Next year the North Dakota Nurses Association will celebrate its 100th birthday. History is important. It has been said that he who controls the past controls the future. Our view of history shapes the way we view the present, and therefore it dictates what answers we offer for existing problems.

Over 100 years ago a number of strong nurse leaders came to North Dakota. Each of these enlightened leaders recognized early that quality nursing was vital and an essential component of the health care in our growing young state. They saw many small hospitals crop up across the prairie and adjacent to the hospital was a “training school” for young women to become nurses. In exchange, for a few science lessons from a physician and some elementary instructions on the art of nursing the students took care of the patients. There were no education standards among these training schools and a need for regulations and standards for nursing education became apparent. These leaders knew nursing education needed to be built from a broad body of knowledge, and nurses needed to be taught to think and make decisions rather than be dependent followers.

These leaders made significant and long lasting contributions to nursing. They worked to design and implement solutions to regulate nursing and nursing education. These strong nurse leaders created the North Dakota Nurses Association on May 6, 1912 and worked to develop the Nurse Practice Act that passed the North Dakota Legislature and became law July 1, 1916.

These nurse leaders created a significant social good for society by recognizing nursing was responsible to society and that the interests of society would be served by providing quality nursing care and standardizing nursing education. Nursing continues to be responsible to society. Today, like the strong nursing leaders in the early 1900’s we need to continue to focus on quality health care and quality education. Our principle motive and effort should be about “doing good.”

Consider joining NDNA as a way to celebrate North Dakota Nursing’s 100th birthday. Join us on September 21, 2012 in Bismarck!
You are cordially invited to join the North Dakota Nurses Association

See the NDNA Website at www.ndna.org

Click on Membership Under how to join

Click on Membership Application (ANA website)

Click on Full Membership (Be ready to provide your email address)

Full membership is just $20.50/month! Less than 70¢ a day!

The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.

Online Resources: Nurse Practices Act, Scope of Practice, Delegation, Code of Ethics

North Dakota Nurse Practices Act
http://www.legis.nd.gov/cencode/t43c12-1.pdf

Decision Making Model for Scope of Practice
https://www.ndbon.org/practice/decision_making_model.asp

ANA Scope and Standards of Practice
http://www.nursingworld.org/ScopePractice

Joint Statement on Delegation
https://www.ncsbn.org/Joint_statement.pdf

ANA Principles of Delegation

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Southwest Healthcare Services, a Community-Minded healthcare organization located in Bowman, North Dakota is looking for a registered nurse with proven leadership capabilities to serve as our Director of Nursing at our 23-bed Critical Access Hospital. High performance is essential in improving operation effectiveness; assuring resident, family and staff satisfaction; clinical excellence, and compliance with regulatory requirements. Previous management or supervisory experience is preferred. We offer: competitive salary & benefits; sign-on bonus; clinical excellence; and compliance with regulatory requirements. Effectiveness; assuring resident, family and staff satisfaction; and high performance is essential in improving operation effectiveness; assuring resident, family and staff satisfaction; clinical excellence, and compliance with regulatory requirements.


*Please note LPNs cannot delegate to RNs. LPNs cannot “supervise” RNs.

Delegation Dilemmas
http://www.nursingworld.org/MainMenuCategories/ANA/Marketplace/ANAPeriodicals/OJIN/TableOfContents/Volume152010/No2May2010.aspx

Code of Ethics (view only mode)

Writing for Publication in the Prairie Rose

The Prairie Rose accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and in APA format. The article should be submitted electronically in MS Word to becky@ndna.org. Please write Prairie Rose article in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don’t know how or where to start, contact the office at NDNA: 701-223-3385.

The Prairie Rose is one communication vehicle for nurses in North Dakota. Raise your voice.

The Vision and Mission of the North Dakota Nurses Association

Vision: North Dakota Nurses Association, a professional organization for Nurses, is the voice of Nursing in North Dakota.

Mission: The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.
The North Dakota State Nurses Association held its first meeting in May of 1912 in Grand Forks, ND. On September 21, 2012, the North Dakota Nurses Association will hold its 100th anniversary meeting in Bismarck, ND at the Ramkota. ANA president, Karen Daley has been invited to attend this celebration. Watch for details in upcoming editions of the Prairie Rose and check the NDNA website at www.ndna.org.

While many things have changed (including the organization's name), there are a few occurrences were the story is murky. In an attempt to unearth those stories, we are asking for help from past and present members to fill in the gaps.

In 1934, Alice O. Danielsen compiled the history of the North Dakota State Nurses Association (1912-1934) to the best of her ability. As she wrote “should not be regarded as a complete history . . . but rather as a collection of scattered notes gathered during a busy life that may from a foundation upon which other recorders may build...” Then in 1967 the NDNA history committee compiled a list of events that helped fill in some blanks. Another treasure was published in September of 1979 by Lucille Paulson. It is titled “A 75-Year History of Nursing Education in North Dakota 1903-1978.”

In an attempt to build a repository for NDNA history we are asking for your help. NDNA will be 100 years old, which is 10 decades of history. To better organize our recollection and investigative work we would like to arrange history collection into 10 categories that are represented by the decades NDNA has grown through to reach the 100 year mark.

Our idea is to accumulate 10 events, activities, and or actions per decade. We have access to past Prairie Rose newspapers, but would like your input regarding which events to showcase at the 100 year celebration. While it is relatively easy to go for the “big ones”, it would be especially wonderful to have those lesser known and maybe hardly known activities to add to each decade of history. Here is the matrix / structure under which we will gather information.

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Please consider helping us with this project. You can email information or you can mail information to NDNA at PO Box 292, Mandan, ND 58554. Information should have correct dates and details so we can categorize appropriately. If you are storytelling and it involves another person, please make sure they have given you permission to use their name when sharing the story. Please include your contact information should we need to clarify or follow-up regarding the content you send.

Seasonal Influenza . . . Time for your Flu Shot

By now many of you will already have gotten your flu shot. For those of you who have not, here are links to websites for resources that discuss the recommendations of the Centers for Disease Control and Prevention and the American Nurses Association.

http://www.cdc.gov/flu/about/season/

http://www.anaimmunize.org/

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I'm inventing new models of Veteran’s health care.

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  • Technology enhanced learning
  • Scholarships available

Dickinson State University

For more information follow the link: http://www.ndsu.edu/nursing/

Contact the NDSD Department of Nursing

Graduate Program at 701-231-5692

Department of Nursing, North Dakota State University, Fargo, N.D.
The annual NDNA business meeting took place after Dr. Strauss’s presentation. The meeting opened with approval of the agenda and approval of minutes from last year’s meeting. Newly elected officers were inducted, VP Communication: Susan Pederson, VP Government Relations: Karen Macdonald, VP Membership Services: Mary Smith, House of Delegate: Jane Roggensack, Susan Pederson, Donelle Richmond, and alternates: Karen Macdonald and Jack Rydell. Wanda Rose, NDNA President addressed the membership. A special recognition was made to Jean Kautzman for her dedication to the CNE-Net program over the last 3 years. Without Jean and Susan Pederson NDNA would have been unable to continue with this program.

All reports from the VPs were available as written reports at the conference website and published in this edition of the Prairie Rose. Old business included an update on last year’s main motions and progress report on activities for celebration of the 100 year anniversary in 2012. A steering committee (Karen Macdonald, Marlene Batterberry, Mary Smith, Becky Graner, and Karla Haug) was appointed to keep the planning and details on track. Members are encouraged to send ideas, help with fundraising, and send stories.
Carrots and Sticks Don’t Work: Building a Culture of Supportive Feedback—Expectations–Empowerment–Recognition–Partnering–Expectations–Consideration—Trust

The principle of engagement is discussed; readers will be left with the understanding that engagement has been defined in a variety of ways in the literature. Marciano plainly makes a distinction between work engagement and non-engagement, is and what the underlying causes of engagement are; differentiating the terminologies by conceptual and operational definitions.

Research on engagement distribution and retention/turnover statistics provide a revealing insight into the magnitude of the problem when one attempts to engage the general workforce. While the statistics are not specific to nursing, it is easy to remember acronym to help build a healthy work environment. (Recognition–Empowerment–Supportive feedback–Partnering–Expectations–Consideration–Trust).

Becky Brodell, RN, PhD, presented a research poster at the 2011 Improvement Science Summit & Summer Institute on Evidence-Based Practice held on June 28–July 2, 2011 in San Antonio, TX. This year’s institute focused on aspects of change in healthcare, emphasizing patient safety and quality evidence-based improvement strategies. The Institute set a new record with 516 registrants representing 5 countries and 45 states, reaching a wide and varied audience.

Dr. Brodell's research topic is caring in nursing education. This year’s poster was titled “Group Caring Environment in Nursing.” Caring is not only an important attribute of nursing, it is a driving force for patient satisfaction. In today’s health care market, satisfaction with nursing care in an important factor in rating the quality of the services received and whether patients will return as future customers. Study of caring behavior is important because students are susceptible to the attitudes of their peers, instructors and the nursing staff within the clinical agencies.

Connect a woman to Women’s Way and you could save her life.

Do you know a woman who hasn’t had a recent Pap test? She may be able to get that Pap test through Women's Way, a breast and cervical cancer early detection program. Many North Dakota women are eligible for Women's Way, and you could connect them, like Peggy Piehl of Custer Public Health in Mandan does.

"Share because you care. Spreading the message about Women's Way is another way to make a difference in the life of a woman and the life of her family. Early detection of breast and cervical cancer matters. Letting a woman know about the program could save her life."

Services offered to eligible women include:
- Mammograms.
- Pap tests.
- Clinical breast exams.
- Pelvic exams.

Women who qualify for Women's Way:
- Live in North Dakota.
- Don’t have insurance.
- Have insurance that doesn’t cover Pap tests or mammograms.
- Are ages 40 through 64.
- Meet income requirements.
- Can’t afford to pay a deductible or copayments.

SAVE THE DATE!

The Nursing Student Association of North Dakota is planning their annual conference at the Best Western Doublewood in Fargo, ND on February 3 & 4, 2012. Hotel phone number: 701-235-3333.

For more information about Women's Way, call 800.280.5512, or visit www.nhealth.gov/womensway.

For further information and registration contact Audra Rosenow, President of NSAND (amrosenow1@umary.edu) or Susan Pederson, student advisor (susan_pederson@bis.midco.net).
North Dakota Partners In Nursing
Gerontology Consortium Project

In the fall of 2010, the NDSU Department of Nursing and Dakota Medical Foundation were awarded a two-year, $250,000 grant from Partners Investing in Nursing’s Future to address nursing workforce shortages specific to gerontology in North Dakota. Dakota Medical Foundation also provided $250,000 in matching funding for the project. Nine grants were received nationwide. “We need nurses to care for the elderly as they age—especially with the baby boomers aging, there’s going to be the high demand,” says Dr. Loretta Heuer, professor and project director. Partners Investing in Nursing’s Future (PIN) is a partnership of the Northwest Health Foundation and the Robert Wood Johnson Foundation to support the capacity, involvement and leadership of local foundations to advance the nursing profession in their own communities. The unique partnership of local and national foundations promotes innovative, localized strategies to create an adequate nursing workforce appropriate in size and equipped with the specific skills necessary to meet the demands of the 21st century patient population.

The purpose of the North Dakota Partners in Nursing (PIN) Project is to assure there is a well-prepared, adequate gerontology nursing workforce across the continuum of care settings to meet the needs of older adults. With Dakota Medical Foundation acting as a catalyst, 50 partners have come together to develop grassroots strategies for local nursing workforce solutions. Consortium partners include agencies, businesses, nursing schools, professional associations, high schools, health care providers, insurers and other parties. The unique partnership of local and national foundations promotes innovative, localized strategies to create an adequate nursing workforce appropriate in size and equipped with the specific skills necessary to meet the demands of the 21st century patient population.

These stakeholders understand too well the following concerns:

- North Dakota’s aging population, along with continued shifts in our population from rural to urban areas, presents a significant challenge to the health care workforce, especially in very rural and frontier counties.
- Just when additional nurses will be needed to care for our growing elderly population, a large cohort of nurses will be reaching retirement age.
- The threat to access to health care, quality of care, safety, and cost is a concern for all North Dakotans and requires a collaborative effort to come up with creative and sustainable strategies.

The PIN partnership, which has had three Consortium meetings so far, has already proven great value in the building of relationships and developing a better understanding of the concerns held by respective stakeholders. While the full Consortium of partners meets regularly, smaller work groups have been formed around the main goals of the project. The goals are as follows:

- **Education**—to strengthen gerontology education for faculty, nursing students, and practicing gerontology health care workforce
- **Positive Image**—to enhance the image of working with older adults across all settings of care
- **Recruitment**—to promote recruitment and retention efforts which encourage traditional and non-traditional students to nursing as a career, with a special focus on rural and Native American and Latino high school students
- **Sustainability**—to provide for the sustainability of project activities beyond the grant period

Work group members are making significant progress in developing strategies, activities, and tools that will help achieve the project’s goals. The electronic Blackboard organizational site is being used to communicate and to facilitate effective and efficient meetings of partners located across the state. For a complete description of the scope of activities being implemented, please contact Jane Strommen, Project Coordinator at NDSU Department of Nursing at jane.strommen@ndsu.edu or view the project’s website at: www.ndsu.edu/pin. To learn more about the 50 PIN partnership projects in 57 states, see the National PIN website: www.partnersinnursing.org

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**Announcement**

CNE-Net, the education division of the North Dakota Nurses Association, is now renewing their status as an Accredited Approver or an Accredited Provider of continuing nursing education. Individual applicants are no longer being accepted; instead applicants are encouraged to work with another Accredited Approver Unit. A list of all Accredited Unit providers can be found at the ANCC website. [http://www.nursecredentialing.org/Accreditation/AccreditedOrganizations.aspx](http://www.nursecredentialing.org/Accreditation/AccreditedOrganizations.aspx)

CNE-Net is working with the Washington State Nurses Association in transferring oversight of our approved providers to their CEARP division. The acronym, CEARP, stands for Continuing Education Approval and Recognition Program, and is a review process that WSNA uses to assure carefully-planned educational activities using ANCC criteria for nurses. [http://www.wsnna.org/Education/Cears](http://www.wsnna.org/Education/Cears)

Please note: Continuing nursing education activities published in the Prairie Rose over the last 2 years will expire on a new date: November 15, 2011. No contact hours will be awarded after that date.

The Refresher Courses and the LPN IV course no longer will be awarded contact hours as Refresher Courses are NOT continuing nursing education rather they are refreshing of previous knowledge. The LPN courses are no longer specific for the LPN scope of practice and do not have RNs in the intended audience. Contact hours will not be awarded for completion of these programs effective October, 2011.
### The functions of NDNA shall be to:

1. **Promote the professional and educational advancement of nurses.**
2. **Support the personal and professional development of nurses and support them in the workplace.**
3. **Foster high standards of nursing.**
4. **Facilitate nurses in North Dakota.**
5. **Operationalize NDNA purpose # 5 and function # 6, 7, 8**

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<th>President</th>
<th>Wanda Rose</th>
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<td>Represents NDNA to the public, lobbying, and at ANA. Serves on the ND Center for Nursing board.</td>
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<th>VP Communication</th>
<th>Susan Pederson</th>
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<td>Operationalize NDNA purpose #4 and function #11, 13, 14, 15. Serves as the liaison between NDNA and the ND Student Nurses Association and is the President of the Sigma Theta Tau International, serves with the student nurses on the ND Center for Nursing. Monitors and safeguards items of historical interest for NDNA, securing a safe home for the ND Historical Society. Provides input into the Prairie Rose content, and development of the materials for the 2011 NDNA Fall conference/meeting business.</td>
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<th>Donelle Richmond</th>
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<td>Monitor NDNA fiscal affairs. Assists in budget development and fiscal operations monitoring. Assessed and determined accreditation renewal will not be sought in 2012.</td>
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<th>VP Government Relations</th>
<th>Mary Kay Herrmann (outgoing), Karen Macdonald (newly elected)</th>
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<td>Operationalize NDNA purpose #3, 9 NDNA supported the advanced practice nurse in seeing to delete the need for a physician's signature on a collaborative practice agreement for prescriptive privileges. Law changed and signature need deleted. NDNA opposed the registering of lay midwives under the ND board of nursing as the law confused the public regarding lay and nurse midwives. Bill defeated. NDNA supported school nursing, the bill was defeated. Lobbying was provided by Karen Macdonald. A website with updates was activated during the session, and the GR committee held teleconference meetings each Friday and invited members to attend. NDNA monitored but did not take a stand on a number of introduced bills.</td>
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<th>VP Membership Services</th>
<th>Jane Boggsennack (outgoing), Mary Smith (newly elected)</th>
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<td>Operationalize NDNA purpose #4 and function #15 Provides information regarding membership, promotes recruiting and retaining members. Becky Graner applied for and NDNA received membership recruitment and retention grant from ANA. All material developed for ANA membership grant is available to members for use to recruit and retain members at local meetings.</td>
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| VP Practice, Education, Administration, Research | Stacey Pfennin | Operationalize NDNA purpose #1, 2, 3 and function #1, 2, 4, and 12 Facilitates the ND Online Journal Club, NDNA has showcased nurses work from across the state to improve practice, education, administration (leadership) and research. Nancy Joyner has contributed to the Prairie Rose on the topic of palliative care, Kathy Fox on a number of care of the dialysis patient topics. NDNA members have access to reduced priced or free continuing nursing education. NDNA continues to promote the SAGE (Seminars to Achieve Geriatric Excellence) program. NDNA is represented at the ND Partners in Nursing Gerontology Consortium Project by Becky Graner. |
Dyspnea is a very common yet challenging symptom patients with serious or life-limiting advanced disease may suffer from which can seriously affect their quality of life. Anxiety and fear often accompany dyspnea; either diseases or treatments can be the underlying cause. Understanding dyspnea and its pathophysiology can support comprehensive symptom assessment, management, and treatment (Dudgeon, 2010; Indelicato, 2006).

Defining dyspnea

Dyspnea can be defined as difficult, painful breathing or shortness of breath. It is a subjective sensation and can only be reported by the patient. Therefore it should not be confused with objective signs of respiratory distress, such as increased respiratory rate, labored breathing, tachypnea, dyspnea, hypoxia or hyperventilation. The terms dyspnea, shortness of breath and breathlessness are used interchangeably. In healthy individuals, dyspnea may be appropriate with exertion from a physiological standpoint and may need no further intervention, than to rest. However, in advanced disease, dyspnea may develop with little or no exertion. Patients may describe the feeling as shortness of breath, the inability to get enough air, suffocation or drowning. This subjective experience in breathing may be extremely uncomfortable and may vary in intensity. It is the difference between the apparent need to breathe and actual breathing ability (American Thoracic Society, 1999; Hallenbeck, 2003). Dyspnea can affect a person’s overall well-being as well as other aspects of his/her life, physically, psychologically, or emotionally.

Etiology of Dyspnea

Dyspnea, similar to pain, is multi-dimensional, with components from physiological, psychological, social and environmental factors. Breathing is normal very complex, involving the interaction of somatic and autonomic nerves. The respiratory center, located in the medulla and the pons, integrates peripheral and central afferent input, coordinating the diaphragm with intercostal and accessory muscles to generate the respiratory rhythm (American Thoracic Society, 1999; Manning & Mahler, 2001). Respiratory effort is a physiological function that is unique in having both reflexive elements and self-control. We continue to breathe when asleep or even in a deep coma; yet we can hold our breath to escape through smoke or be underwater. This psychological and physical state of breathing makes it more complex than other physical symptoms. The etiology of dyspnea is multifactorial; the condition can result from impairment of one or more body systems (Krayenbühl, von Gunten, & Von Roon, 2005; Hallenbeck, 2003).

Pre-existing diseases are the usual contributors to the development of dyspnea. Respiratory distress can occur both objectively and subjectively in diseases such as chronic obstructive pulmonary disease (COPD), asthma, congestive heart failure, interstitial lung disease, pneumothorax, pulmonary vascular disease, anemia, neuromuscular disorders and cancer. Acute onset may be related to a pulmonary embolism. Other factors such as chest wall deformity, anxiety, obesity or deconditioning may also contribute. The patient’s understanding of dyspnea and quality of life issues such as overall well-being, physical, psychological, social and environmental factors can support comprehensive symptom assessment, management, and treatment (Dudgeon, 2010).

Dyspnea can be defined as difficult, painful breathing or shortness of breath. It is a subjective sensation and can only be reported by the patient. Therefore it should not be confused with objective signs of respiratory distress, such as increased respiratory rate, labored breathing, tachypnea, dyspnea, hypoxia or hyperventilation. The terms dyspnea, shortness of breath and breathlessness are used interchangeably. In healthy individuals, dyspnea may be appropriate with exertion from a physiological standpoint and may need no further intervention, than to rest. However, in advanced disease, dyspnea may develop with little or no exertion. Patients may describe the feeling as shortness of breath, the inability to get enough air, suffocation or drowning. This subjective experience in breathing may be extremely uncomfortable and may vary in intensity. It is the difference between the apparent need to breathe and actual breathing ability (American Thoracic Society, 1999; Hallenbeck, 2003). Dyspnea can affect a person’s overall well-being as well as other aspects of his/her life, physically, psychologically, or emotionally.

Etiology of Dyspnea

Dyspnea, similar to pain, is multi-dimensional, with components from physiological, psychological, social and environmental factors. Breathing is normally very complex, involving the interaction of somatic and autonomic nerves. The respiratory center, located in the medulla and the pons, integrates peripheral and central afferent input, coordinating the diaphragm with intercostal and accessory muscles to generate the respiratory rhythm (American Thoracic Society, 1999; Manning & Mahler, 2001). Respiratory effort is a physiological function that is unique in having both reflexive elements and self-control. We continue to breathe when asleep or even in a deep coma; yet we can hold our breath to escape through smoke or be underwater. This psychological and physical state of breathing makes it more complex than other physical symptoms. The etiology of dyspnea is multifactorial; the condition can result from impairment of one or more body systems (Krayenbühl, von Gunten, & Von Roon, 2005; Hallenbeck, 2003).

Pre-existing diseases are the usual contributors to the development of dyspnea. Respiratory distress can occur both objectively and subjectively in diseases such as chronic obstructive pulmonary disease (COPD), asthma, congestive heart failure, interstitial lung disease, pneumothorax, pulmonary vascular disease, anemia, neuromuscular disorders and cancer. Acute onset may be related to a pulmonary embolism. Other factors such as chest wall deformity, anxiety, obesity or deconditioning may also contribute. The patient’s understanding of dyspnea and quality of life issues such as overall well-being, physical, psychological, social and environmental factors can support comprehensive symptom assessment, management, and treatment (Dudgeon, 2010). Dyspnea can be defined as difficult, painful breathing or shortness of breath. It is a subjective sensation and can only be reported by the patient. Therefore it should not be confused with objective signs of respiratory distress, such as increased respiratory rate, labored breathing, tachypnea, dyspnea, hypoxia or hyperventilation. The terms dyspnea, shortness of breath and breathlessness are used interchangeably. In healthy individuals, dyspnea may be appropriate with exertion from a physiological standpoint and may need no further intervention, than to rest. However, in advanced disease, dyspnea may develop with little or no exertion. Patients may describe the feeling as shortness of breath, the inability to get enough air, suffocation or drowning. This subjective experience in breathing may be extremely uncomfortable and may vary in intensity. It is the difference between the apparent need to breathe and actual breathing ability (American Thoracic Society, 1999; Hallenbeck, 2003). Dyspnea can affect a person’s overall well-being as well as other aspects of his/her life, physically, psychologically, or emotionally.
Oxygen is often thought of as first line therapy. However oxygen therapy continues to be very controversial in the management of dyspnea, as there is little evidence supporting its use in patients that are not hypoxic. Elevations in carbon dioxide levels, however, cause more dyspnea more than do low oxygen levels. (Bruea, Sweeney, Willey, Palmer, Strasser, Morice, 2003; Hallenberg, 2003). The role and effects of symptomatic oxygen for patients with chronic obstructive pulmonary disease is still unclear. Oxygen should be seen as a pharmacological agent and not be given based on benchmark recommendations. (Currow, 2009, Weissman, 2009).

Non-pharmacological management of Dyspnea

Changing a patient’s physical environment often is the most beneficial method in treating dyspnea. Patients may benefit from sitting upright in bed or a chair, or over a bedside table. Ensure the individual is positioned in a way that is appropriate and comfortable for them, while increasing the efficiency of the diaphragm. Patients who experience dyspnea appear to benefit from a cool, smoke-free and dust-free room with low humidity. A breeze from an open window or from a fan directed at the face may lessen the sensation of breathlessness. Stimulation of mechanoreceptors on the face or a decrease in the temperature of the facial skin may alter feedback to the brain and may modify the perception of dyspnea (Taylor, 2007).

Improving breathing efficiency can be achieved by teaching patients to breathe at a slow and steady pace, using a matching tone of calm, slow voice and speech. Using expressions such as “smell the roses and blow out the birthday candles” can aid as a visual example. Slowing the rhythm of the breathing and implementing activity pacing will empower the patient to be in better control of their actual breathing, activities, and their rest periods, enabling them to find improved balance, and allowing for less tiring and more efficient breathing. In addition to these interventions in the environment, the use of durable medical equipment such as a hospital bed, walker, wheelchair, bedside table, or bedside commode may decrease exertion and breathlessness.

Reduction anxiety

Anxiety can be a significant cause and exacerbating factor with dyspnea. Implement strategies that have worked in the past to reduce anxiety. Medications can be considered, but other methods should be utilized first. Include progressive muscle relaxation, guided imagery, and distraction as new or ongoing techniques. Music therapy also can help patients reduce their respiratory rates. A referral for psychotherapy could be considered (Indelicato, 2006).

Surgical and physical methods

There are numerous invasive strategies for treating dyspnea caused by underlying physical factors. External beam radiation to the primary bronchial lesion is used in cancer. Endobronchial stenting can be used to open a closed major bronchus and can also help keep the trachea open in patients with proximal tumors. Thoracocentesis also known as thoracocentesis or pleural tap is an invasive procedure to remove fluid or air from the pleural space. It can remove effusions that are either malignant or caused by cardiac failure, secondary to infection or even tuberculosis. Pleurodesis (adhesion of the two) or long term indwelling catheters may be used as an alternative to repeated thoracocentesis in selected patients (NCCN, 2011).

Conclusion

Dyspnea is frequently seen in patients with advanced illness and disease. It is a multidimensional symptom requiring thorough assessment and varying interventions. There is little correlation between severity and objective measurements. Although subjective in nature, dyspnea requires a thorough, comprehensive evaluation before a treatment plan is developed. Palliative sedation should not be the only medication used to manage dyspnea since patients that are not hypoxic. Elevations in carbon dioxide levels appear to cause more dyspnea than do low oxygen levels. (Bruea, Sweeney, Willey, Palmer, Strasser, Morice, 2003; Hallenberg, 2003). The role and effects of symptomatic oxygen for patients with chronic obstructive pulmonary disease is still unclear. Oxygen should be seen as a pharmacological agent and not be given based on benchmark recommendations. (Currow, 2009, Weissman, 2009).
assessment. It is important to treat pre-existing conditions that may contribute to the development of dyspnea and to educate patients and families on what to expect and how shortness of breath can be relieved.

**Dyspnea References**


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