MARN wishes a fond thank you to both outgoing president Toni Abraham and to Anne Manton who accepted the gavel at the end of the Ninth Annual Convention on April 17, 2010. Anne will lead the organization into its second decade. Below are the remarks of two remarkable nurse leaders.

Toni Abraham RN MSN APRN-BC
As I finish my second year as MARN’s president, I want to thank from the bottom of my heart, the people that guided and mentored me along the way. I could not have sustained myself without Mary Manning. Last year I called her my educator and supporter, both of which remain true today.

The Board of Directors continues to amaze me with their depth of knowledge and commitment to the nursing profession and MARN. I want to thank Anne Manton who was the cornerstone of the search committee, which facilitated hiring our new Executive Director, Diane Jeffery. Thank you also is extended to Lisa Presutti, MARN’s part-time Administrative Assistant who does a full-time job with a smile, helping all of us stay afloat.

The MARN committees have been very active and passionate in their focus to grow our organization. Many new members have come to me to express their excitement about the work of the committees they have joined, stating how much they are learning and truly enjoying the experience. My deep thanks to all committee chairs and their members.

VOLUNTEERISM
As you know, I chose to focus on volunteerism for my platform these past two years. MARN nurses stepped up and volunteered in a number of ways including writing articles for our quarterly newsletter, working at the Boston Marathon as well as at an information day for the homeless in Springfield called Project Homeless Connect. The theme continues as we set sight on the 114th Vital and the membership committee for their creative thinking about ways to increase our membership.

The Health Policy Committee is also alive and thriving. They have created the MARN Action Team (MAT) who will guide us through the legislative processes, provide testimony and increase the visibility and influence of MARN on legislative issues that affect the lives of all professional nurses in the Commonwealth.

REACREDITATION APPROVED FOR ANOTHER SIX YEARS
This past year our talented and dedicated Continuing Education Committee received a 6-year reaccreditation by the ANCC of the MARN Approver Program. Judy Sheehan and the committee are bustling and are true models of volunteerism at its best.

I end my term as MARN President, I continue my commitment to grow this organization. Thank you for your trust in me.

Anne P. Manton, PhD, APRN, RN, FAAN
As I accept the MARN presidency, I recognize that I have big shoes to fill.

I’d like to take a moment to thank Toni for her outstanding leadership as MARN President for the past two years. For those of us who have had the good fortune to serve on the board of directors during her presidency, it is clear that she strikes just the right balance between encouraging dialogue and ideas to be put forth, and making sure that decisions are made and the work of MARN is accomplished. All MARN members have benefited from Toni’s leadership, and MARN as an organization has profited as a result of her presidency. Thank you Toni!

I also want to recognize our retiring Executive Director—Mary Manning—for the incredible work she’s done for MARN. Mary will always be recognized as a cornerstone of this organization. We’re so fortunate to have had her as our Executive Director! And I welcome our new Executive Director—Diane Jeffery. We are delighted that Diane has joined us and look forward to working with her for many years to come.

As I begin my term as President, I will do my very best to follow the excellent example of all of my predecessors. MARN is a relatively new organization, and we have experienced remarkable growth since its inception—but we need to grow more...both in numbers and in influence...and that will be one of my goals for this organization.

As some of you are aware, I spent several years as the co-chair of NOLF—Nursing Organizations Liaison Forum—which was an official entity of ANA. In that capacity, it was my honor to represent the many other nursing organizations at ANA Board of Directors meetings. As the voice for the nursing organizations, I also served on some important ANA Task Forces such as the Continuing Competencies Task Force and the "Futures" Task Force. I am also a proud past-president of the Emergency Nurses Association and past board member of the Massachusetts Emergency Nurses Association.

My experience as NOLF co-chair and as a leader of a specialty nursing organization, brings me to my second goal for MARN—to bring all the nursing organizations in Massachusetts together...
Thanks Mary

Barbara A. Blakeney

Have you ever noticed that some people just make things easier, more interesting and well, fun? If it’s a colleague, going to work is easier; you look forward to it. If it’s volunteer work, you want to give more time. Such people have a way of getting the best from others—the best thinking, the best commitment, the strongest support and, when that happens everyone and every thing flourishes. Such people are leaders, they get things done and they have a good time doing it.

Mary Manning is such a person and MARN has been so fortunate to have benefited from her skill since its very beginning. Mary is stepping down as the MARN Executive Director after a distinguished career as a nurse, an educator and an administrator. You see, she thinks she is retiring but I suspect her life in retirement will be just as busy, full and rich as it has always been. Mary loves being with people, she invites community wherever she goes and people respond; drawn by Mary’s calm energy, good humor and can do spirit.

In the years to come when I think of Mary, and I will, I will remember a little stone she often has with her—etched on that stone is the simple word “Believe.” Mary is a strong believer in all things possible. Mary is a creative and pragmatic problem solver who can see possibilities long before most others. She is a strategic thinker who anticipates possibilities and plans for them.

I’ve known Mary for a number of years (no Mary I’m NOT going to tell them how many), both good and bad and no matter which it has been she has always been a calm presence and a level head. And while there were some times when I thought the letters would be rubbed off that stone there would not a change in her. Mary Manning is that rare person who you just know has enriched you, strengthened you and helped you be a better person for knowing her. There is just no other way to say it—Mary Manning soars and because she does we have too.

Thanks Mary.
Dear Editor,

I was delighted to get the March 2010 Massachusetts Report on Nursing Newsletter in the mail and was even happier to see that Dr. Nancy Rappaport’s Address, “Other Mothers” was reprinted. I would like to clarify that the presentation was made to the clinicians (nurse practitioners, physician assistants, nurses, and mental health providers,) as well as administrators who attended the October 8, 2010 workshop on school mental health that was sponsored by the MA Department of Public Health School Based Health Center Program and developed by the MGH Institute of Health Professions as part of a contract for mental health capacity building.

Dr. Rappaport’s words rung true to the audience of experienced, talented, and dedicated advocates for children’s access to care:

“Take inventory and reflect on what you need to cultivate the necessary stamina and compassion for the road ahead.... Remember those who have influenced you: other mothers or fathers who helped you along the way with tireless encouragement. ...remember that you may be other mothers or fathers to mothers.”

Dr. Rappaport has herself been a tireless advocate for school based health centers and supporter of the role of nurse practitioners. Thank you for publishing the article and I look forward to the continued publication of your excellent newsletter.

Sincerely,
Gail B Gall, Clinical Associate Professor
MGH Institute of Health Professions

Making Connections

Myra F. Cacace, Editor

The Encarta World English Dictionary defines the word “connection” as the linking of people or things; the joining together of two or more people, things, or parts. It goes on to define the physical link: something that links two or more things and the logical link: a linking association between people, things, or events. Even the most reclusive humans are connected to the world in some way... to nature, to history and to society (even the society of self). As nurses we are all connected by our common profession our need to fix and care for others.

The Physical Link

As humans we are connected to each other. From our earliest umbilical connection to our mothers, and through to our ancestors and families we share a common history.

The Logical Link

Events such as the MARN Student Forum (see p 10 & 11), Annual Awards and Living Legends Celebrations (see p 4) and The MARN Ninth Annual Convention (see p 6 & 7) connect and rejuvenate us as professional nurses as we commune with friends, and colleagues who share a common history, common experiences, and common values. Joining professional organizations like MARN fulfill our need to be a part of a whole.

We try to pass on these values to the ones who follow. To that end, I am working on a new program called “Connections” to help new graduate nurses stay engaged while waiting to find their first job. The idea is to provide opportunities for new graduate nurses to continue to increase their nursing experiences during the interim between graduation and finding their first nursing position. The program will pair expert professional nurses with novice nurses and is completely voluntary for professional and novice nurses. Look for more information on the MARN website MARNonline.org and in future editions of the Massachusetts Report on Nursing.

We all bear the responsibility to feed our connections to keep them healthy and viable. We must continually take inventory...strengthen the worthy and sever the unhealthy ones.

I am proud of the connections I have made in MARN and I encourage all nurses to make the logical link to be a part of an organization that can enhance your nursing career.

Letter to the Editor

Editorial
May Futrell, PhD, FAAN, FGSA

by Myra Cacace, (Former Student)

Dr. May Futrell is a pioneer, an avid educator, prolific researcher, author, and advocate for older people. Dr. Futrell’s contribution to the educational preparation of Gerontological Nurse Practitioners and the research she has conducted in the area of gerontology has improved nursing care to older adults. She was the primary author for the text Primary Health Care of the Older Adult (Futrell, Brovender, Mullett & Brower, 1980) a blueprint for master’s level education for nurse practitioners in the area of gerontology. She is a member of the Editorial Review board of the Journal of Gerontological Nursing.

Dr. Futrell has long professed that gerontology, geriatrics and international health are the future and that nurse practitioners are important to this future. She advocates that gerontology be incorporated into the educational preparation of nurses at the baccalaureate, master’s and doctoral level. Dr. Futrell strongly believes that advanced practice nursing preparation should focus on the person rather than on the place, and that all specialties that care for older patients must be educationally prepared to meet the health care needs of this population today and in the future.

Unfortunately, May was unable to attend this event. She was due to return from a trip to Ireland, but nature had other plans. But, May is a plan-ahead person (“you never know when there will be trouble with the airplane or the weather.”) I’m not sure she was thinking about volcanic eruptions when she left her acceptance speech with Dr. Karen Melillo, who accepted the award in May’s absence.

MARN is happy to call May Futrell a Living Legend in Massachusetts Nursing.

Ethically competent clinical care is significantly escalating in complexity and diversity across all healthcare settings. Ethical issues encountered in practice impose new demands on us to be experts in recognizing, assessing, and intervening in complex situations. The role of the Clinical Ethics Consultant is at the forefront of guiding patients, families, and providers toward resolution of challenging issues through education, application of evidence-based research, and collaboration.

Nursing has benefitted from Christine Mitchell’s work in the field of Clinical Ethics. Christine has informed countless numbers of nurses, and other interdisciplinary team members through documentary films, scholarly articles and education. She has edited, authored, and co-authored innumerable manuscripts in books and professional journals on a wide variety of ethically-related topics. Her work on the documentary film, Code Gray, earned her an Oscar nomination from the Academy of Motion Picture Arts and Sciences. Code Gray (1983), spotlights the difficult ethical decisions nurses must frequently make and the internal conflict and moral distress encountered when experiencing opposing views of patients, families and staff while caring for patients. Other documentary films include A Perspective of Hope and Nursing Ethics and Law (American Journal of Nursing Company Video Productions, Inc). She has also received numerous awards and honors.

Christine Mitchell has paved the way for nursing and medical ethics as a nursing leader and clinician. We are indebted to her endeavors and the fortunate recipients of her knowledge and expertise. MARN is proud to honor her personally and professionally for her many accomplishments in recognizing her as a 2010 Living Legends in Massachusetts Nursing Award.
Ninth Annual Convention of the Massachusetts Association of Registered Nurses, Inc.

Saturday, April 17, 2010
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Theresa Spinelli
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Cidalia Vital
Angela Nannini received her Bachelor of Science Degree in Nursing from George Washington University in 1971, her Master of Science Degree in Nursing and Health Sciences at University of Massachusetts, Boston since 2004. She is a consistent mentor and nursing leadership and education. She is a former Professor of Women's Health Program at Kent State University. Dr. Glazer is a 2001 fellow of the Robert Wood Johnson Nurse Leadership Program and a graduate of Case Western Reserve's PhD Program. Dr. Glazer leads a nursing program that serves the largest number of nursing students in the Commonwealth. This program grazes the commencement of hundreds of undergraduate and graduate nursing students annually. Greer successfully recruits and retains outstanding nursing faculty.

Dean Glazer places a high value on practice-academia collaborations and partnerships which have led to the development of several innovative programs including the Accelerated Baccalaureate to PhD Program in Oncology and Health Policy with Dana-Farber Harvard Cancer Care and the "Go Kids" initiative with Children's Hospital. Dean Glazer also initiated an innovative program in student mentorship and placements with Partners Health Care hospitals.

Dr. Glazer is very active, volunteering her time and intellect to major local and national nursing and health care associations. She has contributed her talents in the international communities and academic programs in Israel, Korea, Cuba and others.

Dean Glazer consistently keeps students and faculty at the heart of all her work and decision-making, knowing her students will ultimately impact the care of lives of patients and families. There is no one more deserving of the MARN award for Excellence in Nursing Education.

MARN Award for Excellence in Nursing Practice
Karen Sherwin, RN

When I think of excellence in nursing practice certain traits come to mind: knowledge and skills, care and nursing leadership, compassion and a non-judgmental approach. Karen Sherwin is the epitome of a nurse. When I first met her approximately 15 years ago, she was working as a Nurse Practitioner at New England Baptist Hospital. I was a student and working on her floor as a nursing assistant. Karen was there every weekend in her white scrub dress and shoes taking care of multiple issues at once. Though always multi-tasking, she always found time to teach me about the essence of nursing, caring for patients in a gentle, kind and knowledgeable way.

Years passed and Karen once again became a part of my nursing career. She came to Boston Health Care for the Homeless Program and brought her knowledgeable, caring and compassionate skills with her. She warmly works with the new staff and continues to serve as a professional role model for all. Her nursing skills are excellent and we all seek her advice because her varied experiences give her important insight to help sort through so many complicated issues. Her non-judgmental, compassionate style is well received by our patients, which is evident by the way she is greeted by both patients and staff members. Karen does her best to help every patient.

Karen Sherwin is an excellent nurse in every way and very deserving of this award. Congratulations.

Mary Manning Mentoring Award
Theresa M. Gallivan, RN, MS

Theresa M. Gallivan, RN, MS, Associate Chief Nurse, Massachusetts General Hospital, is the quintessential mentor. Her mentees describe her as a "broad-based mentor" and the "ultimate role model, consistently and energetically encouraging them to seek growth opportunities, highly sensitive to their needs, recognizing when they need direct assistance, support, or independence. She has impacted the lives and careers of countless nurses and developed many torchbearers.

When Nursing Spectrum recently presented its 2009 Nursing Excellence Awards, two of the six national honorees were Theresa’s mentees. Both represent remarkable and steady ascents under her exquisite mentorship.

Theresa creates an open, trusting, honest, respectful environment in which staff are positioned to do their best work. She solicits input, actively listens, and encourages the expression of alternative ideas. She also deftly advocates behind the scenes to open doors for her mentees. This mentoring approach creates a breeding ground for innovation and excellence. Theresa inspires, motivates, positions, challenges, and coaches her mentees to reach their full potential, and in the process, she not only advances their skills and leadership potential, but impacts the delivery of care to countless patients and families, both within her own organization and well beyond.

Ruth Lang Fitzgerald Memorial Scholarship 2010
Pamela Gorgone, BSN, RN, CNOR

It is with great pleasure we present the 2010 Ruth Lang Fitzgerald Memorial Scholarship to Pamela Gorgone. The Fitzgerald scholarship was founded by the Fitzgerald family in memory of Ruth Lang Fitzgerald, a 33-year member of MARN, and a long time member of the American Nurses Association, who passed away in January 2005. Ruth was proud of her sixty-two years as a nurse and of her service to her country during World War II as a Lieutenant in the Army Nurse Corps in the South Pacific and her work as an advocate for seniors.

This scholarship is presented annually to a member of the Massachusetts Association of Registered Nurses (MARN) to pursue an area of interest or special project that will be beneficial to the member and/or the Association. The Scholarship is used to defray the costs of attending an educational conference, a nursing degree program or some other activity or project which the recipient believes will benefit the member, the Association, or the nursing profession.
other educational activity. It may also be used for participation in a humanitarian aid project.

This year’s recipient of the Ruth Lang Fitzgerald Memorial Scholarship is Pamela Gorgone. Pamela obtained her BSN from the University of Connecticut and is currently a candidate for Masters in Nursing Administration from Northeastern University. She is a member of Sigma Theta Tau International, and the Association of Operating Room Nurses. Pamela retired from the US Army Reserves in 2002 after 22 yrs of service.

Pam is a CN III who works in the OR/Peri-operative department at Children’s Hospital Medical Center. Pamela has a great interest in legislative issues; she took graduate courses in Health Policy and Law as part of her Nursing Administration program at Northeastern University. She is a member of MARN’s Health Policy Committee. Pamela is also a member of The Massachusetts Organization of Nurse Executives (MONE) Government Affairs Committee and a member of Children’s Hospital Legislative Action Interest Group.

Pamela attended the Massachusetts Student Health Policy Forum, and the MARN program, “Advocacy Beyond the Bedside.” She is a graduate of MONE’s Legislative Boot Camp. Pamela has also testified at the statehouse regarding the Staff Nurse Ratio Bill. She will be using this scholarship to attend the George Mason University Health Policy Institute in Washington D.C. or the National Invitational Conference for Executive Nurse Leaders.

Arthur L. Davis Publishing Agency Scholarship
Nicole Ashton
(Charge Nurse Pine St. Inn Women’s Clinic)

Nicole has worked at Boston Healthcare for the Homeless Program for the past ten years. She also works as a full-time nurse at Boston Medical Center. During that time, I have witnessed Nicole complete her BSN at Emmanuel College, and be inducted into Sigma Theta Tau. She also received the Clara Barton Humanity Award for her contributions in community service. Nicole is a nurse who gives her all...110%! She takes time with her patients, and makes the effort to develop a rapport with them.

Nicole decided to return to school to further her education and is pursuing a Master’s of Science in Nursing, with an Education specialty. Nicole is determined and focused on her work and is quite capable of balancing all the elements of her busy life. Nicole absolutely deserves the Arthur L. Davis Scholarship.

First Annual MARN Loyal Member Award
Maura Fitzgerald, MS, RN

In a complete surprise attack the members of the MARN Board of Directors and the Awards committee introduced a new award to be given to a loyal MARN member. They could not have chosen a better recipient. Maura Fitzgerald is a second generation nurse and founding member of MARN. She has served on the BOD and as the chair of the Awards Committee for the last 10 years. Maura is a wonderful nurse, hard working and never complains. Congratulations Maura!

President’s Award
Massachusetts Board of Registration in Nursing—100th Year Anniversary
Toni Abraham, MARN President 2008-2010

As many of you may know (especially if you read our MA Report on Nursing) 2010 marks the centennial of nursing registration in Massachusetts. If you have not taken the time to read Clio’s Corner, you will find a wealth of history around nursing’s fight for regulation to protect both their patients and our profession.

Years leading up to the establishment of the Board reveal a history of well developed discussion, documentation of events and evidence based research. In 1902 the first resolution was read at Faneuil Hall written by 300 nurses and stated:

“Resolved: We the trained nurses of Massachusetts declare in a mass meeting assembled, that it is expedient and advantageous to have a bill passed to regulate the practice of professional nursing in the State of Massachusetts.”

It took many attempts by some very persistent nurses in the days of patriarchy and subservience but finally the year would come. That year was 1910, when Mary Davis spoke at a public hearing in Dean Hall in Worcester stating a law entitled “An Act to Provide for the Registration of Nurses” would protect the public from “counterfeiters, fakers, incompetents and exploiters.” Imagine, women weren’t even allowed to vote and yet, this brave, insightful woman fought for standardization in nursing practice (By the way, the right to vote came in 1920)! And although the bill wasn’t exactly what they wanted and fought for, it did give trained nurses a legal status.

I am proud to be part of the community of nurses who fought for our right to be registered as competently taught men and women who rose to the task of meeting the qualifications of the title “RN.”

Today, the Board continues to promote patient safety through its regulation of over 132,000 LPNs, RNs and APRNs, and 71 entry-level LSN and RN education programs. Principles that provide the framework in the Board’s efforts to insure safe nursing practice include: nursing competence; shared accountability; strategic collaboration; evidence-based standards; assurance of due process rights; responsiveness to the health care environment that is timely and thoughtful; and fair and ethical practices and policies.

To honor the women of a century ago, and all the nurses who have provided guidance and leadership for the BORN these past 300 years, I would like to present this year’s President’s Award to Rula Harb, the current Executive Director of the Board of Nursing and to Janet Sweeney Rico, RN, NP, Chairperson of the Massachusetts Board of Registration in Nursing.
The bill was reported out favorably by the Joint Committee on Public Health and referred to the Joint Committee on Health Care Financing in February 2010. Since April 1, 2010, the Joint Committee on Health Care Financing is collecting testimony before presenting the bill before the joint session.

Currently 31 states have language within their nurse practice acts (NPAs) or state law allowing medication to be administered by unlicensed workers. In fact, Massachusetts allows administration by unlicensed assistive personnel (UAPs) in schools and mental health community programs.

Language in the Massachusetts Nurse Practice Acts (NPA) makes it possible for nurses to delegate to others. Incorporating nurse delegation of medication administration into the NPAs requires a well designed regulatory framework that incorporates all aspects of the delegation process. The decision to delegate the task of specific portions of medication administration to unlicensed assistive personnel starts with an assessment of appropriateness by the registered nurse. This assessment includes the following considerations:

- Can the patient direct their own care?
- How complex is the task?
- Are there clear parameters of a “stable and predictable” condition?
- How prepared is the (UAP)?
- How much supervision is required?

Nurses have a unique opportunity to guide the structure of this new model of care allowing more patients to remain home. It is imperative for nurses to tailor evidenced based individualized care to maintain and promote the health and safety of the public. Nurses must collaborate with key stakeholders and participate in the process to develop and implement programs that ensure patient safety and optimal outcomes, support nurses and promote nursing practice.

Professional nursing is dynamic and must reflect the changing needs of our society. This bill challenges Massachusetts nurses to consider this question: How can we supply the leadership to create positive changes that allow home care patients to receive the right care, at the right time, in the right place, and by the right care giver?1

References


Diane Miller RN, BSN, CEN

Let Your Voice Be Heard Participate in a MARN Health Policy Committee survey about Mandatory Overtime.

To take part, go to www.MARNonline.org and click on Health Policy.

MARN Health Policy in Action

A New Model of Care for Home Health Nursing: The Right Care...Right Time...Right Place...Right Caregiver

On January 7, 2009 Senate Bill 860: An act relative to home health aides was filed with the Massachusetts legislature1. This bill provides a new model of delegation for the home health nurse that will protect the public safety with the task-only portion of the medication administration process for patients at home whose medical conditions are stable. Frequently patients requiring assistance with medication administration (i.e. eye drops, creams, and oral medications), and have no family to assist them, often receive care in an extended care facility.

The bill was presented by Senator Richard Moore with the support of eighteen additional legislators. It states:

- [that] such aide has completed agency training (the agency training and regulations to be drafted by the Board of Registration and the Department of Health)
- administration or assistance [of medication] is performed under the supervision of a registered nurse
- [the] delegation permitted shall be limited to medications which are oral, ophthalmic, otic, topical, intranasal, transdermal, suppository, prefilled, or products which are administered by inhalation.
- no registered nurse shall be required to delegate if the registered nurse determines it is inappropriate to do so
- the regulations shall specify that the registered nurse delegate, and the home health aide are accountable for their own actions
- a nurse licensed under this chapter who determines that a specific nursing activity or task in compliance with the adopted regulations shall not be subject to disciplinary action for the performance of a person to whom the nursing activity or task is delegated.

MARN Weighs In... Advanced Practice Registered Nurses: Part of the Solution

by Toni Abraham

The Massachusetts Association of Registered Nurses (MARN) appreciates the opportunity to submit comments on controlling health care costs through proposed health care payment reform. The leadership and vision of legislative, policy, and health care providers and consumers to support and advance meaningful payment reform that does not discriminate.

American Academy of Nurse Practitioners, Nurse Practitioner Facts. AANP Web site: www.aanp.org/NR/rdonlyres/51C6BCOF-F1CO-4718-34EF-3BDECFBF615/0/ AANPNPfacts.pdfUH.

The right care…right time…right place…right caregiver?2 Positive changes that allow home care patients to remain home. It is imperative for nurses to tailor evidenced based individualized care to substantial boost the number of providers to lead the Medical Home Model. We want to be sure that any change in the payment system design utilizes the expertise of nurse practitioners as primary care providers and that the payment system reflects the needs of the patients and the health care community.”

In order to successfully transform the Commonwealth’s healthcare system and control costs, we must have a holistic workforce policy that fully recognizes the vital role of advanced practice nurses and other providers in the provision of primary care services. The Medical Home Model that is based on “community-based multidisciplinary teams” to support primary care demonstrates a commitment to coordinated care among all health providers, and shifts beyond a treating illness model to that of wellness and prevention. In Massachusetts, NPs have been recognized as primary care providers and would be authorized to lead Medical Homes. NP’s skill and education, which emphasizes patient and family-centered, holistic care, make them particularly well-suited to lead the Medical Home Model. We want to be sure that any change in the payment system design utilizes the expertise of nurse practitioners as primary care providers and that the payment system reflects the needs of patients and their families across the Commonwealth.

MARN and nurses across Massachusetts are ready to work with policy-makers, industry leaders, providers and consumers to support and advance meaningful payment reform that does not discriminate.


1 The Massachusetts Association of Registered Nurses (MARN) appreciates the opportunity to submit comments on controlling health care costs through proposed health care payment reform. The leadership and vision of legislative, policy, and consumer leaders, providers and consumers to support and advance meaningful payment reform that does not discriminate.

2 Positive changes that allow home care patients to remain home. It is imperative for nurses to tailor evidenced based individualized care to substantial boost the number of providers to lead the Medical Home Model. We want to be sure that any change in the payment system design utilizes the expertise of nurse practitioners as primary care providers and that the payment system reflects the needs of the patients and the health care community.”

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Diane Miller RN, BSN, CEN

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To take part, go to www.MARNonline.org and click on Health Policy.
Fewer than half of all adults over age 50 received effective, evidence-driven, preventative care. System Performance in 2007 indicated that fewer citizens may be enjoying new coverage, they still are having difficulty gaining health care access, resulting in many patients seeking nonemergency care at emergency departments. Further, although the health connect provides affordable insurance plan options, our current model is not financially sustainable at the current rate of inflation in health care premiums.

Since passage of Section 44 of Chapter 305, a Special Commission on the Healthcare Payment System was established to determine what insurance policies would meet the standard for insurance coverage under the 2006 law. On September 8, 2009, the Joint Health Care Finance Committee hosted a public hearing about the Special Commission’s recommendations, listening to testimony from interested stakeholders. Representatives of the nursing profession, including Karen Daley, Board Member of the American Nurses Association, Jan Towers, Policy Director for the American Academy of Nurse Practitioners and BethAnn Rowlands, Legislative Chair for the Massachusetts Coalition of Nurse Practitioners provided testimony. The Executive Office of Health and Human Services is also hearing from stakeholders prior to the drafting of legislation some have dubbed, “Health Care Reform II.” Policymakers are eager to move forward with an omnibus proposal before the end of this legislative session designed to realize cost efficiencies and enhanced quality measures all Massachusetts citizens, taxpayers and businesses, benefit from. Nurses from all practice settings will be impacted and should inform their own legislators about the critical role nurses play in the quality and cost of care. MARN will continue to monitor the progress of this groundbreaking system change.

Welcome New Graduate Members of the MARN Board of Directors

Christine Ruiz was appointed to be a member of the MARN Board of directors and has been serving since February 2010. She has been a registered nurse since May 9, 2009. She presently is working in a long-term care and a sub-acute unit in Acton. This is Christine's first nursing job and she reports that she is gaining wonderful experiences. "I have planted my nursing seeds there and my roots are growing strong. The people I work with are amazing and are willing to teach as much as I am always willing to learn.”

“My journey to the nursing profession is kind of a funny story. I went to a vocational high school and the trade I originally went for was Cosmetology. It was not what I expected at all. I oriented in a few other trades and absolutely was intrigued by the health assistant program. I could see myself taking care of people. I just knew I was meant to do more than just beautify someone, I really wanted to take care of people.”

Christine is learning every day. When asked: What have you learned so far that you didn’t learn in school? Her answer is, “Time management, time management, time management!” Christine is currently in school and is thinking about becoming a family nurse practitioner. Christine enjoys spending time with family and friends, walking her dog, reading and playing cards and board games. “I am determined, a go-getter, I love to learn and teach, and I am compassionate. I also love a real challenge!”

Debbie Cullen, RN is the second new graduate member who has been serving on the MARN BOD since February 2010. Debbie is currently still looking for a staff RN position, but is currently working as a Clinical Assistant at Childrens Hospital in Boston. She has also worked as a clinical assistant at Carney Hospital in Dorchester.

“Nursing is my second bachelor’s, I always admired the profession. I worked at South Shore Hospital in the ED as transport when in high school and college, I admired the nurses but didn’t have the confidence at 18 to think I would make a good nurse. I was a psychology major and after graduating and one year of work I knew I wanted to return to nursing. I knew I had the confidence and some professional working experience. I also had a friend working in the hospital setting and she reminded me of my admiration for the profession.”

Debbie is interested in the Pediatric ICU and has hope to continue her education. Debbie loves her friends and is very close to her family. She loves the outdoors and being busy... snowboarding in the winter and surfing in the summer. “I love life and live for everyday. I am the friend everyone talks to about their problems... I think this maybe because of the psych background but I enjoy being able to be a rock for my friends!”

Welcome Debbie and Christine!
MARN & MaSNA Collaborate

On March 25th more than 100 students gathered for a forum entitled Strategies to Secure an RN Position in Massachusetts, sponsored by MARN and MaSNA (the Massachusetts Student Nurses Association). Regina Cullen, PHR, Lead Nurse Recruiter from North Shore Medical Center, Partners Health Care and Dina Juhasz, RN, BSN, Senior Nurse Recruiter from Children's Hospital in Boston gave invaluable advice about interview techniques and staying involved in nursing even if it means not working at the “job of your dreams” right after graduation.

Joining the panel of expert nurses, Christina Ruiz, RN and Nickie Burne, RN shared their experiences in the job market, and stories about securing their first job in nursing. Christina is a newly appointed “new-graduated” director on the Board of Directors of MARN. Nickie was also a mentee in the MARN Mentoring Matters Program in 2009-2010.

Massachusetts Student Nurses’ Association 2010 – 2011 Board of Directors & Committee Chairs

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Sabianca Delva, Vice President
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Assistant Professor
Massachusetts College of Pharmacy and Health Sciences School of Nursing

MassNA.FacultyAdvisor@gmail.com, mahmoud.Kaddoura@mcphs.edu

Twenty five enthusiastic nursing students from Brockton Hospital, School of Nursing, Cape Cod Community College, Massachusetts College of Pharmacy and Health Sciences, Simmons College, and the University of Massachusetts in Amherst & Boston, gave up sleeping in on a rainy Saturday to attend the MaSNA annual meeting which was held during the MARN Annual Convention on Saturday April 17, 2010. A new Board of Directors was elected and plans were made for an exciting new year for student nurses in Massachusetts, under the guidance of faculty advisor Dr. Mahmoud Kaddoura (MCPHS).

Dear MARN,

I am excited to have been given a year membership to MARN. It was quite an honor and is much appreciated. I hope to stay involved and become as active in MARN as I am now in MaSNA.

On behalf of MaSNA, I want to sincerely thank you for your guidance and support during our term, especially in executing our spring convention and annual meeting. We had an excellent turnout and energetic meeting that promises the beginning of a vital new year.

As a well-established organization, MARN provides a role model for MaSNA and sets a high bar of excellence to aspire to. With your benefaction and example, we have facilitated the evolution of MaSNA to its current state of success.

As we transition to our new board of directors, we hope to maintain our relationship with MARN. In order continue our collaboration I am happy to introduce you to 2010-2011 MaSNA Board of Directors.

The members of MaSNA thank you again for your advocacy for our organization and the nursing profession as a whole. It was our honor to collaborate with you this past year and look forward to future partnership.

Sincerely,
Christina Buettner, President;
Catherine A. Ferreira, Vice President;
Beth Kinsella, Secretary

IMPORTANT CONTACT INFORMATION

Massachusetts Student Nurses’ Association website: www.mastudentnurses.org

Massachusetts Association of Registered Nurses website: www.marnonline.org

National Student Nurses’ Association website: www.nsna.org

American Nurses Association website: www.ana.org
A World Away from Home: Striving to Make a Difference
by Jody Roper, Graduate Nurse

The March issue of the MARN newsletter featured an article about our Nursing Students without Borders (NSWB) trip to Ghana. As promised, here is the story about my 24 day emotionally overwhelming and, sometimes shocking, philanthropic adventure. Writing this article two months later, I know that my desire to help others at the start of my own nursing career was enhanced by this adventure and memories of this trip will help me as I care for my future patients.

There is extraordinary need in Ghana. The Ministry of Education reports that 40% of people live in poverty. Intellectually, I was armed with information gained by my own research about infant mortality rates, educational structure, environmental concerns of deforestation, limited clean water supplies, economic limitations and the appalling low rate of educated healthcare professionals in Ghana. Upon arrival, however, I discovered that I was not even remotely prepared to witness it all first hand.

I don’t think anyone can be ready for the culture shock. We met people who thought that white Americans lived in gold houses. Compared to the living quarters I saw relatively speaking, we might as well. Despite their relative poverty, the welcoming spirit of these people, and their appreciation for any small source of aid we could give, was impressive and inspiring.

As we travelled to each village, visiting homes and offering blood pressure clinics, I was humbled that individuals would wait for hours to be seen by us; standing barefooted, in the heat of the afternoon, babies on their backs, wares for sale perched atop their heads. Their gratitude was heartbreakingly, at times embarrassingly undeserved, since I felt that I barely met their needs. I recognized symptoms of many ailments, but felt rarely capable of helping: hepatitis, kidney stones, venous ulcers, umbilical hernia, ringworm…the supplies we did have to offer, for pain control, infection, or elevated blood pressure were limited. NOT a long term solution.

At times, these overpowering realities left me with despair and feelings of futility. Some days were exhausting, I missed hot showers with water pressure, longed for the comfort of an ant-free bed, and yearned for a large 3-course American meal. I asked myself why on earth I’d imagined that, as a nurse student, could make a difference…offer anything of worth.

Then, I experienced a once in a lifetime, kind of day. Early in my trip, I blogged about a post-partum room we visited that made me cry. A few days later, an email arrived from my mother asking “who do we make the check out to?” The Labor and Delivery nurses on her unit were touched by my writing and wanted to donate new beds to the clinic! Then, at the Christian Children’s Home, an orphanage in HoFoo, a young girl grabbed my hand and dragged me over to her cubby and proudly showed me all her earthly possessions. She graciously shared her only unbroken crayon, and encouraged me to use her one coloring book. Later, I witnessed this same child’s joy when she received new crayons, a dress, and a coloring book. THIS was a good day!

We conducted an educational session in Nkonya, a village without access to a hospital or health clinic. The teenage participants, girls who came from absolute poverty, delayed their consumption of free Coca-Cola and snacks to ask me personal questions about the risk of HIV infection when they engaged in “deep kissing” or oral sex. Their thirst for knowledge helped me to learn a valuable lesson: 1. as a nurse, have skills and knowledge to share. As a nurse I have the power to empower!

My trip to Ghana taught me about nurses’ accountability to any community of people in need. My calling to the nursing is confirmed as is my appreciation for my good fortune as an American. I will continue to support NSWB in their future endeavors. I am happy I did my part to improve the lives of such warm, hardworking, needy and deserving people. The lessons learned on this trip will be with me for the rest of my career.

To learn more about my trip, please read my online blog at http://blog.uml.edu/NSWB/students.

Jody Roper is a graduate nurse from the University of Massachusetts in Lowell.

An Invitation for MARN Members!

Become an active member— Join MARN today!

Are you a MARN member who is looking for a way to become more involved in the organization? Do you have a special talent or interest? Can you fit the time into your schedule to take on one of these roles? If you are looking for new opportunities, then we are looking for you! Listed below are the descriptions of several active committees for the Massachusetts Association of Registered Nurses (MARN).

New—MARN Conference Committee: Plans and executes Annual Spring Conference & Business Meeting and Annual Fall Conference. Focused on topics of clinical relevance. Responsibilities include site selection, speaker selection, developing contact hour application, assisting with marketing and on-site registration. Meetings monthly by teleconference and/or email to plan.

MARN Awards Committee: Develops criteria for and selects winners for three annual nursing excellence awards, two scholarship awards and Living Legend awards. Meets quarterly by teleconference and email and once/year in person to prepare for Awards Luncheon/Dinner. Members expected to attend Annual Meeting and Awards Luncheon/Dinner during the Spring Convention.

MARN Bylaws Committee: Reviews MARN Bylaws annually to create and propose changes and additions as suggested by the membership and/or Board of Directors and to maintain compliance with ANA Bylaws. Meets in person as necessary (usually once per year) and by teleconference and email as necessary to prepare for Annual Meeting.

MARN Continuing Education Committee: The Massachusetts Association of Registered Nurses, Inc. is accredited as an approved provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. This committee plans and executes an Annual Provider Forum, writes quarterly newsletter articles, and functions as the MARN Approver Unit in reviewing provider and activity applications for continuing education credits. Meetings quarterly in person.

MARN Health Policy Committee: Reviews proposed legislation and health policy issues for recommendation to the Board of Directors. Provides analysis to the Board and the membership for recommendations; will also be meeting with legislators. Meets monthly on the first Tuesday evening of each month by teleconference (7-8pm) and quarterly in person.

MARN Membership Committee: Develops new membership initiatives, reviews membership statistics, and contacts new members to welcome them to the Association. Presents to schools and colleges of nursing, attends other professional organizational programs and meetings to promote MARN and the importance of professional organizational membership. Meetings are monthly by teleconference (5:30-6:30pm) and quarterly in person.

MARN Newsletter Committee: Meets exclusively by email to review articles for publication, develop story lines, and create a quarterly newsletter circulated to every RN licensed by the Commonwealth. ALL MARN MEMBERS ARE INVITED TO SUBMIT ARTICLES OF INTEREST.

For more information or to sign-up, please contact Executive Director Diane Jeffery at dieffery@MARNonline.org or Lisa Presutti at info@MARNonline.org or (617) 990-2856.
Understanding Fluid Shifts

Independent Study

Understanding Fluid Shifts
ONF-08-11

Movement

You are a home care nurse visiting Mr. Johnson. He states at times he feels a little dizzy when he gets out of bed in the morning. You notice he has dry skin, but he says that it has always been a problem for him. His heart rate is elevated at 102 beats per minute. His sitting blood pressure is 114/62 while his standing blood pressure is 98/58. He says he drinks an adequate amount of liquid each day, but does he really? Is Mr. Johnson dehydrated? Mrs. Overton is admitted to your unit with a diagnosis of heart failure. Her ankles reveal 3+ pitting edema. She says she “watches how much fluid she drinks” and everyday she takes “all of her medications.” Is this an exacerbation of her heart disease, or is she really following her medical plan? Just how fluid overloaded is Mrs. Overton?

Body fluids

“Understanding Fluid Shifts” is the fourth of four units provided in solution. Solutes may be substances such as sodium, potassium, calcium, carbon dioxide, oxygen, hydrogen, phosphorus, bicarbonate and glucose. Water is the main solvent or liquid in body fluids and comprises 50% to 60% of our body weight. Body fluids are categorized as hypotonic, isotonic or hypertonic, based on their concentration. Normal body fluids are considered isotonic. If a solution is less concentrated than normal body fluids, it is considered hypotonic; while a solution more concentrated than normal body fluids is considered to be hypertonic. Osmolarity and osmolality are two methods employed to measure the concentration of fluids. An osmol is the unit used when discussing a solution divided by weight or volume. An osmole is number of milliosmol per kilogram (mOsm/kg) of solvent. Osmolality is number of milliosmol per liter of solution, i.e., mOsm/L.

Homeostasis

Homeostasis is the maintenance of fluid, electrolyte and acid-base balance in the extracellular fluid spaces. So in spite of what one eats, inhales, metabolizes or excretes, as long as one has normal cellular function, laboratory values remain within normal limits. In other words, we remain in a state of homeostasis. When cellular functions become abnormal, such as with disease, swelling occurs or fluid moves from one state of homeostasis and we will have abnormal laboratory values.

Volume Imbalances

Volume imbalances primarily affect the extracellular fluid space and result from an expansion or loss of this compartment. Extracellular fluid (ECF) is the fluid outside the cells and accounts for one-third of the total body fluid. The extracellular fluid compartment is divided into two compartments: The interstitial fluid (ISF) is the fluid in the space between cells. The intravascular fluid or plasma is the fluid in the vascular system. Some solutes are normally more abundant in certain body compartments. For example, sodium is more abundant in the extracellular fluid compartment while potassium is more abundant in the intracellular space.

The following diagram, indicate the direction of diffusion of sodium by adding an arrow and sodium molecule. The darker shading indicates a higher concentration of sodium. In osmosis, water movement is primarily dependent on the concentration or osmolality of sodium. It is often said sodium “pulls” water behind it. There is another saying regarding the relationship between water and sodium that is “Wherever sodium goes, water follows.” Because sodium is our most prevalent electrolyte, it primarily establishes our osmolality or concentration and thereby influences the movement of water. The concentration of sodium in the extracellular fluid space determines use to move from one compartment to another. Remember solute is a substance such as electrolytes that are dissolved in solution. Electrolytes diffuse through a semipermeable cell wall membrane. Due to osmotic pressure, electrolytes will diffuse from an area of higher concentration to an area of lower concentration. By diffusing into an area of lower concentration, the concentrations will become balanced and ultimately achieve homeostasis. The darker shading indicates a higher concentration.

On the diagram below, indicate the direction of water osmosis by adding an arrow and water molecule. The darker shading indicates a lower concentration of sodium. In osmosis, water movement is primarily dependent on the concentration or osmolality of sodium. It is often said sodium “pulls” water behind it. There is another saying regarding the relationship between water and sodium that is “Wherever sodium goes, water follows.” Because sodium is our most prevalent electrolyte, it primarily establishes our osmolality or concentration and thereby influences the movement of water. The concentration of sodium in the extracellular fluid space determines use to move from one compartment to another. Remember solute is a substance such as electrolytes that are dissolved in solution. Electrolytes diffuse through a semipermeable cell wall membrane. Due to osmotic pressure, electrolytes will diffuse from an area of higher concentration to an area of lower concentration. By diffusing into an area of lower concentration, the concentrations will become balanced and ultimately achieve homeostasis. Your diagram should appear as follows:

In osmosis, water movement is primarily dependent on the concentration or osmolality of sodium. It is often said sodium “pulls” water behind it. There is another saying regarding the relationship between water and sodium that is “Wherever sodium goes, water follows.” Because sodium is our most prevalent electrolyte, it primarily establishes our osmolality or concentration and thereby influences the movement of water. The concentration of sodium in the extracellular fluid space determines use to move from one compartment to another. Remember solute is a substance such as electrolytes that are dissolved in solution. Electrolytes diffuse through a semipermeable cell wall membrane. Due to osmotic pressure, electrolytes will diffuse from an area of higher concentration to an area of lower concentration. By diffusing into an area of lower concentration, the concentrations will become balanced and ultimately achieve homeostasis. The darker shading indicates a higher concentration.

On the preceding diagram, you should have added an arrow showing movement of sodium entering the extracellular fluid space of the intracellular fluid space. The sodium would move from the more highly concentrated extracellular fluid space into the more dilute intracellular fluid space. As the sodium moves into the intracellular fluid space, it brings water along with it, thereby diluting the extracellular fluid space.

Another passive transport mechanism is filtration. Filtration is the movement of fluid, such as water and some solutes through the semipermeable cell wall membrane. The volume of solution contained within a fluid containing solutes exerts pressure on the compartment wall and creates hydrostatic pressure. For example a pitcher of water containing salt put on the pitcher wall, as opposed to the same sized pitcher that is empty. How much pressure will be created? The amount of water and hydrostatic pressure is high; fluids and solutes can be “pushed out” of that compartment through the semipermeable membrane. This pressure will have two effects, 1) it will contribute to the overall blood pressure. When Mr. D’s blood pressure is dropped, does it mean he is hypotensive? Usually we see a drop in the patient’s blood pressure when they become hypovolemic, don’t we? It is the loss of volume or hydrostatic pressure that is causing the hypotension. This is why we have frequently we administer fluids to patients with this condition. By increasing their volume, we are increasing hydrostatic pressure and improve their blood pressure.

Colloid osmotic pressure is another factor that influences the movement of water between body fluid compartments.

Colloid osmotic pressure is another factor that influences the movement of water between body fluid compartments. Colloids are large molecules. Because proteins are so large and they do not easily pass through semipermeable cell wall membranes. Thus proteins tend to stay in the compartment in which they are located. Albumin is our main blood protein. Albumin tends to stay in the blood and does not readily pass into the intracellular or interstitial spaces. Because it is a large molecule and it resides in our blood, albumin increases the concentration of our blood. As a result, colloids are exerted by the concentration of proteins in our blood. The colloid osmotic pressure or concentration of blood helps maintain our blood volume. Water will tend to osmosis into and stay in the extracellular compartment (vascular compartment that accounts for about two-thirds of our blood volume) and does not readily pass into the interstitial compartment.

Active transport mechanisms are mechanisms that require energy to move solutes. Sodium-potassium pumps are a good example of this. The cell produces energy using adenosine triphosphate (ATP) for energy. Anyone who has taken a biochemistry class will recall the Krebs cycle in which glucose and oxygen are consumed to produce ATP. ATP then actively pumps potassium into the cell and sodium out of the cell. This is the mechanism of the sodium-potassium pump. Once enough potassium is pumped into the cell, it will cause the sodium-potassium pump to revert. In other words, the pump is fueled by ATP and it will pump sodium out of the cell and potassium into the cell. The sodium-potassium pump is a classic example of how the cell is able to control its environment.

Water Imbalances

Water imbalances fall into two categories. Volume imbalances primarily affect the extracellular fluid space via equal sodium and water loss or gain. Because the loss or gain of sodium is equal to water, the fluid that is lost or gained in volume imbalances is essentially a loss or gain of isotonic fluid. Because there is a loss or gain of isotonic fluid, patients with volume imbalances will have normal sodium laboratory results. Osmotic imbalances affect the extracellular fluid space via an unequal gain or loss of sodium in relation to water. Due to the fact there is an unequal gain or loss of sodium in relation to water in osmotic imbalances, the laboratory results will indicate an abnormal sodium results. The abnormal sodium will then cause the water to shift either into or out of the cell, thus disrupting the intracellular fluid volume. Fluid imbalances can be a continuum. What starts out as a extracellular volume imbalance, may become an osmotic imbalance as the initial problem may worsen. We will explore each of these in more detail.

Volume Imbalances

Volume Imbalance Fluid Volume Deficit or extracellular dehydration results from equal losses of sodium and water. The loss of volume or hypovolemic state may be caused by dehydration state. One may see this in patients who have had prolonged vomiting, diarrhea, disease or injury. This loss of fluid and sodium results in dehydration. Other causes include hemorrhage or hypovolemia due to dehydration. Osmotic diuretics and/or lack of adequate fluid intake may also be causes for dehydration. This dehydration may result in a fluid or osmotic imbalance whether or not the patient has lost sodium or water. Fluid imbalances are a challenge in the initial phase of the patient's fluid volume status. Patients with this type of dehydration may present with weight loss, hypotension, orthostatic hypotension, tachycardia, oliguria, sticky oral mucous, and perhaps an altered level of consciousness ranging from mild confusion to delirium.
Understanding Fluid Shifts continued from page 12

from mild confusion to coma. Let’s review each of these signs and symptoms. **Weight loss:** for every 500 mL of fluid a patient loses per day, the patient may lose 1 pound. So if in a day the patient loses 500 mL fluid and then today they weigh 380 pounds, they had a 3 pound weight loss. This is something to watch for. **Skin turgor:** how does the skin feel? How is the patient’s skin turgor? Is it diminished? Will this tell you if the patient has lost fluid? **Urine output:** if the patient has lost fluid, then the urine output is going to be less, but will not always be less. The patient may also have oliguria, where they lose more concentrated urine, thus will reveal urine specific gravity, as well as an elevated hematocrit, which can mean decreased intravascular volume. 

Oliguria or diminished urine output the kidneys make urine based on the blood flow that perfuses the kidneys. If the patient has diminished blood volume, there is less blood perfusing the kidneys, thus a diminished urine output will result. **Altered level of consciousness:** in the extracellular compartment, the brain must not get enough blood flow, thus most likely due to a perfusion problem to the brain. Again, if there is a diminished volume of blood and hypotension, diminished blood flow to the brain may result. When the brain does not get adequate oxygen and glucose supplies, neurologic impairment ensues, revealing itself as confusion up to and including coma.

**Orthostatic hypotension, hypotension and tachycardia:** if the patient has lost fluid from the extracellular space, remember the fluid moves from the vascular compartment to the interstitial compartment, which causes hypotension and tachycardia. This results in hypotension. Some patients may experience this as a feeling of lightheadedness upon rising from bed or a chair, or they may have an ongoing hypotension. In regard to tachycardia, it often occurs because the heart receives the signal to pump harder as it senses that the heart responds or compensates for the hypotension with a faster heart rate or tachycardia. **Oliguria or diminished urine output** the kidneys make urine based on the blood flow that perfuses the kidneys. If the patient has diminished blood volume, there is less blood perfusing the kidneys, thus a diminished urine output will result. 

**Extracellular Volume Excess or extracellular fluid overload:** results from an unequal gain of sodium and water, or a gain of isotonic fluid. Body fluid concentrations are not generally affected, as it is a gain of plasma (isotonic fluid). If this occurs too much, some fluids may shift from the vascular compartment to the interstitial compartment that will result in edema. Causes of extracellular fluid overload may include: over infusion of fluids that are sodium or hypertonic, such as hypertonic saline, excessive ingestion of sodium, excessive saline enemas, corticosteroid administration, congestive heart failure, chronic kidney disease, chronic liver diseases and hypovolemia (as often seen with chronic liver or renal disease). In the examples of sodium and water, or a gain of isotonic fluid, the extracellular compartment hypertonic. As a result, the extracellular compartment becomes hypertonic, and this in turn will pull fluid into the interstitial compartment. Hyperglycemia is another cause of intracellular dehydration. With hyperglycemia, the high blood glucose causes a hypertonic extracellular compartment that will in turn pull water out of the cells. Think about your diabetic patients who are not eating well, controlling their diabetes or causing a hypertonic extracellular compartment?

**Signs and symptoms of intracellular dehydration** include a lot of neurologic findings such as restlessness, delirium, seizures and coma. Neurovascular insufficiency can lead to a loss of neuromuscular function and a loss of sympathetic activity. Patients with intracellular dehydration will lose fluid and electrolytes through the skin and mucous membranes. In extreme cases of intracellular dehydration, severe hypotension, hypovolemia, low blood pressure, hyperventilation and increased dehydration. It takes the evaporation of water to help control our body temperature. If a person is so dehydrated, increased core body temperature from lack of water through evaporation through the lungs will begin to rise. As their body temperature will rise, they will then begin to hyperventilate. So this may at first be seen with chronic liver or renal disease. In the examples of sodium and water, or a gain of isotonic fluid, the extracellular compartment hypertonic, and this in turn will pull fluid from the intracellular compartment, resulting in hypovolemia. The sudden loss of fluid results in hypovolemia and hypotension. To restore the intravascular fluid return, supply intravenous fluids. (greater than 145 mEq/L). It is the elevated sodium level resulting from the loss of plasma (isotonic fluid) that is causing the osmotic imbalance. The patient may or may not present with evidence of hemoconcentration (elevated blood urea nitrogen, hematocrit or glucose). Patients will have an ongoing hypotension and tachycardia, but they may or may not have an elevated sodium specific gravity.

The hypotonic extracellular compartment then causes water to leave the vascular compartment to the interstitial compartment. So once again we have fluid shifting from one compartment to another. The mechanism for this is called fluid shifts. Some patient may develop intracellular dehydration by maintaining fluid shifts in the wrong direction, causing dehydration. For example, a patient who continues to have vomiting and/or diarrhea, and is not able to take in adequate fluids for a prolonged period of time may initially develop an extracellular dehydration that may worsen to become an intracellular dehydration. Patients who have continued insensible water loss may develop intracellular dehydration. Insensible water loss is water loss we cannot measure, such as evaporation through the skin and lungs. For water loss through the skin, the average sized adult will lose 700 to 1000 mL per day as insensible water loss. 

**Causes of intracellular fluid overload may include:** Prolonged diuretic therapy with low salt intake can result in loss of sodium in relation to water, or results from a high loss of sodium in relation to water. Either way, the end result is that the intracellular compartment becomes hypotonic (either through the loss of sodium, or gain of water). By comparison the intracellular compartment is now more hypotonic than plasma and the extracellular compartment. 

The hypertonic extracellular compartment then causes water to leave the intracellular compartment, especially water that is lost from the skin and mucous membranes. So this fluid loss is called water intocation. Intracellular fluid overload may result from a high loss of sodium in relation to water, or results from a gain of too much water in relation to sodium. Either way, the end result is that the extracellular compartment becomes hypertonic (either through the loss of sodium, or gain of water). By comparison the extracellular compartment is now more hypertonic than plasma and the intracellular compartment. The hypertonic extracellular compartment then causes water to leave the intracellular compartment, especially water that is lost from the skin and mucous membranes. So this fluid loss is called water intocation. Intracellular fluid overload may result from a high loss of sodium in relation to water, or results from a gain of too much water in relation to sodium. Either way, the end result is that the extracellular compartment becomes hypertonic (either through the loss of sodium, or gain of water). By comparison the extracellular compartment is now more hypertonic than plasma and the intracellular compartment.
Understanding Fluid Shifts continued from page 13

fluid overload. Emergency Department or pediatric nurses sometimes see infants with intravascular fluid overload. Often the situation is that they give too much fluid due to lack of assistance, and as they begin to run on their formula supply, the parents may begin to down the formula in an effort to make the formula last until they can get more. As they continue to feed the infant, the infant is ingesting more water, or hypotonic solution, thus creating water intoxication. Syndrome of inappropriate antidiuretic hormone (SIADH) can create a water intoxication, as can chronic heart failure. SIADH is due to a patient having too much antidiuretic hormone (ADH). With too much ADH, the patient does not diuresis enough fluid, and this results in water intoxication.

Signs and Symptoms of intravascular fluid overload also include a lot of neurologic findings such as headache, confusion, disorientation, muscle twitching, seizures, nausea as well as vomiting, and coma. These neurologic findings are related to the development of cerebral edema. As water shifts into the brain cells, cerebral edema results. Patients may also present with polyuria and peripheral edema.

Laboratory studies will reveal a hypotonic extracellular compartment as evidenced by a low serum sodium level (less than 135 mEq/L) and low serum osmolality (less than 275 mOsm/kg). Patients may also present with a chronically low serum albumin level.

Nursing care for the patient with an intravascular fluid overload will include the previously mentioned intake and output, weight monitoring, and meticulous skin care. Fluid restrictions, often equal to insensible water loss of 1000 mL per day are employed. Again, you will want to restore the osmotic balance for this patient and achieve an isotonic extracellular compartment. To do this, we will need to concentrate the hypotonic extracellular compartment by using hypertonic fluids. It is important to bear in mind though, the patient also has a fluid overload. Giving more fluids will contribute to the fluids in the extracellular (EC) spaces. As you are giving fluids, you may also find yourself administering diuretics to the patient. In some instances a 50% decrease in the urine output along with intermittent fistulae may be used. DR 50% dextrose and a furosemide IV drip may be employed.

Osmolality is a measurement that result from cerebral edema, an osmotic diuretic such as mannitol may be used to pull water from the brain cells and the extracellular compartment, thereby pulling the water out of the cells, to be dispersed via the kidneys. It will also be important to monitor the patient’s neurologic status for signs of increased intracranial pressure.

Osmolality: Another Tool for Assessing Hydration

Osmolality is a calculation based on the patient’s laboratory values for sodium (Na+), glucose and blood urea nitrogen (BUN). Here is how osmolality is calculated.

If the patient’s glucose and blood urea nitrogen values are within normal ranges, the osmolality is 2 times the sodium. This calculation can be made on the patient’s laboratory results to determine if the patient is dehydrated. Osmolality is calculated based on the patient’s laboratory values for sodium (Na+), glucose and blood urea nitrogen (BUN). With the patient’s laboratory values for sodium, glucose and blood urea nitrogen being normal, the osmolality is calculated as: Osmolality = 2 x Sodium.

Now that you know Mr. Johnson is dehydrated, the next question becomes, what kind of dehydration is he exhibiting? Earlier we discussed extracellular and intracellular dehydration. One of the hallmarks of extracellular dehydration is the patient’s serum sodium level being greater than 145 mEq/L. While in intracellular dehydration, the patient will have an abnormal osmolality, low sodium level and high glucose level.

Let’s consider Mrs. Overton, also mentioned at the beginning of this module. Mrs. Overton is admitted to your unit with a diagnosis of heart failure. Her ankles reveal 3+ pitting edema. She says she “watches how much fluid she drinks” and everyday she takes “all of her medications.” Her current medications include furosemide and digoxin. You assess her blood pressure to be 106/62, her heart rate is 116, and her respiratory rate is 24. She has inspiratory crackles or rales upon auscultation. Her admission weight is 183 pounds.

Other item you may consider exploring with Mrs. Overton before she is discharged might include: Does she understand her medications? Can she identify her pills? Does she know what they do? Does she understand why she is taking them? Does she have easy access to a pharmacy to obtain her medications? Does she have a car to go to the pharmacy or is she able to get further follow up? Does she weigh herself on a daily or every other day basis? Does she know when to call her physician? Does she have a refrigerator for cold fluid in case she is dehydrated? If she is in a chair, does she sit with her legs elevated? Does she wear her support hose?

What other item can you think of that you might explore with Mrs. Overton to make her discharge go smoother?

This concludes this module regarding fluid imbalances. It is hoped you have achieved a good understanding of the fluid imbalances and will be able to apply this information with patients you see in clinical practice.

References

Bickley, Susan Lynne; Boushy, Robyn, RN, MS, et al., HANDBOOK OF CRITICAL CARE NURSING, Springhouse Corp, Springhouse, PA, 2004.


Understanding Fluid Shifts
Post Test and Evaluation Form

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name: ____________________________ Final Score: ________________________

There is only one correct answer.

1. Solvents are substances dissolved in solution.
   A. True
   B. False

2. Normal body fluids are hypertonic.
   A. True
   B. False

3. Intravascular fluids are part of the intracellular fluid compartment.
   A. True
   B. False

4. Passive transport mechanisms do not require any energy source.
   A. True
   B. False

5. Osmosis is the mechanism water uses to move from an area of low concentration to an area of high concentration.
   A. True
   B. False

6. Sodium is our most abundant electrolyte and establishes our osmolality.
   A. True
   B. False

7. Diffusion is an active transport mechanism used by electrolytes to move from an area of low concentration to an area of high concentration.
   A. True
   B. False

8. Colloid osmotic pressure is created by the concentration of proteins, primarily albumin.
   A. True
   B. False

9. Ascites and peripheral edemas may result from low colloid osmotic pressure.
   A. True
   B. False

10. Active transport mechanisms use ATP to move solutes against their concentration gradients.
    A. True
    B. False

11. Volume imbalances affect the intracellular fluid, while osmotic imbalances affect the extracellular fluid.
    A. True
    B. False

12. Extracellular dehydration results from a loss of isotonic fluid.
    A. True
    B. False

13. 800 mL is equal to one pound of weight.
    A. True
    B. False

14. After diuretic therapy, a patient’s weight changed from 225 pounds to 220 pounds. How many mL of fluid did this patient lose? ______

15. With extracellular fluid deficits, one will see a normal sodium level.
    A. True
    B. False

16. Hemococoncentration is due to loss of isotonic fluid and presents as elevated hematocrit, glucose and/or blood urea nitrogen levels.
    A. True
    B. False

17. Tachycardia is an expected outcome for a patient who has been rehydrated.
    A. True
    B. False

18. Heart failure, over infusion of 0.9% normal saline IV solutions, corticosteroid use, renal disease and liver disease may all cause extracellular fluid volume excess.
    A. True
    B. False

19. Hemodilution presents as low hematocrit, glucose and/or blood urea nitrogen and is seen with extracellular fluid volume excess.
    A. True
    B. False

20. Intracellular dehydration is often treated with hypertonic IV solutions.
    A. True
    B. False

21. An average sized adult may lose 700 to 1000 mL per day through insensible water loss.
    A. True
    B. False

22. Fever, flushed skin and hyperventilation are early symptoms of intracellular fluid loss.
    A. True
    B. False

23. Patients with intracellular fluid dehydration will have low sodium levels.
    A. True
    B. False

24. Intracellular fluid excess is also known as water intoxication and patients with this condition will have a high sodium level.
    A. True
    B. False

25. Normal osmolality is 275 to 295 mOsm/kg.
    A. True
    B. False

26. High osmolality indicates fluid overload, while low osmolality indicates dehydration.
    A. True
    B. False

27. What is this patient’s osmolality?

28. Is this patient dehydrated or in a fluid overload? ________________________________

29. Is this an intracellular or an extracellular problem? ________________________________

30. Which type of IV fluid would be best to correct this patient’s hydration problem?
    A. 10% Dextrose & Water?
    B. 0.9% Normal Saline?
    C. 2.5% Dextrose & Water?

Evaluation:

1. Were the following objectives met?  
   a. Identify four types of fluid imbalances.
   Yes ☐ No ☐
   b. List nursing interventions to be employed with each imbalance.
   Yes ☐ No ☐
   c. Using case studies, use osmolality as a tool to assess a patient’s hydration status.
   Yes ☐ No ☐

2. Was this independent study an effective method of learning?  
   Yes _____ No _____
   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form? ______

4. What other topics would you like to see addressed in an independent study?

MARN
Understanding Fluid Shifts
INDEPENDENT STUDY
Registration Form

Name: ____________________________ (please print clearly)

Address: ____________________________

Day phone number: [ ] RN [ ] LPN

MARN Member: _____ Yes _____ No  MARN Member Number: ______________________

Please return:
—Completed Post-test and Evaluation Form
—Registration Form
—A check made out to MARN ($25 members; $35 non-members)

TO: MARN Newsletter, P.O. Box 285 Milton, MA 02186

MARN OFFICE USE ONLY

Date Received: ___________ Amount: ________ Check No. ________ Additional Amount Due: $ ________
Governor Sargent's Reorganization Bill Imperils The Born

Mary Ellen Doona

The RN after a nurse's name is the stamp of legitimacy. No matter how many degrees graduates of approved nursing programs earn, until they pass the State Board Exam, proving their competency, they cannot be hired as RNs. Since 1910 RN marks the exposure of the Pentagon Papers. These issues and controversies like Watergate, the Vietnam War and the one hundred year era of diploma programs was coming to an end. Twenty had closed during the 1970s while the baccalaureate programs increased to ten and associate degree programs to ninety-four.

As nursing argued about which program best prepared the practitioner, the country was in an uproar. The public's trust was sorely tested by controversies like Watergate, the Vietnam War and the exposure of the Pentagon Papers. These issues would recede into the background of nursing's consciousness on March 19, 1973 when Governor Francis Sargent submitted his bill H6120 An Act to Reorganize and Modernize State Government by creating a Department of Human Services with a plan to expedite its passage. Nurses were especially interested in the Health Services Regulation Administration (HSRA) and its implications for nursing. On March 21, 1973, nurses gathered in Framingham for the Massachusetts League for Nursing convention listened as the Governor's Secretary of Human Services, Peter Goldmark, Jr. and his assistant, Charles Stover, could not answer questions about the impending legislation. The reality of being a nurse. For the public, RN signifies the public's trust was sorely tested by controversies like Watergate, the Vietnam War and the exposure of the Pentagon Papers. These issues would recede into the background of nursing's consciousness on March 19, 1973 when Governor Francis Sargent submitted his bill H6120 An Act to Reorganize and Modernize State Government by creating a Department of Human Services with a plan to expedite its passage. Nurses were especially interested in the Health Services Regulation Administration (HSRA) and its implications for nursing. On March 21, 1973, nurses gathered in Framingham for the Massachusetts League for Nursing convention listened as the Governor's Secretary of Human Services, Peter Goldmark, Jr. and his assistant, Charles Stover, could not answer questions about the impending legislation. The reality of being a nurse. For the public, RN signifies

Mary A. Baroli (courtesy of Mildred Davis)

and who expected everyone serving the Board to behave likewise. Though excellent leaders, DiMaggio and Baroli were unable to convince the Division of Personnel, and later, a legislator, that Board members' salaries must be competitive with the nursing market if the Board was to attract qualified nurses as staff. Alas, salaries remained low in spite of the Board's surplus of $215,000 which exceeded the cost of running the BORN.

On February 15, 1973, DiMaggio alerted Consumer Affairs about the upcoming vacancies of critical personnel and its implications for the State Board Exam in August. The retirements of Eileen Bean, (Registrar), the Executive Secretary and a nursing supervisor between March and June 1973, had a direct impact on the Board's ability to give the national exam. The illness of Board appointee, Marie Andrews, and her death in 1973 further added to the strain. Yet the Board staff carried out their tasks so well that few on the outside knew of the difficulties.

At the direction of Louis Resteghini, the Director of Registration, DiMaggio prepared a fact sheet on the BORN's functions and activities hoping to reach beyond the information impasse to "responsible" officers in Consumer Affairs. At the same time, she sent a memo to nursing schools, practical nursing schools, the Massachusetts Nurses Association, the Massachusetts Hospital Association alerting them of the Board's business: granting and renewing licenses, approving new nursing programs, overseeing standards for 101 nursing programs, conducting and reviewing the results of the State Board Exam, investigating schools whose graduates had a high failure rate, evaluating reciprocity requests, evaluating foreign graduates' credentials, conducting competency, exposing imposters and responding to queries from consumers, national organizations and government agencies.

On February 15, 1973, one month before Sargent submitted his bill DiMaggio and the Board received part of report from Verani (Secretary for Consumer Affairs) revealing some details of the Governor's "hidden plan." Meanwhile, rumors about a possible "hidden plan." Meanwhile, rumors about a possible

To be continued in the next Clio's Corner.

Sources:

H6120 An Act to Reorganize and Modernize State Government by creating a Department of Human Services, Massachusetts State Archives.

Minutes of the Board of Registration in Nursing, Massachusetts State Archives.

Gellerstrina DiMaggio rc: Mary Baroli to Mary Ellen Doona

Estelle Lombardi re: Mary Baroli to Mary Ellen Doona.

Anna Kuba to Donald C. Hillman, April 5, 1973. MNA Collection. History of Nursing Archives, BU.

There would be no professional nurse at the licensure level. And worst of all, non-nurses would be establishing standards of nursing education and nursing competency!
For the past six years, I have had the pleasure of volunteering for the Boston Marathon. For four of those years I ventured out and did it alone. I will never forget what it was like to walk into that Medical Tent A, located right after the finish line. Talk about a fish out of water! Last year, Trish Bowe asked me if I would think about volunteering as a member of Team MARN. I agreed without hesitation, and got to meet so many great nurses from MARN. I joined MARN soon after the Marathon.

This year I looked forward to being a part of Team MARN again. This time I was a MARN member and I loved being part of the event with my MARN colleagues. We were located in Medical Tent B [near the John Hancock Hall], which is located 2 blocks from the finish line. Thirteen MARN members were responsible for caring for the runners in 60 cots...and from 2-5pm the tent was packed. We cared for runners from around the world: Germany, Italy, Peru, Africa, and the United States who suffered from hypothermia, GI distress, dehydration, blisters, muscle cramps, and even one runner who had a myocardial infarction.

It was hard work, but totally worth it. I took care of a runner who had bilateral quad cramps. She was screaming in pain. The physical therapy students went right to work. As she was leaving she looked at me and said, “Believe me you don’t know how good it feels to have people like you guys help us through this!” As I sum up this experience, the nurses stuck together completely defining the word teamwork, and got the job done. I sure am glad that MARN found me!

Nickie Burney, Yolanda Starling and Barbara Gray wait for the runners to arrive.

Foraging for equipment.

The calm before the storm . . .
These programs have not sought approval by the Massachusetts Association of Registered Nurses, an accredited approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Practice of Wise Leadership: 2 Day Advanced Health Care Leadership Program

by Mary J. Connaughton, RN, MS, and Jim Hassinger, EdM.

Provides diagnostic tools and practical skills to expand leadership capability for novice and seasoned leaders. Improve your ability to manage difficult situations and communicate more effectively.

Conference Center at Waltham Woods
October 21 & 22, 2010
8:00am-4:30pm
Fee: $795
11.75 Contact Hours
Registration Information:
www.connaughtonconsulting.com
or 617-244-5478

Willing to Lead...Let’s Chart the Course

by Mary J. Connaughton, RN, MS

A program designed for nurse leaders with significant responsibility but little formal authority...resource/charge nurses, supervisors, etc. The program will provide diagnostic tools to assess leadership strengths and areas needing improvement.

You are not alone...come and learn with new colleagues!

Conference Center at Waltham Woods
August 10, 2010
8:00am-4:30pm
Fee: $225
5.5 Contact Hours awarded
Registration Information:
visit www.connaughtonconsulting.com
or 617-244-5478

Talk Like a Leader...Why Not Make Communication Your Strong Suit?

Presented by Mary J. Connaughton RN, MS

The second in a series of leadership programs for nurses leaders. This program offers intensive coaching to identify barriers to effective communication and practicing skills to overcome them.

Pre-requisite: prior attendance at the “Willing to Lead” Program.

Conference Center at Waltham Woods
August 12, 2010
8:00am-4:30pm
Fee: $225 Number
5.5 Contact Hours
Registration Information:
visit www.connaughtonconsulting.com
or call 617-244-5478

MARN Advisory about the National Nurses Union (NNU)

Marketing Brochure

You may have received in the mail or have seen a marketing brochure from the National Nurses Union (NNU) asking you to join their organization. Please be advised that the organization is a Union comprised of three main groups including the California Nurses Association, Massachusetts Nurses Association and the United American Nurses. Both California and MNA disaffiliated from the American Nurses Association.

MARN does not support the NNU and advises members not to join or send them your personal contact information.

The National Institute for Occupational Safety and Health Releases “Safe Patient Handling Training for Schools of Nursing” Toolkit

Publication No.: 2009-127

The final version of the “Toolkit” was produced by the National Institute for Occupational Safety and Health (NIOSH). The material includes a booklet and the safe patient handling and movement web-based training. Play the flash media from your computer, print the PDF of the booklet, or download the entire CD contents (booklet and flash presentation). The “Toolkit” was developed in partnership with the National Institute for Occupational Safety and Health (NIOSH), the Veterans Health Administration (VHA), and the American Nurses Association (ANA).

Available at www.cdc.gov/niosh/docs/2009-127/

ANA Supports Nation’s First Lady In Combating Childhood Obesity

SILVER SPRING, MD—The American Nurses Association (ANA) is eager to support the First Lady Michelle Obama in her critical efforts to combat childhood obesity and stands ready to support the First Lady’s program, “Let’s Move: America’s Move for a Healthier Generation.”

“Nurses are firsthand the devastating effects of obesity,” said ANA President Rebecca M. Patton, MSN, RN, CNOR. “We recognize the impact it has on our society and our health system. Obesity can increase the risk of stroke, diabetes, heart disease and hypertension as well as many other illnesses. In addition to the impact on the health of our population, it also threatens the health and safety of nurses and other health care providers who may injure themselves while assisting obese patients. ANA recognizes the effects of obesity and pledges its ongoing support of programs that serve to address the issue.”

Registered nurses, as the largest group of health care providers touch the lives of parents and children and is dedicated to the development and distribution of the educational materials about obesity and its impact on our nation’s children.

The 2010 National Nurses Week theme Nurses: Caring Today for a Healthy Tomorrow further underscores ANA’s ongoing commitment to promoting healthy choices for our patients, our families, and the communities we serve. To learn more about Let’s Move, please visit www.letsmove.gov.
Policy for Accepting Announcements for the Newsletter:

MARN encourages organizations of higher education to submit announcements about continuing education opportunities and upcoming events that are of interest to nurses. Fees must be included with submissions.

The Fee Schedule is as follows:
- Non-MARN Approved Providers/ Sponsors—$50
- MARN Approved Providers/Sponsors—$25

Payment can be mailed to MARN, PO Box 285, Milton, MA 02186. Please include a copy of the announcement and contact information (name, address, telephone, Email) with the check. Please email copy to www.MARNonline.org.

Announcements are limited to 75 words.

ATTENTION POTENTIAL PROGRAM ADVERTISERS

Please be sure to clearly state if your educational program is approved by the MARN Approver Unit in all program submissions!

MARN News is an up to date information service about a variety of issues important to nurses in Massachusetts. You must be a MARN member to be included, so join today!

MARN member: Have you gotten your MARN News message? If not, then we don’t have your correct email address. If you want to begin receiving this important information, just send an email to: info@MARNonline.org with “ADD” and your name on the subject line.

We also welcome any pictures that show MARN members in action...at work or at play. Interested persons, please contact Myra Cacace at myra@net1plus.com.

Announcements are limited to 75 words.

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