpose of Registered Nurse Community Volunteers (RNCV) is to promote and support health care, to assist community nurses through education, and to facilitate professional volunteer opportunities (Volunteer Central of Greater Tulsa website). Working as an RN Community Volunteer, Ginger worked weekly for twenty years, primarily with Project Get Together Clinic. She also gave flu shots for the City-County Health Department. She shared in student scholarship award ceremonies and in RNCV leadership. She was instrumental in getting their scholarship program to cover advanced education for nurses–they now offer scholarships to those in masters and doctoral level programs. Even now, members of the organization remember Ginger's faithful service.

Ginger Clutter was one to inspire others to do well in formal and informal programs of education. I remember being in the throws of despair when writing my master's thesis. My mother-in-law stepped in with editing assistance, practical help, and encouragement. She championed other's academic successes.

It was never too late for Ginger to learn, to teach, to encourage learning. Her own education in nursing carried her through her latter years. Erikson lists "generativity versus stagnation" as the seventh stage in his psychosocial theory of development. The individual's task is to contribute to family, community, and world. It is the phase around 25-65 years of age when productive involvement aides in the succeeding generations. Ginger Clutter was certainly generative! Stage eight, "integrity versus despair" is the final phase focused on reflecting back over one's life. Integrity is the review of life with a sense of having few regrets, and a general sense of satisfaction. My thought is that my mother-in-law was generative well into her eighth stage. Her sense of satisfaction came with continued generativity! She finished life well. Her later education helped in the pleasant unfolding of life transitions. We can learn from her.

It is never too late to be a learner. If you are reading this, you likely are already a nurse. It is not too late for you to be a learner. It may be that reading this article triggers a thought of someone else who has voiced a dream of further education. It may be that Ginger Clutter's "latter life learning" will spark a fresh vision for you. I have been inspired myself and am pleased to say that 2009 marks the completion of my PhD in nursing …at the age of fifty-three. I look forward to fruitful contribution to the profession for hopefully decades.

Adult learning is a wonderful thing. I was not a student in early undergraduate education. I only started appreciating self-directed learning as I became an adult. As I became aware of my own learning styles I improved and overcame obstacles that were very present in my earlier years. The hunger for growth can enliven and strengthen individuals, families, and in turn communities. We see it in the example of Ginger.

Learning these days is not just for those who read well. Technology has advanced to offer strength for those with other learning styles such as auditory, visual, or kinesthetic modes (learning by doing). Nursing education embraces the use of all styles of learning. Multimedia venues are used in virtually all programs. Besides that, a "seasoned person" knows that one can learn at a comfortable pace and in an environment of choice. Again I say, it is never to late for education. Enjoy your learning. It will boost your life contribution.

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Volunteer Central of Greater Tulsa website, <http://www.1-800-volunteer.org/1800Vol/tulsavc/OpenAboutOrganizationAction.do?organizationId=238804>

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NHNA volunteers from Concord Hospital, Aleta Billadeau, RN, MSN, and Amanda Callahan, RN, BSN, MBA, doing some member recruiting!