Board of Nursing has been reviewing the Consensus Model for APRN Regulation and has issued a report based on the work of the APRN Task Force. In 2011 the Board introduced HB 1275 that by creates a separate licensure for Advance Practice Registered Nurses, changes title from APN to APRN aligning Advance Practice in Oklahoma with the Consensus Model.

The Oklahoma Nurses Association has been in support of APRN's working at the top of their license. OHA has joined the Coalition for Patients Rights (CPR) Nationally, ANA is a founding member of this organization. CPR, consisting of more than 35 organizations representing a variety of licensed healthcare professionals. It was formed to address scope of practice barriers and ensure that patients have direct access to the full scope of services offered by the quality health care providers of their choice. http://www.patientsrightscalization.org/

IOM Recommendation 2: Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.

Private and public funders, health care organizations, nursing education programs, and nursing associations should expand collaborative efforts with physicians and other members of the health care team to conduct research and to redesign and improve practice.

The Future of Nursing continued on page 4
Oklahoma Nurses Association

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Oklahoma Nurse:

June, July, August 2011

Oklahoma Nurses Association

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ONA Core Values

ONA believes that organizations are value driven and therefore has adopted the following core values:

Code of Ethics for Nurses  
Cultural Diversity  
Health Parity  
Professional Competence  
Embrace Career Mobility and Professional Development  
Human Dignity  
Ethical Care  
Professional Integrity  
Quality and Safe Patient Care

Committed to the Public Health of the Citizens of Oklahoma

ONA Mission Statement

The ONA is a professional organization representing a community of nurses across all specialties and practice settings.

Oklahoma Nurse Electronic Guidelines and Due Dates

Submit Information for “The Oklahoma Nurse”

View online: http://www.oklahomanurses.org/displaycommon.cfm?an=1&subarticlenbr=137

Manuscripts are due on the second Monday of January, April, July, and October for consideration of publication in the following respective issue. Below, please read the revised submission guidelines.

Email a word processing document to ona@oklahomanurses.org: file extensions should be *.doc, *.txt, or *.rtf.

Include:

– Suggested title, authors, author affiliation, ONA membership status, and appropriate references pertaining to the context of the article.
– Sub-headings are expected where indicated and tables/illustrations are encouraged to summarize key points as appropriate.
– Photographs should be of clear quality and in a digital format with appropriate resolution for printing.
– Black & white photographs are preferred but not required.
– Email images with the correct name(s), place/event, date, and descriptions.
– Images are not guaranteed to be run even if submitted.

Space limits:

– Due to space limitations, the following lengths are strongly recommended. While ONA will make every effort to publish articles in their entirety, ONA reserves all editing rights prior to publication.

– Feature articles: 500 to 750 words preferred, exceptions may be granted to 1,000 word max.
– Research articles: 1,000 to 1,500 words; exceptions may be granted to 2,000 word max.
– Regular Reports: 500 words (Executive Director, President)
– All other submissions: 250 to 500 words, content dependent, please include a clarifying statement if you are submitting an article exceeding these guidelines, such as special report on Mortality or Board of Nursing Annual Report.

The Oklahoma Nurses Association thanks you in advance for your contributions to our official quarterly publication. As always your support is appreciated. If you have any questions, please respond via email or phone to the office.

Thanks for making Nursing Positively Possible!
The Future of Nursing

Jane Nelson, CAE
ONA Executive Director

This is an exciting time to be a Nurse! Last fall the Institute of Medicine and The Robert Wood Johnson Foundation released its newest report on nursing, The Future of Nursing. Committee of the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine was tasked with creating a blueprint on the role of nurses in the design and improvement of public and institutional policies at the national, state and local levels. As a result of this report we have identified programs and initiatives that address the recommendations that move us forward. Our next step is to involve physicians and the community at large at a Summit on June 9. During this Summit we will share and discuss the report with other health providers and community members so that we can continue to move these recommendations forward by including our communities and the Legislature.

Since January the Legislature has been in session and ONA has had great representation at the Capitol by including our communities and the Legislature. Here is the status of those pieces of Legislation:

HB 1275—Changes the Nurse Practice Act to align advance practice nurses with the APRN Consensus Document as a changing Advance Practice from recognition to a licensure. Included is language regarding federal background checks and fingerprinting along with other minor changes to the act. In addition this bill increased the number of FTEs at the Board of Nursing so as to accommodate the changes and implement the Continued Competency rules. HB 1275 has passed both houses and is now on the Governor’s Desk. The proposed rules regarding Continued Competency are also on the Governor’s Desk.

I hope you agree that this is an exciting time to be a Nurse!★

Correction

There is an article in the Oklahoma Nurse, March, April, May 2011, Volume 56, Number 1 about Carole A. McKenzie, PhD, CNM, RN presenting in Tulsa in October 2010. Unfortunately, her associated university was listed incorrectly. Nurse McKenzie is affiliated with NORTHWESTERN Oklahoma State University. ★
environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices.

ONA is also involved with working collaboratively with other providers and health care entities at the State Capitol.ONA is involved with state wide groups such as the Electronic Health Record Consortium and a group focused on Health Insurance Exchange. Other examples of collaborative work include: Joanna Briggs Institute of Oklahoma, NDQNI Collaborative and Oklahoma Health Care Workforce Center.

IOM Recommendation 3: Implement nurse residency programs. State boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses’ completion of a transition-to-practice program (nurse residency) after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas.

ONA recognizes that well designed mentoring programs support the growth and development of novice nurses in their transition to professional practice and provide opportunities for leadership development.ONA has adopted a position on Nurse Residency Programs and the transition of novice nurses to the workplace. The ONA Committee on Professional Practice in the workplace has established a task force on Nurse Residency. The focus of this task force has been to review what currently exists in Oklahoma and ways to create a state system.

IOM Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020. Academic nurse leaders across all schools of nursing should work together to increase the proportion of nurses with a baccalaureate degree from 50 to 80 percent by 2020. These leaders should partner with education accrediting bodies, private and public funders, and employers to ensure funding, monitor progress, and increase the diversity of students to create a workforce prepared to meet the demands of diverse populations across the lifespan.

The 2009 ONA House of Delegates adopted a resolution supporting initiatives to require registered nurses (RNs) to obtain a baccalaureate degree in nursing within ten years after initial licensure. It exempts (or “grand-parents”) those individuals who are licensed or are enrolled as a student in a nursing program at the time state legislation is enacted.

IOM Recommendation 5: Double the number of nurses with a doctorate by 2020. Schools of nursing, with support from private and public funders, academic administrators and university trustees, and accrediting bodies, should double the number of nurses with a doctorate by 2020 to add to the cadre of nurse faculty and researchers, with attention to increasing diversity.

Oklahomanow has two universities providing Nursing Doctorates—Oklahoma City University, Kramer School of Nursing and University of Oklahoma, College of Nursing.

IOM Recommendation 6: Ensure that nurses engage in lifelong learning. Accrediting bodies, schools of nursing, health care organizations, and continuing competency educators from multiple health professions should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan.

The Oklahoma Board of Nursing is in the process of adding language in Rules for continued competency requirements in section 485:10-7-3 [485:10-9-3] for the renewal of a nursing license to be effective January 1, 2014. Each licensee will be required to demonstrate evidence of continuing qualifications for practice through the completion of one or more requirements within the past two years prior to the expiration date of the license. If audited, the licensee must present documentation supporting the continuing qualifications. The continued competency requirements are:

1) Verify employment in a position that requires a registered nurse (practical nurse) with verification of at least 520 work hours; or
2) Verify the completion of at least twenty-four (24) contact hours of continuing education applicable to nursing practice; or
3) Verify current certification in a nursing specialty area; or
4) Verify completion of a Board-approved refresher course; or
5) Verify completion of at least six (6) academic semester credit hours of nursing coursework at the licensee’s current level of licensure or higher.

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5) Verify completion of at least six (6) academic semester credit hours of nursing coursework at the licensee’s current level of licensure or higher.

The National Health Workforce Commission, with oversight from the Government Accountability Office and the Health Resources and Services Administration, should lead a collaborative effort to improve research and the collection and analysis of data on health care workforce requirements. The Workforce Commission and the Health Resources and Services Administration should collaborate with state licensing boards, state nursing workforce centers, and the Department of Labor in this effort to ensure that the data are timely and publicly accessible.

The Oklahoma Health Care Workforce Center participates in the Forum of State Nursing Workforce Centers, which is a group of nurse workforce entities who focus on addressing the nursing shortage within their state. The workforce center has an established Data Committee and has been working on this issue with all the health related licensing boards.

Sources and More Information Available Online

American Nurses Association: www.nursingworld.org
The Future of Nursing Website: http://www.thefutureofnursing.org/
Coalition for Patients Rights: http://www.patientsrightscoalition.org/
Chemical Policy Reform ~
Nurses Must Say “YES”

by Barbara Sattler, RN, DrPH, FAAN

Author Information: Dr. Sattler is Professor, Director of the Environmental Health Education Center at the University of Maryland School of Nursing. She also serves as Chair of the Board of Directors for the Alliance of Nurses for Healthy Environments (ANHE).

Over the last several years, we have all been hearing and reading about toxic chemicals that are in a variety of products that we use every day. Bisphenol A (BPA), flame retardants (PBDEs), and phthalates are hazardous chemicals that can be found in our foods, mattresses, baby pacifiers, and personal care products, respectively. The range of health risks that they create include cancer, infertility, and a host of endocrine-related problems. States around the country are passing legislation to ban these and other individual and categories of toxic chemicals. The question that we, as nurses, should be asking is “how come these toxic chemicals are allowed in our products in the first place?”

The main reason that they have been “allowed” is because we do not have any rules that say they can’t be in our products. We are all familiar with the tight government oversight that guides the development of new pharmaceuticals. Drug companies must apply to the Food and Drug Administration as soon as the idea of a drug is merely a twinkle in their eyes. From the onset, through clinical trials and final approval, there is continuous FDA oversight. But what oversight exists when a manufacturer wants to bring a new paint or cleaner, or for that matter a cosmetic or baby lotion to market. The answer helps to explain why we have so many potentially toxic chemicals in the formulas for our every day products.

The answer is that there is NO requirement for pre-market testing of the ingredients nor the final product before it comes to market.

So, what’s the result of this “under sight?” We have fragrances in our products that can trigger asthma, carcinogens in our hand creams, and reproductive toxicants in our insect sprays. Do the labels on these products warn us about these risks? No. Not required.

A bit of U.S. chemical history is useful here. At the beginning of the 20th century, women were reproductive toxicants in our insect sprays. Do the asthma, carcinogens in our hand creams, and have fragrances in our products that can trigger product before it comes to market. This odd oversight for processed foods lasted about 6 or so years. Then they disbanded the process. But. As silly as the previous oversight was, they did not replace it with anything. So, there is no requirement of pre-market testing for food substances in the U.S. either.

We can continue to try to pass legislation state by state, chemical by chemical and we’ll be at this for a very, very long time. There are an estimated 80,000 registered chemicals for which there is at least one, peer-reviewed study indicating a risk of toxicity. If we take them on on-by-one, it will still leave us with a trail of health risks for the century to come. Alternatively, we can support legislation that calls for pre-market testing and appropriate labeling and a mechanism to remove products and chemical processes that create significant, known health risks. Sounds like a no brainer but it is actually quite an uphill battle. Industry spent over $50 million to defeat last year’s Congressional version of a comprehensive chemical reform bill. We, in health care, don’t have that kind of war chest for a national campaign. But what do we have? We have a lot.

First of all, there are A LOT of us—mothers, fathers, nurses, other health professionals—all who have a stake in reducing toxic exposures. One in every one hundred Americans is a Registered Nurse!! We are the most trusted professional for conveying information about health and health risks, and we have incredible organizational structures—the American Nurses Association, State Nurses Associations, nursing subspecialty organizations, nursing organizations by race (i.e., National Black Nurses Association, National Association of Hispanic Nurses), and so on. We have nursing honor societies and sororities. We meet and greet to mobilize ourselves when professional practice issues are at stake and other nursing concerns. We educate policy makers and lobby in statehouses and on the hill. We can harness this incredible power to help make our immediate environments—our homes, schools, daycare centers, and workplaces—healthier and safer places by engaging in the new campaign to reform chemical policies in this country.

We’re also a very civically engaged lot. We are active members of our faith-based organizations, our PTAs, as well as being den mothers (and fathers) and leaders a myriad local organizations. We have an amazing opportunity to talk with our friends and neighbors to help them understand that this is an issue that truly affects each and every one of us.

The Centers for Disease Control (CDC) has been sampling urine and blood from a cross-section of Americans for the presence of toxic chemicals. They’ve been finding that we are awash in chemicals that are associated with cancer, birth defects, neurological disorders, learning disabilities, depression, and a broad range of other common and uncommon diseases. These chemicals should never be found in the human body. They are clearly trespassing.

An even more disturbing study by Environmental Working Group and subsequently corroborated by several peer-review studies indicates that the same range of chemicals found in adults can also be found in the umbilical cords blood of newborns. This final fact is a very loud alarm that should be sounding in every nurses’ head. This is the compelling evidence that our chemical policies are BROKEN and that comprehensive chemical policy reform is needed. We should not be delivering newborns who have a body burden of toxic solvents, plasticizers, and pesticides. As nurses, we find this completely unacceptable.

I invite you to join me and other nurses who are working with the national campaign for safer chemicals (www.saferchemicals.org) by working with the Advocacy and Policy Work Group of the new Alliance of Nurses for Healthy Environments (www.EnvRN.org). In our daily work, we care for people when they are at their most vulnerable. We need to add another element to our professional practice—a concurrent engagement in an effort that is truly designed to prevent diseases.
As our marketing efforts increase, so will the work to convey the ONA's value to members and their employers. This will be done through many channels all in the name of extending our appeal to a wider audience of nurses.

We're working to leverage technology by promoting the functionality of the ONA Web site, which continues to be updated with links to the ANA, Center for American Nurses and other resources. We're also exploring our options with social networking, which will help us communicate more effectively with current and future nurses.

2) **Advance the Nursing Profession:** The ONA supports the Institute of Medicine's recent recommendations to enhance the profession of nursing by advancing full scope of practice and by promoting education and learning at all levels. We also support the Oklahoma Board of Nursing's initiative to revise the rules for continued competency requirements for nursing license renewal, effective January 2014. These improvements coincide with the ANA's strategic imperatives and they'll have a positive effect on the future of nursing.

3) **Refine ONA Structure and Bylaws:** In recent months, ONA board members formed a steering committee that met to discuss revising our 2004 bylaws. The bylaws have now been updated and the committee will meet again to consider some additional board recommendations. These revised bylaws will be available on the ONA's Web site by June 2011.

4) **Empower Nurses:** ONA believes in providing resources that will help empower nurses. Most nurses will agree they feel empowered when they have some control over their environment. As health care providers, we set the example for the rest of the state in adopting healthy habits and it's important that we extend these into our work place, as well.

One of my favorite resources that I recently discovered was a link on the Center for American Nurses Web site, which offers evidence-based solutions and other tools useful for dealing with challenges to healthy work environments. One of these is the Conflict Engagement Resource Center which provides education on how to have critical conversations and how to address conflict at work.

More now than ever, Oklahoma nurses need to be involved in legislative activity, such as the Nurse of the Day program. This program gives nurses the opportunity to interact one-on-one with state legislators, who consider many issues affecting health care and our profession. Your participation gives nursing a voice to weigh in on these important issues. I served as Nurse of the Day at the state capitol last February and I'm glad I did. I encourage you to look into this program if you haven't already done so. Information can be found on ONA's Web site.

In March, the ONA Legislative Day for Nurses kicked off at the National Cowboy and Western Heritage Museum in Oklahoma City. Like the Nurse of the Day program, this event was designed to give nurses the opportunity to get involved and make a difference in the issues affecting nursing in Oklahoma. We had 800 nursing students show up this year and this event provided them great insight into some of today's nursing issues.

Speaking of students, I'd like to remind you of the importance of mentoring and the impact it can have on our profession and on young people in general. The Oklahoma Nursing Student Association has established a mentorship program to provide students with advice and guidance from nursing professionals, and I'm happy to say the ONA board of directors is serving as a partner. Each of us is an ambassador for the profession of nursing and I encourage you to get involved and take the time to mentor a student or someone new to the field.

Recently, the ONA board was given a proposal for an emerging nurse program—a special interest group here in Oklahoma for nurses with less than five years of experience. The board was very accepting of this proposal and will be piloting this project very soon. There is more information to come on this program, so check the ONA Web site soon for updates.

In the meantime, thank you for the work you do each day in caring for Oklahomans and the nursing profession.
What makes a Good Leader?

Over the years I have read countless books on what makes a good leader and almost all of them describe this leader as having certain attributes such as: being visible, supportive, leads by example, involved, creative, fair, visionary and collegial, just to name a few. Let’s discuss a few of those traits in more detail starting with leadership by example.

The Leader Sets the Tone

It is well known that every leader sets the tone of his or her organization. Whether we like it or not, our employees follow our example. Often employees look to see how a leader is behaving or what they are currently doing and follow suit. If the leader is honest, open, creative and involved then the work environment takes on the same persona. All of us have seen this time and again during our career.

The Leader Creates the Vision

Leadership is about creating a vision for the future and being able to transmit that vision throughout our departments and organizations. In order for leaders to anticipate what the future of healthcare holds, we must be knowledgeable about the opportunities, trends and issues facing our organizations. Some easy ways for leaders to remain updated to impact our health care delivery systems and improve health care in our communities is by becoming involved in our professional organizations, reading nursing and healthcare related publications and remaining active on the political front. All of these activities take time but are crucial for nursing to be seen as a leading profession in the healthcare arena.

The Leader Exemplifies Collegiality

The nursing profession is blessed to have leadership guidance through the American Nurses Association’s Scope and Standards for Nurse Administrators which apply to all nursing leadership including Nurse Executives, Chief Nursing Officers, Vice President’s of Nursing and Nurse Managers. The sixth standard is Collegiality—“The nurse administrator fosters a professional environment” and the measurement criteria for the sixth standard states—“The nurse administrator shares knowledge and skills with colleagues and others, and acts as a role model/mentor.” I strongly believe that when the criteria states colleagues and others it is talking about the community of nursing as a whole and not just within our own organizations.

The Leader Actively Participates in Professional Organizations

There are numerous opportunities for leaders to be involved in professional organizations. Both the Oklahoma Organization of Nurse Executives (OONE) and Oklahoma Nurses Association (ONA) are looking for leaders who would be willing to participate in leadership roles within their regions. Currently, ONA is looking for volunteers that would be willing to become involved in the “Future of Nursing Project.” The Future of Nursing Project involves the actualization of the Institute of Medicine (IOM) initiative related to their recent publication “The Future of Nursing: Leading Change, Advancing Health.” The IOM study was undertaken to explore how the nursing profession can be transformed to help exploit the opportunity and contribute to building a health care system that will meet the demand for safe, quality, patient-centered, accessible and affordable care.

Challenge to Nurse Leaders

Please remember as leaders we profoundly affect our employees and that our optimism and pessimism is equally infectious. Go out there, get involved and make a difference for the profession of nursing!
Blogs are an emerging writing tool for blog within their website (http://www.institute-one.org/) as one of your favorite and click scholarship through blogging is a natural extension. Within the state; therefore, the promotion of to support nursing education and nurse educators of the OK Nurse Educator Blog. IONE is designed to education . A dissemination of scholarly views and a collaborative activity, knowledge sharing, critical technology which strives to engage individuals in feedback a distinctive style emerges which reflects the personal character of the blog’s creator. 

Blogs have been described as a disruptive technology which strives to engage individuals in collaborative activity, knowledge sharing, critical reflection and scholarly debate. In fact, blogging has been described as a form of micro-publishing. The OK Nurse Educator’s Blog is designed to stimulate scholarly dialogue with other scholars (nurse educators) within the state to enhance nursing education. A dissemination of scholarly views and a sharing of knowledge will be the ultimate impetus of the OK Nurse Educator Blog. IONE is designed to support nursing education and nurse educators within the state; therefore, the promotion of scholarship through blogging is a natural extension. So, bookmark the IONE website (http://www.institute-one.org/) as one of your favorite and click on the link titled, OK Nurse Educators Blog to take part in the scholarly discourse. ★

The Institute for Oklahoma Nursing Education (IONE) launches an Oklahoma Nurse Educator blog within their website (http://www.institute-one.org/). Blogs are an emerging writing tool for scholarly communication. Scholarly communication has been described as the creation, exchange and dissemination of knowledge within the context of academic discourse. A large portion of scholars are educators who are concerned with scholarship as if relates to teaching. Blogs are thought to intersect scholarship and teaching. As places for sharing, blogs, over time have become a repository of information which can be linked to relevant sites. Therefore, blogs have contributed to research and data collection. An added benefit of blogging is the interactive and interlinking of posts between other nurse educators (scholars) which enhance networking and sharing of information. Scholarly conversation takes place which leads to analysis and interpretation of information causing further refinement through continued blogging. The continuation of blogging could be seen as further refinement through continued blogging. The Silver Award is the highest award that Girl Scouts, ages 11-14, may earn as a cadet. To attain this award, a young woman works to complete a series of leadership challenges and an extensive service project in her community. For many, the leadership skills, organizational skills, and sense of community and commitment that come from the community project set the foundation for a lifetime of active citizenship.

OKLAHOMA CITY—More than 40 handmade comfort pillows were delivered to the INTEGRIS Cancer Institute of Oklahoma by members of Girl Scout Troop 402 of Oklahoma City. The cadets made the pillows for patients undergoing cancer treatment at INTEGRIS in fulfillment of their community service project for their Girl Scout SilverAward. The Silver Award is the highest award that Girl Scouts, ages 11-14, may earn as a cadet. To attain this award, a young woman works to complete a series of leadership challenges and an extensive service project in her community. For many, the leadership skills, organizational skills, and sense of community and commitment that come from the community project set the foundation for a lifetime of active citizenship.

NEW REGULAR COLUMN

“Stories of Success: The Journey of the Nurse”

The Oklahoma Nurses Association is proud to celebrate the success of nurses in Oklahoma, especially its members. This new column is dedicated to Stories of Success submitted by nurses like you that have triumphed in your career whether laterally, upwardly, or in an emotionally fulfilling manner. Please share your success story with us. Your success might be the encouragement that the next nurse in line needs. Email ona@oklahomanurses.org.

Kimberly Graham

If I knew now what I knew then! When I started this journey, I would have never thought I would be where I am today! My life has never been a fairytale, but I would not change a minute of it. In 1993, I became a divorced single mother of two small children. My son was 6 months old and my daughter was a year and a half when I was accepted into the Rogers State University’s (RSU) ADN nursing program. I remember how humbling it was to go on state assistance, but it was the only way I could focus on school and take care of my children.

My current husband and I were set up on a blind date some time after mutual friends witnessed us literally running into each other in the hallways of RSU. He was a student of the Emergency Medical Services program. I would say we were study buddies, but if I was able to stand still I was sleeping! During nursing school I can recall several mornings waking up crying, because all I wanted was ONE more hour of sleep. Nursing school was Monday through Thursday and I worked the weekends at St. Francis Health Systems, Tulsa, in the Trauma Emergency Room. I loved it! Everything we talked about in school I got to see firsthand.

When I graduated, I moved directly into Cardiac ICU working nights and weekends FOREVER, or so it seemed. I moved among departments frequently, not because I was dissatisfied, but because I wanted to learn more. I thirst for knowledge. I spent time in neuro and trauma ICUs. As a matter of fact, ICU patients were my favorite because they made you think and work hard. I was blessed to be assigned with the new hires and students as a mentor. Education is perhaps my second calling.

Need more time with my children, I moved to Interventional Radiology to get a day shift. I found another love—cerebral artery embolizations! The complexity and the challenge was just up my alley. I eventually wanted to move towards a leadership position, so I enrolled in the RN-BSN Bridge Program at Bartlesville Wesleyan University. Again loving education, I returned to RSU not as a student, but as an instructor of nursing! It was such a proud moment for me to work beside some of the same instructors who taught me. I considered it a privilege. Soon after I completed the BSN degree, I returned to school once again. This time I earned a master's degree in nursing from the University of Oklahoma. During the past two years, I was a Director of Nursing (DON) for a local home health agency in Tulsa and also a Director of Nursing for NeuroRehabilitation Oklahoma, a neuro-rehab hospital in the CityPlex Towers also in Tulsa. Recently I accepted the position of Chief Executive Officer/Program Director for the same program. It has been a very long road, but I am so very proud of each step. To think I started as a twenty-something single mother with two small children to now a CEO of a hospital! Dreams do come true...with a little hard work! ★

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The INTEGRIS Cancer Institute of Oklahoma provides numerous services to cancer patients and their families. This is just one example of the partnership between our organization and the community, to provide supportive patient care. Girl Scout participants presented the comfort pillows to cancer survivors Wednesday April 6, as their “Silver Award.” The Girl Scout Silver Award represents a girl's accomplishments in Girl Scouting and her community as she grows and works to improve her life and the lives of others. The first four requirements of the Girl Scout Silver Award help girls build skills, explore careers, gain leadership skills, and make a commitment to self-improvement. ★

Silver Award Girl Scout Cadets Provide Comfort and Support to Cancer Survivors at the INTEGRIS Cancer Institute of Oklahoma

June, July, August 2011
The December 7, 2010 Gallop Poll revealed that nurses rank above all other professions in honesty and ethics. This is a tremendous compliment considering nurses coordinate care, advocate for the patient, develop and implement plans of care to achieve positive patient outcomes, and provide much of the point of service care. Nursing also protects patient confidentiality by keeping health records secure and sharing information when absolutely necessary.

Recently, Margaret (Peggy) Budnik spoke at the ONA Region 2 meeting. She discussed the key regulatory agencies that have the most powerful impact on nursing practice and she related the role of informatics in that impact. Peggy pointed out a relatively new fact about the role of nursing informatics: Nursing informatics, which will include determining what patient information should be shared and who it should be shared with, will be tied to reimbursement. The purpose of this article is to share briefly some of the important facts Peggy shared with RNs and students.

Signed February 17, 2009 the American Recovery and Reinvestment Act (ARRA) provides financial incentives for adoption and “meaningful use” (MU) of Electronic Health Records (EHR). Hospitals have the opportunity to gain 9.2 million. “The Medicare EHR Incentive Program will provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals that demonstrate meaningful use of certified EHR technology.”

Eligible professionals can receive up to $44,000 over five years under the Medicare EHR Incentive Program. There’s an additional incentive for eligible professionals who provide services in a Health Professional Shortage Area (HSPA).

To get the maximum incentive payment, Medicare eligible professionals must begin participation by 2012.

Incentive payments for eligible hospitals and CAHs may begin as early as 2011 and are based on a number of factors, beginning with a $2 million base payment.

Important! For 2015 and later, Medicare eligible professionals, eligible hospitals, and CAHs that do not successfully demonstrate meaningful use will have a payment adjustment in their Medicare reimbursement.

The ARRA includes 24 hospital objectives with 14 core measures. One of these core measures is that physicians must enter their own orders into the computer. When patients request their EHRs, their records must be available within 48 hours of the request. One barrier to meeting this expectation may be the lack of a standard electronic language that can transfer patient information between health care systems.

Health Information Exchanges (HIEs) are also included in this effort. The benefit of the HIEs is that they will allow health care facilities and providers to access patient information immediately. This access will provide continuity of care, lessen the chances for mistakes in care and will result in cost savings.

When is all this activity supposed to happen? The answer is now: Participation in the incentive program has begun. Who will it impact? It will impact administrators of organizations, all clinicians, patients, and families. Consumers are expected to be more involved in their care while nurses will be involved in reporting quality measures. These quality measures will include sharing electronic patient information appropriately while keeping the information secure.

In Tulsa, there is an organization known as Greater Tulsa Health Access Network (Greater THAN). It is a non-profit, grass root, community driven organization composed of over 50 health care organizations. There is one common objective of the network: To improve the health of our community by improving the Tulsa area healthcare system for the benefit of all patients, employers and providers. This BEACON organization has been lauded for its innovations.

2015 looms large. Nurses ARE up to the challenge. As nurses we entered this profession to improve quality of life for our patients. While nursing informatics may seem like an obstacle, the end result will be better patient outcomes and greater patient satisfaction. Who could argue that greater reimbursement and patient satisfaction is a negative outcome? ★

References

Budnik, M., (How Regulatory Agencies Affect Nursing Practice, professional presentation, Oklahoma Nurse’s Association, Region 2, March 1, 2011) http://www.cms.gov/EHRIncentivePrograms/ Retrieved April 7, 2011

Screening Patients for PAD: Early Detection = Treatment & Intervention

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Introduction
Over 8 million Americans over the age of 40 are affected by Peripheral Arterial Disease (PAD). PAD is associated with significant morbidity and mortality as well as significant physical limitations. It is crucial that nurses learn to screen patients at risk for PAD. The Ankle-Brachial Index (ABI) is the gold standard screening tool for PAD; however, most nurses have limited information related to identifying at-risk patients. Despite increased awareness of lower extremity arterial disease (LEAD), only 20% of patients with LEAD have been told that they have the disease (Dieter, et al., 2001). This article will review evidence based practice utilizing the ABI as an effective screening tool in the diagnosis of PAD and will also review the American Heart Association and the American Diabetes Association’s guidelines for screening patients with PAD.

PAD Incidence and Causal Factors
PAD is a vascular disease that commonly results from progressive narrowing of the arteries in the lower extremities due to atherosclerosis. PAD is defined as an ankle-brachial index (ABI) less than 0.90 in either leg. It is important to note that more than 95% of individuals with PAD have one or more cardiovascular disease risk factors (Selvin & Ehringer, 2004). In the diabetic population, PAD incidence is twice as high. Interestingly enough, only 10% of patients with PAD are asymptomatic. This means a large percentage of the population is asymptomatic leading to a decreased probability of diagnosis and treatment.

As stated previously a diagnosis of PAD is significantly correlated with a higher morbidity and mortality. The Pandora study conducted by Cicinelli et al., revealed in patients without overt cardiovascular disease the presence of PAD predicts approximately a 30% risk of myocardial infarction, ischemic stroke, and vascular death within five years of diagnosis. This study also revealed that study participants with PAD (78%) were less informed about PAD as compared to those who reported some information related to stroke (74%) and coronary artery disease (67%).

Multiple studies have also shown a correlation between mortality rates of LEAD individuals and the ABI (Dermott, et al., 2004; Golomb, et al., 2006; O’Hare, et al., 2006). A review conducted by Dieter, et al., studied PAD and the correlation of the ABI. Researchers believed that the current awareness of lower extremity arterial disease (LEAD), only 20% of patients with LEAD have been told that they have the disease (Dieter, et al., 2001). This article will review evidence based practice utilizing the ABI as an effective screening tool in the diagnosis of PAD and will also review the American Heart Association and the American Diabetes Association’s guidelines for screening patients with PAD.

The Big Question

The ABI is effective in diagnosing PAD, identifying those at risk and predicting mortality rates for LEAD individuals and the evaluation of vascular compromise in patients with trauma of the lower legs (Grenon, et al., 2009). The only tools required for the testing are a blood pressure cuff and a continuous wave 5 to 10 mHz Doppler probe as well as a skilled technician. The testing time is approximately 15-20 minutes. Recently researchers have compared performing manual ABIs versus accuracy of an automated oscillometric ABI machine. Overwhelmingly researchers have found the manual ABI to have a higher accuracy than the automated machine (Grenon, et al., 2009). As health care providers, nurses should learn to screen patients with suspected PAD with this inexpensive, accurate test.

The following is the step by step instructions for performing the ABI.

1. Obtain systolic pressure in each limb after the patient has been in a supine position for 5-10 minutes (Sacks, et al., 2003).
2. Calculate the ABI by dividing the higher of the ankle pressures of each leg by the higher brachial pressure.
3. When reporting measurement, remember that the ABI is a relative measurement and not an absolute number (Sacks, et al., 2003).

ABI results as high as 1.10 are normal, abnormal values are those less than 1.0. When a resting ABI is normal in patients with symptoms of intermittent claudication, noninvasive testing is recommended to enhance the sensitivity for detection of LEAD (Stein, et al., 2006). The majority of patients with claudication have ABI readings ranging from 0.3 to 0.9. Rest pain or severe occlusive disease typically occurs with an ABI < 0.50. Indexes < 0.20 are associated with ischemic or gangrenous extremities (Sacks, et al., 2003). If the ABI is equal to or less than 0.9 a contrast-enhanced Magnetic Resonance Angiography is recommended as well as a vascular consultation (Leiner, et al., 2005).

In patients with diabetes and heavily calcified vessels, the arteries are frequently incompressible. This results in falsely elevated ankle pressures which can underestimate disease severity. The nurse must identify these patients and perform a toe pressure which will more accurately reflect perfusion. The ABI is contraindicated when a suspicion of deep vein thrombosis is present. In such cases, performing the ABI could result in thrombus dislodgement (Grenon, et al., 2009).

Conclusion: Challenge to Professional Nurses
In summary, the increase in the number of adults with PAD risk factors mandating that professional nurses advocate for increased screenings for PAD. The author trusts that the information provided in this article will stimulate the reader to learn more about the screening for PAD.

References


Hamel, J., Foucault, D., & Fanello, S. Comparison of the automated oscillometric method with the gold standard Doppler ultrasound for access to the ankle-brachial index. Angiology, 6(1); 487-491.


April 2010}
Convention

Call for Abstracts – ONA’s Annual Convention

Submissions must be made online and must be received by 5pm, June 15, 2011. For more information visit the website, or call (405) 840-3476.

Theme: “Creating Avenues to Nursing Excellence.”

200-500 words, addressing one of five concurrent session tracks:
- Administrators/Manager
- Burnout/Life Balance
- Clinical (Practice or Process)
- Educators
- Staff Nurses
- Students

Subject suggestions:
- Emerging Nurse/Newly Licensed Nurse
- Technology & Nursing
- Social Media & Nursing
- Non-adversarial Communications
- Mentoring
- Emotional Intelligence
- Cultural Competency and Appreciation
- Nursing Abroad
- Nursing partnerships with Community
- How to research and Publish as a Nurse
- Infection Control
- Quality Improvement

Submissions must be made online using the submission form and will include: Title, and Abstract, Author(s), credentials, and prior experience. Note: Authors may submit multiple proposals.

Deadline: June 15, 2011: This will be a competitive selection process.

If your proposal is accepted: You will be notified no later than August 8, 2011, and asked to present on Thursday, October 27, 2011, at the Embassy Suites, Norman, Oklahoma. You will be required to complete and sign CNE credentialing forms, which are available online, before August 31, 2011. Failure to do so may cancel the offer to present, and the Committee may select another presenter.

Concurrent Session will be approximately 50 minutes in length, with 30-50 attendees. Electronics versions of all handouts need to be submitted to the ONA office by October 1, 2011. Posters will need to be in place before 9 am on Thursday 10/27/2011. You are required to staff your poster ONLY during the afternoon networking break. Suggested maximum size of posters: 36” by 48”

Compensation: Keynote Presenters will receive one complimentary registration. Concurrent Presenters: receive up to a 40% discount on two Convention registrations. Poster Presenters receive up to a 20% discount on two Convention registrations.

Call for Exhibitors: Creating Avenues for Nursing Excellence

Looking for Oklahoma Nurses? Exhibit at the Oklahoma Nurses Association Annual Convention.

One hundred years later, the Convention invites the Oklahoma Nurse Workforce, including students and educators, members and non-members, bedside nurses and nurse managers alike to meet annually and share ideas, promote education, develop professionally, gather information, confer with their peers, and, overall, advance Oklahoma nursing.

What you can expect to find at this year’s convention:
- Nationally recognized keynote speakers
- 5 Specialized tracks
- 375+ attendees
- 60+ exhibitors
- More Networking Opportunities
- Town Meeting Breakfast
- Rush Hour Reception
- House of Delegates
- Health Fair for Nurses (blood pressure testing to organic foods)
- When you register, you will receive one complimentary registration for the Awards Luncheon (a $30 value)!!
Gerogogy in Patient Education—Revisited

Mary Pearson, M.Ed, RN-BC

Abstract

Gerogogy in Patient Education was first printed in Home Healthcare Nurse, Volume 14, Number 8, (1996), Lippincott. Writers Mary Pearson, M.Ed, RN-BC and Joan Wessman, MA. have revisited and updated the material to meet the needs of a new generation of health care professionals.

Baby Boomers are retiring; they will reach their peak in 2030, with an estimated 72 million drawing social security. With these numbers comes an increase in services to the elderly, mostly in the form of medical expenditure. The problem will not only impact the financial system of Medicare but will have a great toll on families. How will the retirees remain independent in their homes? How will they learn new medical information? Will new health care professionals be able to teach them while taking into consideration the physical and psychological alterations that occur with aging and illness? Gerogogy takes into account the person's disease process, age-related changes, educational level and motivation. Then incorporates these factors into practice, utilizing the same foundations found within the nursing process: assessment, planning, implementation, and evaluation. As stated, the methods for teaching the elderly are unique and require modifications. Gerogogy meets these needs so individuals can remain at home while also reducing unnecessary medical costs.

Introduction

Gerogogy (ger-o-gee') in patient education has been defined by the authors as involving the transferring of essential information that has been specifically designed, modified and adapted to the geriatric nursing: allowing an individual to remain as independent as possible with or without the assistance of caregivers. Gerogogy can facilitate this transition from dependence to independence in an effective caring manner.

Demographics

Baby Boomers who were born between 1946 and 1964 have already begun to retire since the year 2000. In 2008 there were 38.7 million Americans age 65 years and older. In 2030, when the last of the baby boomers reaches age 65 years, the older adult population will double to 72 million individuals, who will account for more hospitalizations than any other age group. A further break down of the Graying Baby Boomers can be listed into three age groups. The first are the Young-Old, those persons whose age ranges from 55-75, second, Middle-Old individuals with an age range from 76-85, finally, the Old-Old which is anyone over the age of 85. In addition this group of adults older than age 85 years are and will be the fastest-growing segment of the population. The number of persons age 85 and over is expected to triple between the years of 2010 and 2040.

Education

Fifteen years ago 55% of the elderly population had completed high school, with 40% having graduated from college. Therefore, leaving 45% with either no formal education or less than twelve years. At that time there also existed a substantial age, race, sex and ethnic difference relative to the number of formal years of education obtained. Women and the then young-old were better educated than those in the middle-old and old-old categories. Older African-Americans had completed more grades than their Hispanic cohorts. Of note, during the writing of the initial article there was limited information found on the Asian population per the census information obtained for the year 1995.

The educational differences, however has lessened as the general population has aged. Whites and Blacks are beginning to reach equal levels of grades completed but only for high school graduates and higher. Whites graduated with an 87.1%, Blacks 83.0% and Asian/Pacific Islanders rating a 88.7%. These percentages reflect the 2010 Census in the year 2008.

There remains a difference with those races having completed college or graduate school. Of those who are Asian/Pacific Islanders 52.6% have completed college or have additional postgraduate education. Within the White population the percentage is 29.8. While Blacks rank 19.6%. Hispanics have continued to be at an educational disadvantage due to the financial and language barriers required to successfully complete school, the Hispanic rating is 13.3%.

The national trend is showing that as time advances educational attainment levels of the elderly in the 21st century will be higher than the present-day elderly. Seventy-six percent of the elderly in 2015 would have completed high school or more.[1]

Physiologic and Psychologic Changes

Skilled nurses must take into consideration the normal physiologic and psychologic effects of aging. Every system of the body deteriorates but all systems do not decline at the same rate. Nor does any specific organ age at the same rate in any individual whether they are related or not. As the body matures further changes transpire and new adjustments must be made to accommodate these alterations.[2]

One illustrates commonly occurring age-related alterations that may be found in an elderly person. Other examples of commonly occurring changes are decreases in sensory process, short-term memory, attention span, and memory sequencing. The ability to learn also changes fluid (cognitive processes related to neurophysiologic status) to crystal (cognitive processes developed through cultural meaning). These and the previous age-related changes do not take into account any ongoing disease process which may exaggerate the existing limitations.

Nurses’ Role in Education

When and how can patients be guaranteed an optimum learning experience? It begins when health professional acknowledge the indispensability of gerogogy to meet the elderly's needs.

The needs of the elderly and the nurse’s role in education are significant, worthwhile challenges. These challenges should not be taken lightly for they could mean the difference between the patient’s living independently, living with moderate assistance or total supervision. Maintaining or improving the elderly patient’s independence is a goal of all health care professionals. The skilled nurse must use every resource available in order to accomplish this.

Achievement of goals with gerogogy incorporates into practice the same foundation used in the nursing process: assessment, planning, implementation, and evaluation.

Skilled professionals first must assess the client’s present level and ability to learn. Second, a plan must be developed for transferring the desired information to the patient. Third, the facts must be transferred to the client. And finally, an evaluation/follow-up of the desired outcome must be performed.

This plan of instruction should commence with hospitalization prior to discharge. By initiating a plan of instruction on admission this will help alleviate possible complications. Complications can arise from misinterpreting orders, consequently, increasing readmissions. This will in turn allow the patient to remain as independent as possible.

Assessment - Factors Affecting Learning

Health care professionals must consider three encompassing but separate factors when educating the elderly: 1) individual physical status, 2) physical status and 3) socioeconomic status. These elements constitute the whole person and are interrelated but not totally interdependent.

Table two lists the factors that can have a positive or negative outcome on learning. Of the factors affecting learning, the educational level and degree of motivation that the patient exhibits must not be
underestimated. The last grade completed by an individual may have ended in college but if there is a lack of incentive then learning will not occur. This deficiency can be referred to as a dispositional barrier, especially if the older person has a low desire to return to health or does not accept impending changes. Motivation can compensate for a lower educational level, ensuring that learning will proceed from teaching. Thus, age-related changes, present disease processes, level of education and the degree of motivation can contribute to the patient’s ability or inability to comprehend vital medical instructions.

Planning—Factors to Consider

Effective instillation of information is the primary goal of the health professional in relation to gerogogy. Learning results in transferring information to individuals to their fullest capacity. All individuals learn but the means of obtaining knowledge varies. When consideration is given to the physical and psychologic changes plus the factors affecting learning, the learning process still may not occur. When professionals recognize there is a deficiency in comprehension they must step back and critique their learning tools or method of presentation. Critiquing can reveal a deficiency in one of the following areas:

1. Essential information was meshed with trivial facts.
2. Information overwhelmed the individual.
3. Repetition of material was not performed sufficiently.
4. Terms used to describe methods or techniques were too medically orientated.
5. Client’s learning was not evaluated throughout the lessons.
6. Multiple personnel instructed the client resulting in confusion.

7. Instilling of information was not individualized.
8. Patronizing the client resulted in discouragement.
9. Physical crises occurred and were of long durations, thus information was forgotten or modifications were not considered to compensate for any new physical changes.
10. Initial assessment before teaching was inadequate.

If one of the above occurs then modifying the material or changing the presentation should yield positive results. When instructing the elderly, skilled professionals must remember that a method proven effective for one person can have disastrous results for another.

Teaching is successful when the client retains the information, recalls it upon demand and performs
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the task with a return demonstration. Thus, the primary goal is achieved.

Implementation—Gerogogy Begins

Implementation of gerogogy begins with a summary of the following: diagnosis, physicians' orders, history of medical problems, social status, cognitive functioning, and educational level. This information determines the effects of aging and establishes the present degree of any disease involvement. From this evaluation the health professional once again incorporates the nursing process of planning, implementation, and evaluation. Blending the theories and techniques used by pedagogy (teaching children) and andrology (teaching adults) enhances the total learning experience.

Examples of topics for instructions that skilled professionals may transfer to the patient or family members are listed in Table Three. These topics may be either complex or simple. But no matter how trivial a chosen topic may appear it is important to the patient. The skilled nurse should remember that when it is successfully taught, a nursing goal is accomplished and a patient need is met.

The following case study describes examples of modified learning tools applied for practical usage.

Patient Information: Mrs. A., an 80 year old white woman.

Diagnosis: Adult onset diabetes.

Physician Orders: Home Health to instruct on administration of 30U NPH insulin, carbohydrate counting, FSBS testing with documentation. History: Progressive Parkinson's tremors for the last five years. Right cerebral vascular accident three years ago with inpatient rehabilitation. Discharge disposition from rehab was home with elderly spouse and home therapy, fair recovery was made.

Social Status: Lives with elderly spouse with multiple medical problems. Only child lives three hours away but a granddaughter lives 20 minutes north of her.

Cognitive Functioning: Orientated to person, place, time and situation, occasionally forgetful.

Educational Level: Last grade completed—seventh grade.

After the initial assessment the skilled nurse discovered that Mrs. A. had perceptual and visual deficits (even with corrective lenses), limited ability to concentrate, short-term memory loss, and memory sequencing difficulty. The previous stroke had impaired her sense of humor, caused poor judgment on dietary food choices, mild impulsive behavior and over estimating her abilities to perform household tasks. It was the concern of the nurse on the initial evaluation that Mrs. A. Impulsiveness may cause her to leave home without administering her insulin.

Although she appeared to have multiple physical and psychologic barriers related to her stroke and age related changes, her motivation was surprisingly high. She had a desire to learn in order to remain living independently at home. The fear of being placed in a nursing home was great.

The educational long-term goal of performing daily injections was established. A time frame of daily morning visits, with a gradual reduction based on competency was developed.

Preferred Method of Learning: The skilled nurse's assessment of Mrs. A. indicated that her primary method of learning came through a variety of stimuli and trial and error.

Listed below are the goals and teaching methods that were implemented.

1. GOAL: Familiarization with required insulin products
   Action: Hands on—Syringes, insulin bottles, alcohol swabs, glucose machine, and disposal after usage.

2. GOAL: Instruct on the American Diabetes Association dietary guidelines and the correlation of food intake and blood sugar readings
   Action: Graph/chart—Documentation of blood sugars and dietary intake for a 24 hour time frame.

3. GOAL: American Diabetes Association food consumption based on her age, weight, height
   Action: Mental stimulus/24 hour—Recall of food intake for carbohydrate count.

4. GOAL: Prevention of under or over dosing of insulin product
   Action: Eye to hand coordination —Develop the ability to judge the amount of insulin in the syringe. Also needed was the capability to move the plunger to acquire the correct amount of insulin due to the Parkinson's tremors.

5. GOAL: Evaluation of patient's comprehension
   Action: Verbal testing—Recall the previous day's lessons, review of her record keeping for food intake and FSBS results

To offset the barriers of sight, concentration, memory and the low educational level, the following methods of instruction were modified.

• SIGHT—The nurse wrote out basic instructions in large, one inch black letters on white paper with lines. Corresponding numbers indicated the procedure order and reduced frustration.

• CONCENTRATION—Lessons were no longer than 15-20 minutes. After her level of absorption was reached it was noted that she became restless resulting in increase number of mistakes.

• SHORT-TERM MEMORY LOSS—this area proved the greatest barrier. The skilled nurse continually modified and condensed steps to encourage progress. These alterations helped to stimulate motivation.

• EDUCATIONAL LEVEL—Although Mrs. A. had a 7th grade level education the lessons were given on a 5th grade level. She appeared to be either complex or simple. But no matter how trivial a chosen topic may appear it is important to the patient. The skilled nurse should remember that when it is successfully taught, a nursing goal is accomplished and a patient need is met.

Evaluation—The Final Step

Evaluation of Mrs. A's progress proved better than expected. Even with her problems of poor eye sight, short-term memory, and lessened eye/ hand coordination she was able comprehend and learn the information. The fear of living in a nursing home proved to be a great incentive. She had a good understanding of the foods and the amounts permissible on her diet. Most importantly she was able to administer her own insulin, which was no small task for a woman with multiple limitations.

Though currently, due to the tremors the only task she was unable to perform with accuracy was to fill her syringes. Seven syringes were prepared by the skilled nurse for the next week to be administered by Mrs. A. The grand daughter had also learned this procedure and will resume the task when the skilled visits have been completed.

Skilled nursing visits continued weekly, consisting of review of her FSBS, dietary intake and a syringe count. Along with the review of compliance Mrs. A has been receiving repeated instruction for each of the previously listed goals. This serves not only as a review for her but as an evaluation tool for the nurse.

With her optimistic attitude, willingness to learn and the desire to remain independent the health professionals involved with her care feel certain that in a matter of time this lesson will be learned.

Conclusion

Many age-related changes can become educational barriers. These alterations may effect the older person's ability or inability to learn. To develop and implement practical patient education the health care professionals must recognize these handicaps and modify existing teaching techniques to compensate for the changes. Only then will effective teaching occur thus allowing the elderly to achieve their full potential and to remain as independent as possible.

References


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<th>Nursing Observations</th>
<th>Nurse/Patient/Family Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neurologic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased reflex response, by age 90 all jerk reflexes are diminished</td>
<td>Time intervals longer to initiate fight or flight response</td>
<td>Reduced ability to drive, home/fire</td>
</tr>
<tr>
<td>Nerve cells are postmitotic; delayed synapse time due to less nerve cells</td>
<td>Loss of neurons causes lessened ability to comprehend new skills, memory loss, and decline in intelligence</td>
<td>Decreased ability for learning, medication compliance compromised</td>
</tr>
<tr>
<td>Autonomic responses lessen</td>
<td>Pulse rate after activity takes longer to return to normal</td>
<td>May over-extend physical limits</td>
</tr>
<tr>
<td>Atrophy of brain by 7%</td>
<td>Decreased ability to process information</td>
<td>Retaining medical information at risk</td>
</tr>
<tr>
<td>Monoamine oxidase serotonin increases, norepinephrine decreases</td>
<td>Depression symptoms may become evident</td>
<td>Increased risk for suicide, poor nutritional intake, refusal care for self, take meds</td>
</tr>
<tr>
<td><strong>Circulatory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No major changes in blood cell/platelet production</td>
<td>None noted</td>
<td></td>
</tr>
<tr>
<td>Plasma protein decreases</td>
<td>Imbalance of fluid exchange between capillaries and tissues</td>
<td>Swelling of dependent limbs</td>
</tr>
<tr>
<td>Reduced cardiac output; fibrous plaques of heart valves</td>
<td>Decreased tolerance to mild or vigorous activity</td>
<td>Unintentional physical activity may lead to exhaustion</td>
</tr>
<tr>
<td>Elasticity of blood vessels/arteries dwindles</td>
<td>Blood pressure elevates, 70-year olds have 50% less elasticity compared to 20 year olds</td>
<td>Increase frequency of B/P monitoring</td>
</tr>
<tr>
<td>Blood flow to all organs reduces in volume</td>
<td>Results dependent on organ in affected</td>
<td>Example—Reduced blood to brain can result in confusion</td>
</tr>
<tr>
<td>SA, AV nodes become infiltrated with fibrosis</td>
<td>Cardiac responses decrease, EKG patterns vary</td>
<td>My note prior to surgeries or physical exams</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trachea/bronchi begin to calcify</td>
<td>Reduction in air exchange</td>
<td>Dyspnea with activity</td>
</tr>
<tr>
<td>Number of alveoli remain constant, walls Separating deteriorate</td>
<td>Reduced respiratory surface, diminished breath sounds, rhonchi in lower lobes</td>
<td>May feel that they can not breath deeply</td>
</tr>
<tr>
<td>Alveoli become more collagen</td>
<td>Decreased alveolar ventilation, compromised air exchanged</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Chemical composition of substance separating alveoli and capillaries are altered</td>
<td>Affects gaseous exchange and lowers O2 levels</td>
<td>Possible confusion especially after physical activity</td>
</tr>
<tr>
<td>Intercostal muscles have increased fibrosis matter</td>
<td>Lung expansion/contraction is lowered resulting in reduced tidal volume</td>
<td>Shortness of breath occurs more frequently</td>
</tr>
<tr>
<td>Mucus secretion increases</td>
<td>Crackles can be heard, inspiratory/respiratory</td>
<td>Risk of pneumonia is present</td>
</tr>
<tr>
<td>Respiratory muscles weaken</td>
<td>Mucus, already thickened, remains in posterior/anterior lobes</td>
<td>Productive cough especially after being supine</td>
</tr>
<tr>
<td>Functional capacity less than 50%</td>
<td>Dyspnea with exertion or stress</td>
<td>Over estimating physical abilities</td>
</tr>
<tr>
<td><strong>Senses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thickening of eye lens</td>
<td>Presbyopia occurs, requires an increase in light to aid visional acuity</td>
<td>Ability to drive after dark is compromised</td>
</tr>
<tr>
<td>Eye lens become yellow</td>
<td>Inability to distinguish blue or green colors</td>
<td>Driving concerns with signal light changes</td>
</tr>
<tr>
<td>Ciliary muscles decrease in strength</td>
<td>Pupils react to light changes at a slower rate</td>
<td>Increase fall risk at night</td>
</tr>
<tr>
<td>Ear wax thickens</td>
<td>Formation of ear plugs causes decrease in auditory recognition</td>
<td>May appear hard of hearing</td>
</tr>
<tr>
<td>Structural changes alter middle ear bone structure</td>
<td>Presbycusis, tone discrimination decreases</td>
<td>Difficulty with high pitch voices or to distinguish sirens</td>
</tr>
<tr>
<td>70% fewer taste buds at age 70 than at age 30</td>
<td>Affects dietary intake and compromises nutritional status</td>
<td>Weight loss may occur from decrease in food intake, may use more salt for taste, potential in raising B/P</td>
</tr>
<tr>
<td>Saliva production decreases</td>
<td>Dry mouth</td>
<td>At risk for oral ulcers, gum disease, tooth decay</td>
</tr>
</tbody>
</table>

**Digestive and Urinary Tracts**

<table>
<thead>
<tr>
<th>Alterations</th>
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<tbody>
<tr>
<td>Digestive secretions and mobility on intestine declines</td>
<td>Food digest slower</td>
<td>Stomach feels full quicker—less intake</td>
</tr>
<tr>
<td>Incomplete relaxation of esophageal sphincter</td>
<td>Difficulty in swallowing,</td>
<td>Ability to consume food/liquid becomes laborious</td>
</tr>
<tr>
<td>Gag reflex diminishes</td>
<td>Incidental choking</td>
<td>Possibility for aspiration escalates</td>
</tr>
<tr>
<td>Loss of anal and urethral sphincter urges</td>
<td>Incontinence, urinary retention</td>
<td>Bladder infection increase, risk for urosepsis</td>
</tr>
</tbody>
</table>
### Alterations and Urinary Tracts continued

<table>
<thead>
<tr>
<th>Alterations</th>
<th>Nursing Observations</th>
<th>Nurse/Patient/Family Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small/large intestine atrophy, walls become weaker</td>
<td>Calcium and vitamins B6 &amp; 12 not readily absorbed</td>
<td>Diverticulosis may occur, colonoscopy should be routine per PCP</td>
</tr>
<tr>
<td>Peristalsis decreases</td>
<td>Decrease nutritional absorption</td>
<td>Constipation</td>
</tr>
<tr>
<td>Incidence of obstruction in pancreatic ducts rises</td>
<td>At risk for Pancreatitis</td>
<td>S/S Pancreatitis, pain upper right quadrant</td>
</tr>
<tr>
<td>Liver function slows</td>
<td>Ability to metabolize meds decreases</td>
<td>Monitoring therapeutic blood levels</td>
</tr>
<tr>
<td>Glomeruli function decreases</td>
<td>Filtration rate at age 75 is 50% than a young adult</td>
<td>Changes in urinary patterns can be present</td>
</tr>
<tr>
<td>Renal tubulars degenerate</td>
<td>Specific gravity decreases, medication metabolism hindered</td>
<td>All meds/OTC should be reported to PCP</td>
</tr>
<tr>
<td>Secretion buffers of tubular cells reduces</td>
<td>Maintaining acid/base balance is a challenge</td>
<td>Potential for confusion</td>
</tr>
<tr>
<td>Bladder capacity less than 50%</td>
<td>Frequency, urgency, nocturia</td>
<td>Increases bladder/kidney infections</td>
</tr>
</tbody>
</table>

### Skeletal/Muscular

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Major loss of calcium in bones, long and short</td>
<td>Severe in older, white, petite women. By age 70 thirty percent of Ca++ is lost in 25% of women older than 65</td>
<td>Bone density testing determine loss degree</td>
</tr>
<tr>
<td>Bone density decreases from calcium deprivation</td>
<td>Increased risk factor for fractures, changes in posture noted</td>
<td>Higher Fall Risk resulting in fractures warrants preventive action, meds and implementation of safety features</td>
</tr>
<tr>
<td>Neuron response time declines</td>
<td>Unsteady gait</td>
<td>Unstable coordination increases the possibility of falls</td>
</tr>
<tr>
<td>Total muscle mass reduction</td>
<td>Decreased strength</td>
<td>Increase injury risk due to over estimation of physical ability</td>
</tr>
<tr>
<td>Reduction in postmitotic muscle fibers</td>
<td>Estimated muscles loss of 30% between ages of 30 &amp; 80 years</td>
<td>Weakness from tired, over worked muscles</td>
</tr>
<tr>
<td>Cardiac muscle becomes thinner after age 50</td>
<td>Reduced cardiac output</td>
<td>Activity tolerance level declines</td>
</tr>
</tbody>
</table>

### Integumentary

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Epidermis becomes thin, skin healing decreases</td>
<td>Skin tears occur more often</td>
<td>Increased infection, can affect self-esteem</td>
</tr>
<tr>
<td>Reduction in sweat gland production</td>
<td>Ability to regulate body temperature decreases</td>
<td>Higher risk from suffering heat exhaustion</td>
</tr>
<tr>
<td>Number of fat cells decreases</td>
<td>Pressure sores/ulcers may develop</td>
<td>Examine pressure points for redness</td>
</tr>
<tr>
<td>Lowered skin temperature</td>
<td>Slow nail growth with calcium deposits</td>
<td>Yellow, thick nails on feet and hands</td>
</tr>
<tr>
<td>Skin cell replacement reduced up to 50%</td>
<td>Hair in ears, nostrils &amp; eyebrows grows, hair on head lessens</td>
<td>Self-esteem may be affected</td>
</tr>
<tr>
<td>Sensitivity to touch diminishes</td>
<td>Decreased to areas lacking hair and extremities</td>
<td>Risk of burns or sores increases</td>
</tr>
</tbody>
</table>

Note: EKG = electrocardiogram, OTC = Over the Counter, PCP = Primary Care Provider
### Turning Trash into Treasure

**Mercy keeps 44,000 pounds of unusable medical supplies and equipment out of the landfill and puts it into the hands of those in need.**

**Midwest, U.S.**—If you think it’s tough cleaning out your garage, imagine trying to get rid of outdated medical supplies, obsolete equipment and slightly damaged surgical goods. It’s not an easy task but the Sisters of Mercy Health System is committed to keeping these items out of the landfill and getting them into the hands of people who need them.

“Co-workers really made this happen,” said Julie Jones, Mercy’s executive director of mission and ministry. “Out of their desire to help others and reduce waste, a number of people began investigating what Mercy could do with extra resources.”

ROi, Mercy’s supply chain division, spent two years looking for an outlet for supplies and equipment that could not be resold or repurposed. Hospital Sisters Mission Outreach fit the bill with a worldwide distribution network.

“They have a team of volunteers that sorts all the donations into usable and unusable. They even have vendors who will refurbish equipment that doesn’t work,” says Greg Goddard, Mercy’s ROI director of operation logistics. “What’s still not usable is disposed of in an ecologically responsible manner and the rest is organized into categories and donated to medical missions around the world.”

Each month, Mercy trucks about four pallets of supplies—worth an estimated $5,000 to $10,000—to the Mission Outreach warehouse in Springfield, Ill. In the last year, Mercy has donated 44,000 pounds of goods. The items come from any of Mercy’s 28 hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from hospitals and 200 outpatient facilities in Arkansas, Kansas, Missouri and Oklahoma with the bulk from.

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Create a paper humor collection
Place an expandable folder with tabs beside your reading spot at home. As you discover comics, articles, pictures, and cards that are funny to you, cut them out and file behind an appropriate topic tab. Scan items into your computer as you need them.

Create a digital humor collection
Quickly drag fun emails, articles, pictures, clip art and photos to an appropriate topic folder within your inbox, as they are received. You can efficiently find them later when needed.

Save fun sites to your favorites tab. Many of the sites below have subscriptions available for daily jokes or periodic newsletters. Their use would ensure regular exercising of your funny bone, contributing to increases in your joy, energy levels and health.

Create a personal humor library
Collect humorous articles, books, pictures, films, costumes, music, props, toys, statues, hats and more. Who are your favorite humorists? What are your favorite LOL movies? What music applies to your topic?

Fun Supplies
Oriental Trading, www.orientaltrading.com
Rhode Island Novelty, www.ninovelty.com
Bubba’s Clown Supplies, www.bubbascapes.com
Priscilla Mooseburger Originals. www.mooseburger.com

Clown Training
http://perth.uw.lax/clowncamp (Oldest clown training program)
www.katlyowns.com (Klownz Around Tulsey Town)
AHHClownUnit@aol.com (AHH (A Health Humor) Clown Unit, Norman, Ok.)

Review previous material from this column
http://www.encyclopedia.com/Oklahoma+Nurse/publications.aspx?pageNumber=1 If you have additional favorite nursing humor resources that you would like to share for consideration, please email them to me via dianesears@sbcglobal.net

Take the Oath of Laughter
I VOW to laugh at the small stuff in life. I VOW to help the humor-impaired learn to giggle. I VOW to remember that laughter helps my body to be healthy. I VOW to moon only those people who really deserve it.

MEN: 1 VOW never to wear black socks and wingtips with shorts.
WOMEN: 1 VOW never to dye my hair purple when I’m having PMS.
I VOW to take time to look for humor.
I VOW never to dance nude on top of a piano while doing a gorilla impersonation. (Jane Kinyon, MSN, PMH CNS-BC, RN)

Humor Resources
You’ve learned about the value of humor and all the positive side effects it produces in yours and others lives. Where do you go when you want to spice up a nursing presentation, handout, poster, meeting, or your life with something funny?

Start with yourself.
Look in the mirror and smile. Make a funny face. Good. Did you laugh? No? Take a picture of yourself making a funny face or with a costume such as a mask on. If no mirth response obtained, imagine yourself as an actor or actress and produce your best fake hysterical laugh. (This is easier to do the first time when you’re alone). If unable to complete, go to http://www.funnyfame.com/videos4-you info/laughing-quadruplet-babies. If you still cannot laugh, you are indeed in humor response trouble. Rate yourself on a depression scale and consult a psychiatric professional as needed or look at any picture of yourself from the 1980s.

If you find or experience something that you think is funny, most of the time other nurses will too, especially if it is humor about their specialty area. Practice using the content selected for your project, especially if you need to speak it. Don’t think you think is funny, most of the time other nurses will too, especially if it is humor about their specialty area.

Create a humor collection
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Save fun sites to your favorites tab. Many of the sites below have subscriptions available for daily jokes or periodic newsletters. Their use would ensure regular exercising of your funny bone, contributing to increases in your joy, energy levels and health.

http://aath.org/index.html (Association for Applied & Therapeutic provides evidence-based information about current research and practical applications of humor)

www.cooal.org (Clowns of America International)
www.comics.com (Comic strips)
www.cybernurse.com/humor.html (Site for numerous humor links for nurses by nurses since 1997)
http://eww.org/Humor.htm (Emergency Room humor)

Google “nurse humor cartoons” for a wide variety of offerings
www.humorproject.com/ (Dr. Joel Goodman, The Humor Project Inc.)
www.jesthealth.com (Nurse Humorist Patty Wooten, website)
www.medi-smart.com/nursing-articles/humor (Variety of articles addressing humor)
http://www.nursesdirect.com/ (Nurses STATION Gift site)

www.nursinghumor.com (Wide variety nursing specialty jokes & cartoons)

www.nurston.com/ (Nursestoon comic strip by Carl Elbing)
www.realtym.com (Stories, cartoons)
www.realnurse.net (Nurse’s dictionary, jokes, cartoons)
www.scrubsman.com/category/humor-and-fun/humor (Stories, cartoons, media, videos)

www.WakeUplauging.com (New age humor)
http://www.workjoke.com/projoke.htm (Jokes by profession)

http://www.rxlaughter.org/t_reference.htm (Reference listing humor articles)

http://www.comics.com/comicstrips.html

by Diane Sears, RN, MS, ONC

“Humor Resources”
Mercy’s Sister Roch Rocks

Sister Roch of Mercy joins Clara Barton, Ted Kennedy and Ben Franklin in Modern Healthcare’s Healthcare Hall of Fame

Midwest, U.S.—The collection of names is impressive. Some are recognizable like the Mayo brothers of Mayo Clinic fame, others are less famous like Ida Cannon who created the first social work department back in 1905. But, it is clear that Sister Mary Roch Rocklage, 75, and a Sister of Mercy, belongs on this prestigious list with more than 50 years of service.

“Sister Rock has been a visionary force in health care leadership, driven by a commitment to provide access to quality health care for all people,” said Lynn Britton, president and CEO of Sisters of Mercy Health System.

As the 90th person ever inducted into Modern Healthcare’s Healthcare Hall of Fame since 1988, this honor only gives visible recognition to what others already knew.

From nursing school to leading the American Hospital Association and Catholic Health Association, Sister Roch understands the inner workings and complexities of the health care world. The opportunity to personally see health care from so many levels, combined with her leadership, helped her gain insight into the difficult needs that exist within health care and the ways in which leaders might bring about change to serve those needs.

In 1986, she brought this knowledge to the Sisters of Mercy Health System as their first president and chief executive officer. This step created today’s Mercy which serves more than 3 million people and includes 28 hospitals and more than 200 outpatient facilities covering Arkansas, Kansas, Missouri and Oklahoma. It also includes outreach ministries in Louisiana, Mississippi and Texas.

Her unwavering work did not end after stepping down as president of Mercy 13 years later. Instead, she continues an active role within the Sisters of Mercy Health System. Today, she serves as the health ministry liaison where she helps guide laypeople in leadership at Mercy.

“Like health care across the nation, Mercy is in a time of change,” said Sister Roch. “Our mission of serving our communities has not changed, but the hands who serve are now the doctors, nurses and many co-workers. What a blessing to see the work of the Sisters before us being carried out everyday by compassionate people.”

Along with Sister Roch’s service as a professor of health care administration at St. Louis University and Washington University, she participates in many governmental, religious and civic agencies, task forces and committees for health planning. She currently serves on the Mount St. Mary’s Academy Board, Whole Kids Outreach Advisory Board, Nurses for Newborns Advisory Board and Mercy Center Conference Retreat Center Board. She is a Fellow of the American College of Healthcare Executives and in 2004 received the AHA’s highest honor, a Distinguished Service Award.

“Her influence has been felt for more than 50 years across the nation,” said Rich Umbdenstock, president and CEO of the American Hospital Association.

“Her induction into the Hall of Fame is one capstone of a long and illustrious career in which she has displayed tremendous leadership and compassion, constantly reminding hospitals to put people first.”
Getting Prepared

As January 2011 drew to a close, weather forecasters were predicting another monumental snow dump accompanied by high winds and single-digit temperatures. More ominously, all forecasted temperatures were trending downward, so this was the real thing. We were about to receive another dose of what we experienced twice last year, so it was time to get moving and prepare for the worst—it was time to implement an emergency staffing plan.

The NICU census at OU Medical Center Children’s Hospital on Monday evening, January 31, indicated that we were near our 92-patient capacity, meaning that we’d have to bring in a full complement of essential staff to meet the needs of the babies. Once they arrived, staff were aware there was a strong potential they could be locked in with a “code yellow.” (A “code yellow” means that the hospital is in disaster mode due to adverse weather and staff cannot leave the facility until it is lifted.) The advanced warnings of the impending snow allowed staff the opportunity to decide if a quick trip home was needed, or to sleepover at the hospital to be the safest decision. The supervisors and I notified all staff of the “opportunity” to stay that evening.

For some nurses, 10-12 inches of snow is not a deterrent. Our department has several wonderful “seasoned” nurses who elected to plow through to the hospital in their 4WD vehicles. For anyone who has seen old reruns of the TV show M*A*S*H, they’ll remember clerk Radar O’Reilly and his bartering skills. Our NICU outdated Corporal O’Reilly in arranging cots for everyone. The hospital secured beds for special needs staff members. We even attempted to match those who snored with those who were married to snorers. Cots were arranged in offices, hallways, an education room and even physician office areas, no private rooms or Four Star Suites. The cafeteria staff extended hours in order to accommodate hospital visitors, families and staff at no charge, so we had the nutrition angle covered.

Tuesday: Oklahoma City Covered with 10-12 inches of Snow

My day began Tuesday morning, February 1, 2011, with a 5:45 a.m. phone call. The dreaded weather had arrived with a vengeance, unexpected babies had been admitted, and staffing for the day shift looked worse than expected. I took what I feared would be my last shower for 48 hours, packed some food and extra clothes, poured some coffee into my husband (he would drive me to the hospital in his 4WD vehicle), and headed for the hospital. I arrived to find that the supervisory staff was running at full speed: Night supervisors had the lodging plan in place for night nurses coming off duty, and day supervisors were still working the phones trying to bring in the last few nurses before we enacted “code yellow.” We then began the process of fine-tuning staff assignments to efficiently and safely meet patient needs, a process known as an “OODA Loop.” Despite a statewide disaster declaration by Oklahoma Governor Mary Fallin, a request by OKC Mayor Mick Cornett for all businesses to close for the day, and in the midst of an all-but-closed medical complex, OU Medical Center was functioning as if it were a peaceful, sunny day.

On that memorable Tuesday, patient care needs were met. Leadership and Bed Board meetings were scheduled every few hours to enhance communication between the departments and ensure all areas were able to meet increased demand for their services. I focused on staffing needs and arranging “change of tours” for staff already at the hospital to work the next day, or night, while others stayed home and assumed shifts later in the week. Between meetings, staffing magic, and reassurance to staff, the day flew.

My husband was eager to bring me home, so I was receiving his text messages asking when he could pick me up. Unfortunately—and despite the great execution of an excellent disaster plan—I couldn’t leave. An issue arose when the families of nurses and other health care professionals didn’t seem to understand that some days don’t end at their usual time. My husband and I spoke for a few minutes in the hospital driveway where I explained that I’d be staying the night. After showing me the crunched door and quarter panel in his car (he was ironically stuck by a motorist who had driven his wife to another hospital that morning), I waved goodbye as he disappeared into the snowy night.

Tuesday night operations proceeded smoothly once additional beds were found. The hospital had prepared for the storm; however, a nearly full facility coupled with adequate staff to cover the bulging patient census meant that we had more nurses needing a place to sleep than we had cots. One of our attending physicians secured several vacant physician sleep rooms for my staff. What an angel!

As the night progressed, I ventured to my office to sleep on what previously was regarded as a comfortable sofa. My opinion has since changed. Sleep was solid for three hours; then the dreaded trip to the bathroom late at night. This time though, I was greeted by on-duty nurses instead of tripping over the dog. The snow had stopped and the wind speeds were decreasing. Metro snowfall reports began arriving which indicated that we received 10 inches—we considered the potential that we might need to continue the lock-in for another night. Many nurses will do just fine taking breaks on cots, clustered around a Yahtzee game and updating friends on Facebook, but when faced with a second night of being snow-bound, even the calmest of people can get frustrated.

Wednesday: Key Decisions are Made

Hospital Leadership met Wednesday morning at 0700. All areas were adequately staffed, day shift was arriving without much difficulty, the snow and wind had ceased the evening before, so the decision was made to release “code yellow.” Many of the staff opted to stay, and lodging was available. But an audible sigh of relief was sounded by those longing to be home.

While many agencies, businesses, government and other services were halted, the work of the hospital nurses continues. The spirit of theses amazing individuals was inspiring. Many offered to stay so others didn’t have to come in, some offered others a ride, some offered their more comfortable sleeping locations to others, and all were sharing their treats. And the patients, especially our little ones, never knew the difference.
What do you enjoy about nursing now? I enjoy seeing nursing students learning, their enthusiasm, and accomplishments. I learn something new everyday regarding the Public Health Arena and how nurses solve problems and make interventions when necessary. Keeping up with changes in health care in general helps me roll with the “flow.”

If you could improve one thing about nursing, what would it be? In order to keep up with America’s health care changing needs, bottom line, we need MORE professors to teach MORE nursing students in order to get MORE trained nurses. If there is a personality conflict with a student and a professor, there needs to be MORE options open to the student in order to facilitate the completion of the educational requirements.

Hobbies: Fishing; boating; playing Dominoes and “42;” and playing with my grandson, Quade.

What is your specialty? Specialty—Public Health Nursing; District Nurse Manager, Oklahoma State Department of Health.

What do you enjoy about nursing now? I enjoy helping people in their communities with prevention and management of chronic health problems and I love teaching nursing.

If you could improve one thing about nursing, what would it be? The one thing I would like to improve about nursing is to make the workloads in all settings of nursing one that nurses could feel that they are providing the best care possible. This would prevent burnout and nurses could feel that they truly are able to provide the care that is desired and have adequate time to spend with their patients.

Hobbies: boating, hiking, nursing, watching my daughter’s ball games, and spending time with family

Unfortunately, Region 4 is currently vacant of officers. Please contact the ONA office and help us pull Region 4 together again. Then you could be here next issue! Email ona@oklahomanurses.org today!

What is your specialty? What is your specialty? Specialty—Psychiatric Mental-Health Nursing is my specialty. I had worked in Medical Surgical Nursing for several years and then the NICU for four years. I was still searching for my passion when I just happened to stumble into Child and Adolescent Psychiatric Nursing. I worked at Primary Children’s Hospital, Salt Lake City, Utah for over seven years and my life was changed. I discovered a tremendous passion for children’s mental health. I was visiting with a FNP the other day who provides women’s health care one day a week in a small rural clinic. She said some of these women are in their 50’s and 60’s and haven’t seen a physician since their last pregnancy.

What would it be? I would like to see nurses becoming more involved with their professional organizations. With the face of nursing changing rapidly, we need to unite for a stronger voice. We need to realize the voice they could have and the changes they could make by uniting together in their professional organizations, they would be joining today. I would like to see nurses become more involved in the political, verbal, and more involved in their profession. I promote this on a daily basis as a nurse educator.

Hobbies: Spending time outdoors, gardening, jogging, cooking, and cleaning house (really, this has always been a stress reliever for me). I am going back to school to obtain my Post Master’s Certificate, Psychiatric Mental Health Nurse Practitioner.

How long have you been a nurse? 29 years

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What would it be? I would like to see nurses becoming more involved with their professional organizations. With the face of nursing changing rapidly, we need to unite for a stronger voice. We need to realize the voice they could have and the changes they could make by uniting together in their professional organizations, they would be joining today. I would like to see nurses become more involved in the political, verbal, and more involved in their profession. I promote this on a daily basis as a nurse educator.

Hobbies: Spending time outdoors, gardening, jogging, cooking, and cleaning house (really, this has always been a stress reliever for me). I am going back to school to obtain my Post Master’s Certificate, Psychiatric Mental Health Nurse Practitioner.

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Region 7

Name with Credentials/ Degree Designations: JoAnna Tripp Ware, BSN, MS, BC, CNS, RN

Position in Region: Member

Why did you become a nurse? I had always thought about it. Tried going on mission trips and maybe make that positive difference!

ONA Board

Name with Credentials/ Degree Designations: Connie Davis RN, BSN attending OU for MSN due to complete May 2012

Position in Region: 2010-2012 Vice-President of ONA, Member of Region 3

Why did you become a nurse? I became a nurse because at the age of 7 I was diagnosed with IDDM. I was hospitalized many times as a child and always felt protected and cared for by the nurses. I wanted to be able to do that for people.

What did you do after you became a nurse? I became a nurse as a speciality in medical evacuation because safety might be a concern. I hope you will never have to look at your patient population and systematically determine the priority for those who would need medical evacuation because safety might be a concern. I hope you will never have to look at your patient population and try to determine who is eligible to take Potassium Iodide to protect them from radiation exposure. But we are nurses, and strategic planning is a part of our everyday whether we are working the step down unit or the CNO of a facility. Nurses have through our recent history, to include Hurricane Katrina or the terrorist attack in Oklahoma City, made decisions about patient care, triage, and strategic planning with sometimes little or no warning. The question is: are you prepared personally to be a leader in this process?

My experience in this disaster and others has shown a few standard strategies which need to be highlighted. First, strategic planning is crucial to quick recovery from any disaster, whether it is natural such as earthquake or tornado, or man-made destruction like a terrorist attack. Key planning to include integration of local, state, and federal authorities provides the best possible solution to a tragic event and regaining control of chaos. As planning and exercises of disaster plans occur, don’t hesitate to be the voice of “what if” comments. What if the disaster happens in winter and temperature controls add to the difficulty of the situation. What if your assumptions about the supply chain is incorrect? What if your linen supply was unavailable? What if you could not get resupply of vital medications or other medical equipment? As patient advocates, nursing leaders need to be involved in disaster planning processes.

Second is the personal preparation for such events. No one can really imagine what it would be like, but you can prepare yourself mentally with proactive planning. Looking at potential scenarios for likely disasters for your facility will be key to personal preparation. Some of the questioning should be geared towards your leadership while others are on the very personal level. Such personal questions: Are you prepared to balance work and personal life during a disaster? Once you know your family is safe, can you step forward and lead a team? Is your personal life in a state that you could be absent from home for extended hours? What about your discipline because there are no other leaders in that area? Can you perform duties required to take care of your facility such as sand bagging entrances to picking up debris to make the facility safe? So why were my colleagues and I having a light hearted moment about my statement, “It was just an earthquake?” Because 6 weeks after this most devastating event and after all the actions of many leaders to ensure healthcare would be available to anyone in need, it was an earthquake that started a great learning process. The quakes continue to this day and the lessons continue as well in many of us. The nursing process has provided a model for working, living, and overcoming many of the challenges we have faced in Japan. The hope is for no one to use these skills, but that is not realistic. When you are faced with your “earthquake,” will you be ready?
Online Registration is available at www.OklahomaNurses.org

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Emerging Nurses at the Oklahoma Nurses Association

Have you been a nurse for less than five years but more than five minutes? If so, then you want to know about Emerging Nurses. This is a new special interest group of the Oklahoma Nurses Association. This is a professional group whose participants are registered nurses from all different backgrounds and levels of experience. Emerging Nurses provides a safe forum where individuals from these different specialty areas can come together to support and learn from one another.

As a new RN it is sometimes difficult to find where you fit in among the health care community. This group provides new nurses the opportunity to share capitalize on their ideas for the nursing community. This group thrives on innovation and fresh perceptions.

Emerging Nurses gives the less experienced nurse a voice and a community. With the help of the Oklahoma Nurse’s Association, Emerging Nurses will prepare professional nurses to become more involved with nursing organizations throughout their career. The primary objective of the group is to help new nurses thrive and grow within the nursing community professionally and personally.

The Oklahoma Nurses Association is proud to present and support the Emerging Nurses special interest group. ONA is the professional association for all registered nurses in Oklahoma across all specialties and practice settings. ONA addresses the issues that face nursing on a daily basis as well as other issues of importance: nurse-force numbers, workplace safety, standards of care, scope of practice, and patient safety.

If you would like to be part of or learn more about the Emerging Nurses special interest group at ONA, please send us an email at EmergingNurses@oklahomanurses.org or call the ONA office at (405) 840-3476.

“Congratulations to the founding members of the Emerging Nurses group! I’m so proud. I have been bragging on this group every opportunity I get. There is so much interest out there. Rest assured that you have my full support. You are all setting the pace for the future!” Linda Fanning, ONA President

SIGNATURE REQUIRED BELOW

Dues Payment Options (please choose one)

- Automatic Monthly Payment Options
  This is to authorize monthly electronic payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize ONA to withdraw $22.83 per month or $274.00 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

- Automatic Annual Payment Options
  This is to authorize annual credit card payments to American Nurses Association, Inc. (ANA). By signing below I authorize ONA to charge the credit card listed below for the annual dues on the 1st day of the month when the annual renewal is due. *SEE AT RIGHT

- CHECKING ACCOUNT: Please provide the credit card information at right and this credit card will be debited on or after the 1st of each month via regular mail, email, telephone and or fax.

- CREDIT/DEBIT CARD: Please complete the credit card information at right and this credit card will be debited on or after the 1st of each month.

- Charge to My Credit/Debit Card
  VISA (Available for Annual or Monthly Draft Payments)
  MasterCard (Available for Annual or Monthly Draft Payments)

- Number ____________ Exp. Date ____________
- Verification Code ____________
- Signature ____________________________________________

- By signing the Automatic Monthly Payment Authorization or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to change the amount by giving the undersigned thirty (30) days advance written notice. Under signed may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date designated above. Membership will continue unless this notification is received. ANA will charge a $5.00 fee for any returned drafts or chargebacks.

- By signing the Automatic Monthly Payment Authorization or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to charge the credit card listed below for the annual dues on the 1st day of the month when the annual renewal is due. *SEE AT RIGHT

- Automatic Annual Payment Authorization Signature

- By signing the Automatic Monthly Payment Authorization or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to charge the credit card listed below for the annual dues on the 1st day of the month when the annual renewal is due. *SEE AT RIGHT

- Automatic Monthly Payment Authorization Signature

- American Nurses Association Direct Membership is also available. For more information, visit www.nursingcp.org

Membership Categories (please choose one category)

- ANA/ONA Full Membership Dues
  Employed full or part-time $22.83 per month or $274.00 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

- ANA/ONA Reduced Membership Dues
  Not employed RNs who are full-time students, newly-graduated RNs, or age 62+ and not earning more than Social Security allows. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

- ANA/ONA Special Membership Dues
  $6.04 per month or $72.48 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

- ONA Individual Membership Dues
  Any licensed registered nurse living and/or working in Oklahoma $11.21 per month or $134.52 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

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Communications Consent
I understand that by providing my mailing address, email address, telephone number and/or fax numbers, I consent to receive communications sent by or on behalf of the Oklahoma Nurses Association (and its subsidiaries and affiliates, including its Foundation, District and Political Action Committee) via regular mail, email, telephone and/or fax.

Signature ____________________________ Date ____________________