Nursing Profession Celebrates 2010 as International Year of the Nurse

Commemorative service April 25, 2010 at the National Cathedral in Washington, D.C.

The year 2010 marks 100 years since the death of Florence Nightingale. Nightingale, recognized as the founder of modern nursing, is still revered and widely respected around the world today.

To honor her legacy, 2010 International Year of the Nurse (IYNurse) founders, the Honor Society of Nursing, Sigma Theta Tau International (STTI); Nightingale Initiative for Global Health (NIGH); and the Florence Nightingale Museum, have launched a sustained public awareness initiative to actively involve the world’s nurses—estimated to be more than 15 million—in a celebration of commitment to promoting health in their communities, locally and worldwide.

Throughout the year, nurses have opportunities to showcase their unique contributions toward the achievement of health and well-being for everyone. This celebration, a global collaboration with citizens around the world, engages nurses in the promotion of world health and demonstrates how they advocate for the achievement of the United Nations Millennium Development Goals.

Events include a service at the National Cathedral in Washington, D.C., from 4:00-5:00 p.m. Sunday, April 25th.

“In collaboration with the Nightingale Initiative for Global Health and the Florence Nightingale Museum in London, we are honored to support this yearlong celebration of commitment, a global collaboration with citizens around the world today.

“Go beyond your current level or location,” says Patricia E. Thompson, RN, EdD, FAAN, STTI’s chief executive officer. “Through the International Year of the Nurse Web site, we demonstrate the impact nurses have on health care worldwide.”

“However, the 2010 IYNurse initiative seeks to recognize the contributions of nurses globally and to engage nurses in the promotion of world health, including all the UN MDGs,” says Barbara Dossey, RN, PhD, AHN-BC, FAAN, NIGH International co-director. “We look forward to bringing nurses from around the world together for a commemorative global service at the National Cathedral in Washington, D.C.”

ANA President, Rebecca Patton

It is hard to imagine that we are beginning a new decade and that they place a high priority on these issues. As a painful and disheartening, finished on a high note with an anticipated future of better times for our profession and for our nation. What will this new decade bring for our profession and the patients we serve?

Let this next decade be one that we call the “Decade of Nursing.” Let us build in it a wave of momentum larger than previous decades. Let us take full advantage of opportunities to define, assist, and elevate our profession and our personal situations as RNs.

For so many reasons, 2010 has begun much differently than did 2000. The growing focus on the nursing shortage and the ongoing discussions and debates and on the critical national issue of health care and health system reform have brought nursing to the fore in the minds of the nation, and our contributions have never been more needed. ANA has a long, proud history of advocacy for nurses and nursing and is dedicated to addressing the major problems that affect all individual nurses and nursing as a whole—and producing solutions. This decade will be no different.

As a country, we can no longer accept or tolerate the status quo in terms of health care financing and delivery. Additionally, nurses must take the lead to focus on wellness versus disease management. We are poised to play a decisive role as caretakers of and advocates for the public.

ANA continues to use visits, meetings, and calls with White House officials to advance our agenda and issues of importance. We enter this decade with a president, Barack Obama, who shows exceptional concern for issues affecting nurses—as evidenced by his personal comments about the nursing faculty shortage, the overall nursing shortage, poor working conditions for nurses, issues of low compensation, and the lack of respect nurses deal with daily. Most importantly, the president has shown an appreciation for the critical, unique role we perform.

At the other end of Pennsylvania Avenue, ANA’s concentrated efforts on Capitol Hill ensure that nursing education has been increased by greater than 40 percent in the past decade, a momentum larger than previous decades. Let us take full advantage of opportunities to define, assist, and elevate our profession and our personal situations as RNs.

As a country, we can no longer accept or tolerate the status quo in terms of health care financing and delivery. Additionally, nurses must take the lead to focus on wellness versus disease management. We are poised to play a decisive role as caretakers of and advocates for the public.

ANA continues to use visits, meetings, and calls with White House officials to advance our agenda and issues of importance. We enter this decade with a president, Barack Obama, who shows exceptional concern for issues affecting nurses—as evidenced by his personal comments about the nursing faculty shortage, the overall nursing shortage, poor working conditions for nurses, issues of low compensation, and the lack of respect nurses deal with daily. Most importantly, the president has shown an appreciation for the critical, unique role we perform.

At the other end of Pennsylvania Avenue, ANA’s concentrated efforts on Capitol Hill ensure that nursing education has been increased by greater than 40 percent (or $72.8 million) to a historic $242.9 million in the next budget cycle. Additional funding for nursing education in the “American Recovery and Reinvestment Act,” also known as the “stimulus package,” totaled around $200 million, which will be divided between the Nursing Workforce Development Programs (Title VIII) and the Health Professions Training Programs (Title VII). That is real progress, but we will keep on pushing for more support in the coming decade.

ANA continues to build upon its strong relationships with other governmental agencies as well, such as the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the Centers for Medicare and Medicaid Services, and others. Our work alongside these agencies and others involved in protecting our nation’s health, well being, and safety continues to improve the working lives of nurses everywhere.

But ANA cannot do it alone in the next decade. The larger nursing community must demonstrate in this decade that it has the collective wisdom and strength to tackle the long-standing issues that hold back our profession and endanger our patients. The lack of collaboration we suffered at times in the past decades does not serve our patients well. By working together, we can accomplish great things in the coming decade.

And there are some tough issues to consider.

Not the least of which is the long-standing issue of the basic nursing education standard. The science is clear and undeniable: Education matters in the safety and care of our patients. We have an opportunity and obligation to find a solution that will work to increase the level of nurses’ education.

Several of our constituent member associations are working to enact legislation in their states that would require nurses to have at least a BSN on their 10-year anniversary as an RN. This approach does not mandate that a nurse have the BSN upon entry into the profession, but rather that it is obtained within 10 years of practice. This workable compromise would achieve the goal of continuing nurse education without setting up a barrier to entry into the profession.

Another goal for the next decade is to make real progress at the national level to address safe, appropriate staffing. The seemingly easy fix—mandated staffing ratios determined by our legislators—falls short of achieving meaningful safe staffing. The better solution, and the guarantee to safe staffing, is a principle-based solution that takes into account all variations that exist in a practice setting. We know that we cannot leave that determination up to a legislator, who likely has no real-life experience in patient care. In the new decade, ANA will continue our groundbreaking work to help states pass legislation that gives the bedside nurse a direct voice in determining the appropriate level of safe staffing.

The future of nursing and the impact this decade will have is yet to be known. But what we do know is that ANA’s goals can be achieved, and that we can improve the lives of nurses and our patients. We look forward to implementing comprehensive changes to improve the work environment for America’s nurses and to improve the quality of health care for everyone.

But regardless of what this decade holds in store, I know that you will always do your best for your patients. And I can assure you that ANA will always do its best for you. That is ANA’s promise. I have no doubt that when 2020 rolls around, we will look back on this decade to see it as a pivotal point in transforming the lives of our nurses and the patients we serve.
Mission, Vision and Values of NHNA

One hundred and four years and counting. That is how long NHNA has been in existence. We were birthed before a NH Board of Nursing was even conceived. The purpose of NHNA, often called the Graduate Nurses Association of NH, was centered on the welfare of its membership and the profession, the health of mankind and the education of nurses. This was a noble and lofty purpose. Over the course of the unfolding century we journeyed into discovering and defining the meaning of professional nursing. We were driven to elevate standards of nursing practice and to elevate our profession but in serving to seek the utmost in quality. As an association we evolved mission and vision statements to guide the work of NHNA and articulate the vision to which we as nurses aspire. But just as individuals grow and change over time so do associations.

Do our current mission and vision statement, last revised over a decade ago, capture who we are today and where we see ourselves into the future?

Findings of a survey conducted at the fall 2009 annual NHNA member meeting and from a focus group (conducted of members and non-members in August of 2009), indicate that it may be time for some re-alignment. A common theme from both queries was that NH nurses were unsure of NHNA’s relevance and mission. Some of the respondents felt that NHNA was not as overtly formulated as many other associations.

Throughout our 104 year history, we have sought to cultivate the profession and its members. Not unlike the monks from the Middle Ages, Florence Nightingale or Mother Theresa, NHNA continually seeks to leverage the potential power embedded within nursing presence. The transformative power of nursing presence is still unfolding today. NHNA’s vision should be to unbridle, unleash and advance the full transformative potential of nursing presence.

What are the core values of NHNA? NHNA does not have an overtly formulated statement of values. But if we review our history and what we as an association embrace in 2010, the statement would probably look something like this:

• Integrity: of being and action.
• Independence: confident enough to cultivate interdependence.
• Knowledge: informed by study and practice
• Clarity: backed by resolve
• Compassion: for those whom we serve and for ourselves
• Curiosity: to better welcome the yet unknown

There may be other essential values not captured above. Values can be a lifeline list of organizationally-correct statements. As such they serve as meaningless clutter. So why do we, as NHNA; bother discerning and articulating our values? We do so because NHNA believes that values are the blood that courses through our collective bodies. Values give us relevance and sustain our being. They have kept us alive for all these years and will nourish us into the future.

We would like to know your thoughts about the proposed revisions to NHNA’s mission, vision and values. Send us your thoughts. Comments may be sent to office@nhnurses.org or to any of the board members listed on the website. We will be using the mission, vision and values as the foundation upon which to build our strategic goals for the coming decade. This is an exciting time for NHNA. Let us cultivate the transformative power of nursing!
Historic Nursing Building A Memory

The historic Emily Smith building on the campus of Elliot Hospital is now but a memory. Known by many Elliot Hospital School of Nursing Alumni as home for 3 years while they attended nursing school and practiced at the hospital, it no longer served as a safe environment for staff or office workers. In addition, room was needed for a safe helicopter landing pad. It remitted.

Emily Smith never married. But her sister, Mary was the wife of Dr. Charles Wells, a physician at the Elliot in its early years. When her parents died, Emily lived with Mary and Charles. The Wells had no children of their own, and their fortune was passed on to Emily. When Emily died in 1909 she was generous to the city of Manchester, and donated the funds for the building. Built in 1910, twenty years after the start of the Elliot Hospital, the three story Victorian brick edifice was designed to house the nursing school and named after its benefactor.

The School of Nursing was closed in 1977, as diploma programs throughout the state were phased out, after having graduated over 800 nurses. Over the past 25 years it has served as offices for the nursing education department of Elliot Hospital in addition to other departments.

Board of Nursing Advisories

Question: Is it within the scope of practice of a licensed nursing assistant to prime IV tubing with fluids that contain potassium chloride (i.e. D5 ½ NS with 20 mEq KCl)?

The Board opined that it is not within the scope of practice for an LNA to spike/prime any IV’s or perform and other sterile procedures.

Question: Is it within the scope of practice for an RN to extract cerumem from ears using instruments such as, ear speculums, ear loops, small alligator forceps, and possibly suction?

The Board opined it is not within the RN scope to remove ear wax via instrumentation.

Question: Is it within the scope of practice to perform cryotherapy with liquid nitrogen in treatment of warts?

The Board opined that cryotherapy is not within RN scope of practice.

Question: Is it within the RN scope of practice to determine distal tip placement of PICC by radiograph?

The board upheld its previous opinion of August 18, 2005 and March 15, 2007 that it is not within the RN scope to determine distal tip placement determination of PICC via radiography.

Ed Note: The New Hampshire Board of Nursing Newsletter is now only published electronically at http://www.nh.gov/nursing/general/documents The Nursing News will review each issue and print important Board decisions.

Correction

HCPro Nursing Excellence award winner Laurie Anderson's credentials published in the December issue of the NH Nursing News should have read RN MS. Anderson is the Clinical Informatics Project Manager at Southern New Hampshire Medical Center. She was nominated for the award by Ann McLaughlin RN BSN, MBA, NE-BC who is the Professional Development Educator, Magnet Coordinator at Southern New Hampshire Medical Center.

Kudos!

Kudos to Rachel Allen and all the other nurses from Dartmouth-Hitchcock Medical Center who are part of a group sent to Haiti through an alliance between the hospital, Dartmouth College, Dartmouth Medical Center and Partners in Health, the Boston-based organization co-founded by Dartmouth President Jim Yong Kim.
My experience as a nurse in Haiti, following the January 12th earthquake, was unforgettable. It is nearly impossible to attach words to the time there; almost as if words will take away from what really was. I was fortunate enough to be one of the eight nurses sent from Dartmouth-Hitchcock Medical Center on Team 2. Few experiences professionally rival the intensity and urgency we faced when we hit the ground at the University Hospital of Port-au-Prince, and it was my sincerest honor and pleasure to be a participant in these relief efforts in Haiti.

Triaging patients and supplies takes on a whole new look in the face of a natural disaster. The luxury of spending copious amounts of time and energy establishing a patient’s plan of care goes out the window. The combination of mass casualties, minimal supplies and acute patient injuries limited the lives that medicine could save. In this country, we are accustomed to fight to save lives. The structure of our Intensive Care Units is programmed to do everything possible to save a life. In Haiti, we had to delete that mentality. Our energy and efforts were focused on patients who could survive with minimal technology, oxygen demand or blood products. If we spent two hours stabilizing an acutely ill patient, utilizing our only oxygen tank, we essentially risked losing 5 other patients who were not as emergety sick. Do you save the one at the expense of losing 5 down the road? It goes against our training to walk past a patient who is acutely ill and who could be saved in a developed country. This internal conflict presented itself daily, as those who were savable were picked from those who had taken a turn for the worse.

Limited supplies posed an alternative set of problems. Resources arrived in mass loads from the international community, but with minimal labeling or organization. Many of the supplies were impractical and unusable in the primitive environment of Haiti. Nurses had to be healthcare MacGyver’s. Intravenous tubing was cut and utilized as a urinary catheters, water bottles filled with stones were transformed into traction devices to be used after orthopedic surgery, gloves became tourniquets, and sterile gown sleeves were used to protect amputated stumps from flies and maggots. Urine sample cups became pill bottles for patients that were ready for discharge. What we easily discard in the West as waste became a trash bag, a sharps container or a urinal.

One point of differentiation that led our success was that a multidisciplinary treatment team was established instantly. In the face of the sheer magnitude of the crisis, it was imperative to maximize all working personnel and make use of their specialized expertise. The DICU (Dartmouth Intensive Care Unit) was run by nurses, but we maintained frequent and consistent rapport with the surgeons and anesthesiologists responsible for our patients. When doing wound rounds, we consistently and systematically went from bed to bed with an anesthesiologist and surgeon to maximize the standard level of care the patients received.

The hospital chaos created an environment in which patient management and follow-up was extremely complicated. Advocating for our patients was of paramount importance in obtaining adequate, and appropriate, care. Specifically, we identified that a large risk to the patients was that they were being taken for multiple procedures or surgeries from different surgical teams who had not communicated a care plan due to a lack of documentation.

It is an intrinsic response as nurses to never leave your patients without an adequate hand-off. This luxury was not available to us in Haiti. The nature of the disaster created a nursing demand that was not easily filled, and lack of documentation on who was going where, and where they should return to created an even bigger complication. By day we struggled to keep track of the twenty or thirty patients we had claimed. Often times just sending a patient to radiography or surgery could create another venue for them being lost to follow-up. Providing our patients with the best care possible was our objective. In this arena, the best care they could receive often meant sending them away to better equipped facilities. While I knew it was the best chance to save my patients limb, it was a horrible thing to place them on the back of a tanker and in broken French convince them that taking them away from their only living relative, our care, and the environment they had finally grown to trust, was in their best interest. What if the care we were promising them was not real? It was very devastating in the aftermath of this earthquake to hand your patient off and relinquish all control.

Though our time in Haiti was short-lived, its impact on each of us will be long-standing. So much was learned from the patients we cared for; such resilience in face of destruction. The beauty of nursing is that its skill and practice transcends cultural barriers. The challenge now is to carry the experiences from Haiti into our daily professions, and ultimately maximize our efficacy as nurses in this country where we have been blessed with abundant resources and opportunities.

Ed Note: MacGyver was an action TV program from 1985-1992 which follows the laid back secret agent, MacGyver as he solves a range of problems with little but his ever present Swiss army knife and the materials he has at hand.

Rachel N. Allen BSN, RN is a clinical research coordinator in the Medical Infusions program at Dartmouth-Hitchcock Medical Center.
On January 9th, 2010, a cold winter's night, a group of 27 doctors, nurses, nursing students, translators, and other volunteers gathered at Manchester Community College in the wee hours of the morning to begin a journey they had been working toward for several months. With over 50 bags full of medication and supplies in tow, the group boarded buses for Logan airport, where they left to set up and run a week of free medical clinics in poor rural communities in the Dominican Republic.

Although this was a “first” for many of the individuals in the group, the idea was borne by others, including three nursing professors from Manchester Community College who had been to the Dominican the previous year on a similar journey. The 2009 trip created such a positive experience, they wanted not only to create a repeat experience, but to enhance it by building their own team to provide healthcare to communities that had not been served in the past.

Over a few months time the group was able to recruit three physicians, one nurse practitioner, two additional nurses, several nursing students, and Spanish and Creole translators, all of whom were able to participate in the week-long mission trip. In conjunction with Orphanage Outreach (http://www.orphanage-outreach.org) a non-profit organization that provides opportunities to orphaned, abandoned, and disadvantaged children as well as organizing free medical and dental clinics in the Dominican Republic, clinic sites were arranged and our goal was within reach.

Much of the Dominican Republic faces extreme poverty, and few people receive regular healthcare. Small wounds fester into big infections, hypertension is left undiagnosed and untreated, and many people live with easily treated conditions, such as intestinal parasites and scabies. The goal for our clinics was to provide the best care we could to as many people as possible with the limited resources we had available. According to the healthcare standards we are used to, it many not sound ideal, but to the people we cared for, it was great. Some quietly thanked us with a smile or with words; others hugged us. One older woman fervently prayed in thanks for the help we gave her. But we were not there to be recognized for what we were doing. We were simply there to serve. And, as we talked about our day each evening, we agreed that we got as much satisfaction caring for them as they got receiving the care.

Clinic days were very long, hard days. The breakfast bell rang at 7:00 a.m. each morning and we would have the buses loaded and be on our way to that day’s clinic site an hour later. Each day’s clinic location brought its own challenges. Electricity was usually not available, and if it was, it was likely to go out numerous times throughout the day. Space was often limited; some days all four practitioners and the pharmacy would crowd into one large room; other days they would be spread a distance apart. The day we were located in a school building, school was cancelled for the day. A free medical clinic took precedence over school.

Lines of people formed quickly, stretching down the dirt roads; crowds gathered long before we were ready to begin each day’s clinic, hoping for an opportunity to see a doctor and to get medicine to treat their symptoms. Each person was registered and given a sticker with their name written on it. From there, they would move to the triage area, where nursing students would take and record their vital signs. Capillary blood glucose levels were checked on individuals meeting certain criteria and urine was screened if deemed necessary. People waited their turn to see one of the doctors or the OB/GYN nurse practitioner—a continual process throughout the day. As Doctor Tim French put it, “the hand sanitizer I just put on my hands wouldn’t even make it, it many not sound ideal, but to the people we cared for, it was great. Some quietly thanked us with a smile or with words; others hugged us. One older woman fervently prayed in thanks for the help we gave her. But we were not there to be recognized for what we were doing. We were simply there to serve. And, as we talked about our day each evening, we agreed that we got as much satisfaction caring for them as they got receiving the care.

Clinic days were very long, hard days. The breakfast bell rang at 7:00 a.m. each morning and we would have the buses loaded and be on our way to that day’s clinic site an hour later. Each day’s clinic location brought its own challenges. Electricity was usually not available, and if it was, it was likely to go out numerous times throughout the day. Space was often limited; some days all four practitioners and the pharmacy would crowd into one large room; other days they would be spread a distance apart. The day we were located in a school building, school was cancelled for the day. A free medical clinic took precedence over school.

Lines of people formed quickly, stretching down the dirt roads; crowds gathered long before we were ready to begin each day’s clinic, hoping for an opportunity to see a doctor and to get medicine to treat their symptoms. Each person was registered and given a sticker with their name written on it. From there, they would move to the triage area, where nursing students would take and record their vital signs. Capillary blood glucose levels were checked on individuals meeting certain criteria and urine was screened if deemed necessary. People waited their turn to see one of the doctors or the OB/GYN nurse practitioner—a continual process throughout the day. As Doctor Tim French put it, “the hand sanitizer I just put on my hands wouldn’t even make it, it many not sound ideal, but to the people we cared for, it was great. Some quietly thanked us with a smile or with words; others hugged us. One older woman fervently prayed in thanks for the help we gave her. But we were not there to be recognized for what we were doing. We were simply there to serve. And, as we talked about our day each evening, we agreed that we got as much satisfaction caring for them as they got receiving the care.

In just four days we saw over 1,000 men, women and children at our free clinics—a large number of people served. But can a well-meaning group of Americans really make a difference in the health of these individuals in such a short period of time? We may not cure their diseases or have enough medicine to keep them supplied over the long-term, but the answer is yes. Poco a poco—which means “little by little” in Spanish—groups like ours can and do make a difference.

Hypertension, diabetes, infections, colds, parasite infestations and sexually transmitted diseases were commonly diagnosed. One man with suspected HIV and Tuberculosis was sent to a clinic, only to come back later stating he had no money to be treated there. One woman with a blood pressure of 230/140 left without being treated but was later found by someone in her community and given medication that may have prevented a stroke. Some individuals were sent to a table set up to provide health information. Others were sent to a student providing wound care. Crutches were given to a man struggling to walk. Reading glasses were fitted to those with vision problems. How amazed they were to be able to see clearly!

Most people were given a prescription for something—medications, creams, vitamins—and would quickly work their toward our “suitcase pharmacy” to collect their goods. The pharmacy was literally run out of suitcases placed on tables or desk tops. Pills were dosed and sorted into sandwich baggies; antibiotic suspensions were reconstituted with “safe” water from a cooler. Volunteers were sent running back and forth to the doctors to clarify orders or to ask for alternative prescriptions, as we ran out of medications. Instruction labels in Spanish or Creole were placed on each medication and verbal instructions were given by translators.

In just four days we saw over 1,000 men, women and children at our free clinics—a large number of people served. But can a well-meaning group of Americans really make a difference in the health of these individuals in such a short period of time? We may not cure their diseases or have enough medicine to keep them supplied over the long-term, but the answer is yes. Poco a poco—which means “little by little” in Spanish—groups like ours can and do make a difference.

Most people were given a prescription for something—medications, creams, vitamins—and would quickly work their toward our “suitcase pharmacy” to collect their goods. The pharmacy was literally run out of suitcases placed on tables or desk tops. Pills were dosed and sorted into sandwich baggies; antibiotic suspensions were reconstituted with “safe” water from a cooler. Volunteers were sent running back and forth to the doctors to clarify orders or to ask for alternative prescriptions, as we ran out of medications. Instruction labels in Spanish or Creole were placed on each medication and verbal instructions were given by translators.
Gail Dufour RN
Emergency Dept., Wentworth Douglass Hospital

My husband and I, for over five years, have been traveling to Mali, Africa with a team of multi skilled individuals to help construct an orphanage and medically treat the poor. Each year as we start to prepare by collecting donated medication, and dressing supplies, peers will ask, “What do you think you can do in the few weeks you will be there? What happens when you leave?” I often try to explain but, I think to myself, “I’ll have the answer when I return and let me tell you then.” Each year there are so many different stories to tell particularly concerning the patients we see at our makeshift village clinic.

One morning as we were preparing for the day, Beth Hutchinson-ER nurse at WDH who organizes, inventories and packs all our medication supplies, as well as directs those working in the clinic’s pharmacy, was walking to the latrine. She noticed a very frail young woman sitting on the ground leaning against the wall holding a tiny bundle. Beth realized the woman was very ill and needed help. The woman held out the tiny bundle to Beth. It was her baby.

A farmer came to our clinic whose arm was broken 2 months prior. He didn’t have a cast. His only complaint was that he couldn’t lift with that arm, was unable to work and provide for his young family. We were able to provide transportation to obtain an x-ray. The humerus was fractured and separated; the radius and ulnar also fractured were starting to fuse but overlapped. The same day a teenage girl and an elderly man were seen both with grossly infected wounds. Without intervention, the girl would lose her arm—the elderly man, his leg. All day long cases like these come in.

When the poor in Mali become ill, there are very few opportunities for them to receive care. Even if they are able to be seen by a physician, they have no money to purchase medication so they go untreated dying from Malaria, malnourished from parasites, losing limbs from oozing wound infections. We heard of a girl who was missing her index finger. When asked what happened she explained that she had gone to a doctor. After her examination she was asked if she could afford the medication it was going to require treating her infected finger. She replied no. The physician then amputated her finger.

What did we do in the few weeks we were in Africa? We tested the young mom found at the latrine and her baby, both positive for HIV. The mom was set up with a clinic which will offer further testing and care. The farmer and teenage girl were connected with a surgeon who was invited to our clinic by a local Malian, Dr. Luther, who works with us each year. The surgeon agreed to treat both. We were able to provide the funding. The elderly man was treated at our clinic daily with IV medication and responded well. A boy who we have been treating over the past year for a wound on his leg which had spread over most of the lower aspect, received a skin graft which took 7 hours. Follow-up reports indicate the leg is healing. Young and old were dispensed medication for Malaria and parasites. Wounds were cleaned and dressed. The remaining medication and supplies were donated to Dr. Luther to be used free of charge for the poorest of the poor.

Daily as our construction team returned to the clinic at the end of the day about 50 children would come running down the dusty road with a cloud of dust behind them anxious to greet the men. They wanted to play or be picked up or twirled. There was not a toy to be had but the games were many.

These village people have nothing, no Tylenol to treat the high fevers of Malaria, no clean bandages or gauze to wrap a wound. There are no corner drugstores or urgent care facilities. We come with a little but offer a lot of hope. The farmer now will be able work; the young gal with the infected arm will grow into a beautiful woman with both her arms, and the elderly man will walk again. As we drove away in our van for the last time, the Malians crowded around not letting us past for a long time, smiles broad, arms waving, all shouting “Al la ca du by I ay” over and over again which means God Bless you. We will never be forgotten by these people.

A huge thanks to the many departments of WDH: Community Relations; Pharmacy; Materials; the Wound Clinic and the ER, which donate dressings, IV supplies, medication and much more each year we have gone over to Mali. We are able to save lives and limbs and provide a little comfort. Without them, we couldn’t be.
The American Nurses Association has established a review board to evaluate proposals from leading health care researchers and scientists who are seeking access to the nation’s richest database of nursing performance measures—ANA’s National Database of Nursing Quality Indicators® (NDNQI®).

The NDNQI Research Council has created a system for submitting the NDNQI data for review and scoring the proposals to determine if they meet the criteria for access to the data housed by NDNQI, a program of ANA’s National Center for Nursing Quality® (NCNQ®).

“NDNQI data program is on the cutting edge of quality improvement in health care and nursing care. The future direction of health care is decision-making based on evidence of what works best, and to have the evidence, you need to collect, compare and report the nursing-sensitive data like NDNQI does,” said ANA President Rebecca M. Paton, MSN, RN, CNOR. “ANA is pleased to be able to open this valuable tool to highly-qualified researchers who will know how to identify and use the data they need to advance the profession of nursing and the quality of health care through their projects.”

The NDNQI program collects data quarterly from individual nursing units from 1,500 participating hospitals, and evaluates the connection between the quality of nursing care and patient outcomes on measures such as patient falls, infections and hospital-acquired pressure ulcers.

In any given quarter, more than 12,000 nursing units are reporting data. The NDNQI data also can be used to determine links between nurse staffing levels, nurse skill mix and patient outcomes, and to measure nurse satisfaction and the practice environment through surveys.

The 15-member council is comprised of nursing scientists, nursing practice experts, nursing administrators, and health information technology specialists, as well as ANA staff and leadership. It is co-chaired by Isis Montalvo, MBA, MS, RN, NCDNP, NDNQI’s director, and Nancy Dungan, PhD, research professor at the University of Kansas’ School of Nursing and NDNQI’s director since its establishment in 1998. The University of Kansas manages the NDNQI program under a contract with ANA.

ANA is encouraging scientists and researchers to submit research proposals to the council for review through a submission process on the NCNQ Web site, www.ncnq.org. NCNQ advocates for nursing quality through quality measurement, novel research, and collaborative learning.

**Gallup Poll Votes Nurses Most Trusted Profession**

For the eighth consecutive year, nurses have been voted the most trusted profession in America according to Gallup’s annual survey of professions for their honesty and ethical standards. Eighty-three percent of Americans believe nurses’ honesty and ethical standards are either “high” or “very high.”

“It is with great pride that the ANA recognizes the trust placed in us by the patients we serve,” commented ANA President Rebecca M. Paton, MSN, RN, CNOR. “At this time, when issues regarding the quality and availability of care are at the forefront of the national debate, we find it especially rewarding to see that nursing’s integrity and commitment continues to be acknowledged.”

Since being included in the Gallup poll in 1999, nurses have received the highest ranking every year except in 2001, when fire fighters received top honors. Results were based on telephone interviews with more than 1,000 adults.

**Patient’s Perception of Quality – It’s All About the Experience**

Kristin Baird, RN, BSN, MHA

Not that long ago, I had a meeting with the executive team of a health care organization during which we talked about the patient experience. I asked the group: “How do your patients gauge quality?” A physician leader in the room responded: “Is it whether or not we’re able to provide them with the clinical care that they need?” The answer was predictable but, based on a lot of research, misinformed.

As health care providers, we see quality from a technical standpoint. But the general public expects us to be clinically competent. They judge us on the experience.

After all, that is the business we are in. We think of quality based on both their expectations and ours. How do patients judge the quality of care they receive? Research suggests that patients tend to judge their care based on more subjective attributes—like how well they were treated, the friendliness of staff, whether their providers listened to them, how well they understood the communication and directions they received from their providers, etc.

Nurses play a critical role in shaping the patient experience. Daily, front-line, direct interactions between patients and nurses can help to create a high quality encounter (from the patient perspective). This is important not only from a service standpoint, but also from a clinical outcomes standpoint. When patients feel positive about their experiences—we have gained their trust and loyalty—compliance increases. When compliance increases, patient outcomes improve. And that’s something that nurses can help to create a high quality encounter (from the patient perspective). This is important not only from a service standpoint, but also from a clinical outcomes standpoint.

How do patients judge the quality of care they receive? Research suggests that patients tend to judge their care based on more subjective attributes—like how well they were treated, the friendliness of staff, whether their providers listened to them, how well they understood the communication and directions they received from their providers, etc.

Nurses play a critical role in shaping the patient experience. Daily, front-line, direct interactions between patients and nurses can help to create a high quality encounter (from the patient perspective). This is important not only from a service standpoint, but also from a clinical outcomes standpoint. When patients feel positive about their experiences—we have gained their trust and loyalty—compliance increases. When compliance increases, patient outcomes improve. And that’s something that nurses can help to create a high quality encounter (from the patient perspective).

Nurses are in an ideal spot to bridge the quality gap by ensuring both solid clinical quality outcomes and positive patient experiences. How do you communicate with the patient and family is one of the most vital elements in forging a positive patient experience. In most inpatient settings there is the nurse at the center of the care plan. In that role, he or she can make or break the patient’s perceptions about teamwork, information about treatment, pain control, responsiveness to requests as well as friendliness and compassion.

Think about the experiences you have with patients on a daily basis and consider the impression from their point-of-view. Your patients are often in unfamiliar and personally uncomfortable situations. They are often intimidated by all of the medical terminology and technology that they don’t fully understand. The sights, sounds and smells to which we are so accustomed often leave them scared, frustrated and vulnerable. Even some of the little things that you take for granted may be foreign to your patients who are not health care practitioners.

What are the moments of truth that most resonate with your patients? If perceptions are reality, are you ready to find out and to act on what’s important to them while, of course, continuing to focus on the clinical outcomes that we know are critical to providing quality care?

There is a lot of discussion these days about improving the patient experience. The question is: do you fully understand what your patients are currently experiencing? If so, are you open and receptive to change? That is the million dollar question. Unless you are open to learning the truth and willing to make necessary changes, you can’t possibly improve the experience.

Everything that we do comes down to trust. Everything our patients see, hear, smell, and touch has to instill a greater sense of trust in the health care organization and the professionals with whom they interact. For too long we’ve been somehow duped into thinking that our patients are judging us on clinical outcomes. In the process, we’ve minimized the myriad of other things that can make or break the trusting relationships we have with our patients.

We can improve the quality of care that we provide our patients. But only if we take the time to learn how they define quality and direct our efforts toward delivering those desired experiences to them.

Kristin Baird president of Baird Consulting, Inc., Baird earned a BS in Nursing from UW-Madison and an MS in Health Services Administration from Cardinal Stritch College in Milwaukee. She can be reached at baird-consulting.com.

**ANA to Open Premier Nursing Performance Database to Top Researchers**

The American Nurses Association has established a review board to evaluate proposals from leading health care researchers and scientists who are seeking access to the nation’s richest database of nursing performance measures—ANA’s National Database of Nursing Quality Indicators® (NDNQI®).

The NDNQI Research Council has created a system for submitting the NDNQI proposal for reviewing and scoring the proposals to determine if they meet the criteria for access to the data housed by NDNQI, a program of ANA’s National Center for Nursing Quality® (NCNQ®).

“NDNQI data program is on the cutting edge of quality improvement in health care and nursing care. The future direction of health care is decision-making based on evidence of what works best, and to have the evidence, you need to collect, compare and report the nursing-sensitive data like NDNQI does,” said ANA President Rebecca M. Paton, MSN, RN, CNOR. “ANA is pleased to be able to open this valuable tool to highly-qualified researchers who will know how to identify and use the data they need to advance the profession of nursing and the quality of health care through their projects.”

The NDNQI program collects data quarterly from individual nursing units from 1,500 participating hospitals, and evaluates the connection between the quality of nursing care and patient outcomes on measures such as patient falls, infections and hospital-acquired pressure ulcers.

In any given quarter, more than 12,000 nursing units are reporting data. The NDNQI data also can be used to determine links between nurse staffing levels, nurse skill mix and patient outcomes, and to measure nurse satisfaction and the practice environment through surveys.

The 15-member council is comprised of nursing scientists, nursing practice experts, nursing administrators, and health information technology specialists, as well as ANA staff and leadership. It is co-chaired by Isis Montalvo, MBA, MS, RN, NCDNP, NDNQI’s director, and Nancy Dungan, PhD, research professor at the University of Kansas’ School of Nursing and NDNQI’s director since its establishment in 1998. The University of Kansas manages the NDNQI program under a contract with ANA.

ANA is encouraging scientists and researchers to submit research proposals to the council for review through a submission process on the NCNQ Web site, www.ncnq.org. NCNQ advocates for nursing quality through quality measurement, novel research, and collaborative learning.

**Common Ground: Practical Approaches to Collaborative Medical/Dental Care**

Friday, June 11, 2010 8:30 a.m. - 4:30 p.m. Contact Hrs: 6.0 Grappone Hall - NHTI Campus

**CONFERENCE PURPOSE:** To provide an overview of the importance of medical and dental collaboration on patient care outcomes, and present concrete information that can be implemented in all healthcare settings to improve the overall health of patients.

**Solutions will focus on collaboration and integration of medical and dental care.**

**Keynote:** Hugh Silk, MD, FAAPA - Closing the Gap in Family Medicine

Endnote: Gretchen Gibson, DDS, MPH - Oral Health in Seniors

**Other Topics:** Discovering the Oral Systemic Health Link, Diabetic Oral Health Cues, Smoking Cessation, Dental Carries Risk Assessment, plus a panel of experts who have found “Common Ground”.

**TO REGISTER:** http://www.nhti.edu/business/training/nursing/common.html Early registration discount before 5/7/10. Program includes lunch.

**MAJOR SPONSOR:** Northeast Delta Foundation

**Accreditation Information:** This program will provide contact hours for Nurses, CME’s, continuing education credits for Dentists and Dental Hygienists. All healthcare providers are welcome.

**NHTI Concord's Community College**
Nurse Staffing

Over the past year, the New Hampshire Nurses’ Association has taken the lead in collaborative work on a steering committee with the NH Organization of Nurse Leaders (NHONL); NH Hospital Association (NHHA); and the Healthcare Human Resources Association of NH to establish a standard for hospital staffing committees. Core principles of such a committee model have been previously published in Nursing News with one key element worthy of note: each committee would be made up of at least 50% bedside nurses. The development of a toolkit to assist executives and staff nurses to establish effective staffing practice—alongside the other health care groups in the State (the “collaborators”) this proposal was subsequently withdrawn as their strategy for safe and effective staffing practice. The motivator for legislation, although not in favor of a voluntary, non-legislative approach to staffing committees as proposed, as their strategy for safe and effective staffing practice.

The Town Hall Forum is a highlight of the legislative process that recommendations for improving this toolkit will emerge.

Background

During the 2009 NH Legislative Session proposed legislation to mandate hospital staffing committees was drafted by the New Hampshire Nurses’ Association incorporating the American Nurses Association’s Principles of Safe Staffing (ANA, 2009). Working alongside the other health care groups in the State (the “collaborators”) this proposal was subsequently withdrawn in favor of a voluntary, non-legislative approach to staffing committees. The motivator for legislation, although not an ideal solution, was the desire for nurse staffing to be influenced by legislation rather than dictated by it as it had been in other areas of the country.

NH nurses were concerned about the unintended consequences of legislatively mandated nurse staffing ratios. In California where hard staffing ratios had been legislated, significant facility and unit closures were reported. Regardless of the consequences, the mandate of professional practice continues to be significant autonomy and input into practice decisions. Legislation of hard ratios is contrary to these professional precepts.

NH nurses also became aware of significant national nursing union activity directed toward legislating ratios. This national activity became very local when in 2009 a lobbyist hired by the Massachusetts Nursing Association (MNA) became certified to lobby in NH. Because of the budget focus of the NH legislature, no legislation was introduced on behalf of MNA but the writing was on the wall. Concern over loss of nurse autonomy (particularly from an organization outside of NH) spurred a decision to propose the subsequently withdrawn legislation.

The Nurse Staffing Steering Committee (the collaboration of the New Hampshire (NH) Organization of Nurse Leaders, the NH Hospital Association, the NH Nurses’ Association and the Healthcare Human Resources Association of NH) was thus formed to:

- Conduct a survey on existing staffing decision making
- Develop a toolkit for hospital management and staff on nurse staffing committees
- Strongly encourage hospitals throughout the State to voluntarily charter and employ nurse staffing committees as proposed, as their strategy for safe and effective staffing practice

We are proud to announce the achievement of the original goals of the Steering Committee and look forward to hearing from nurses around the state who will engage in the staffing process. We invite nurses with concerns or suggestions as staffing committees are chartered and become active to contact NHNA.

Judith Joy, RN, PhD
Chair, NHNA Government Affairs Commission
Most people only have one vocation; I have two. I love being a nurse, but farming is in my blood. Almost every weekend, I take a two-hour trek to my family’s farm in North Bridgewater, Vermont. This farm has been in our family for five generations, and although it is a dairy farm, we also make maple syrup, raise corn and feed crops, and grow pumpkins.

We have a small herd of about 150 dairy cows, which include Holsteins, Jerseys, and three very social Guernseys. In addition, we have eight pet chickens, whose livelihoods depend more on their friendly personalities than their ability to produce eggs.

One of my favorite parts about farming is sugaring. The air is fresh, the woods are beautiful, and everything is waking up from a winter slumber. We generally set out about 1,200 taps—half with tubing and the remainder with buckets. We gather the sap every day and take it to our sugarhouse where a wood fire boils the sap down into syrup. The steam from the boiling sap fills the sugarhouse with the sweet aroma of maple. It generally takes 30 to 40 gallons of sap to make one gallon of syrup.

In the spring, we fix fences, plow the fields, and plant the crops. We raise mostly corn, although in rainy years we have considered raising rice. For those of you who might be interested... Tractor work is fun... for the first three hours.

Our summer is filled with putting up feed for the winter. When we can get several days of good sunny weather, we’re able to bale hay. If the weather doesn’t cooperate, we chop the grass and ensilage it in a bunker.

In the fall, we harvest our corn. The race is on to see who will get the most corn—the bears or us.

In addition to the seasonal activities, I help with both morning and night milkings. Like nursing, milking requires honed assessment skills. If a cow is milked too long, the mechanical trauma can cause an inflammation/infection in the quarter; we call this mastitis. Likewise, if a quarter is not milked out completely, the cow can get mastitis.

With animal husbandry, diagnostic and nursing skills are essential. Cows who have just calved often develop a condition called “milk fever,” requiring emergent IV calcium. Changes in feed (e.g. the percentage of long dietary fiber) can cause other life-threatening conditions such as a twisted stomach. Long-term outcomes are based on early assessment and interventions. Preventative health measures for a herd are also important; these include nutritional supplementation, immunizations, and medications to control intestinal parasites.

As you can see I get to live the best of both worlds.
The 2010 YEAR of the NURSE Initiative (see front page)

encourages nurses to take part in promoting health in their communities.

Since Spring is the season of the Walkathon, we are sharing just SOME possibilities where you might participate individually or as NURSE TEAMS. (Not intended as a complete or exhaustive list.)

WALKS to FUND HEALTH RESEARCH


April 10 – 5K Race for Breast Cancer Awareness Amherst- 10:30AM Amherst Green (register online at www.striped.com or the day of the event at 8:30am) Contact: Sam Lowell samuel.lowell@gmail.com

May 9: Medical Center 6K Nashua, 9:30AM Southern NH Medical Center. Contact: Race Director, SNHMC at 577-2255 or healthmatch@snhmc.org (2010 proceeds to benefit NH Breast Cancer Coalition)

May 19: Merrimack County Savings Bank Rock N Race Concord-6:00PM State House Plaza Contact: Sharon Sweet 603-225-2711 x5234 ssweet@crhc.org (funds go to the Payson Center for Cancer Care)

AVON Walk - May 15-16th (39 miles – fundraising commitment) www.avonwalk.org Or email NHNA member Valerie Keefe-Vincent about her team

June 20 – Annual Skip Matthews Memorial Run Lebanon 10:30AM Colburn Park Contact: Francis Ossodatto 603-448-2421 Fossodatto@gmail.com www.skiprun.org ( Proceeds to Norris Cotton Cancer Research)

American HEART Assoc. 2010 New Hampshire Start! Heart Walk - May 23 10:00am – 1:00pm

Merchants Auto Stadium – 1 Line Dr. Manchester Contact: (603) 518-1556 marilyn.briand@heart.org

CROHN’S & COLITIS Foundation Walk - May 15: 4 PM Derryfield Park, Manchester Contact: Kelly LeRoux; klерoux@ccfa.org; 781-449-0324

MARCH of DIMES Walks – see www.marathontobabies.org or call 228-0317 for details. May 2 – Laconia; May 8 – Manchester; May 15 – Portsmouth; May 16 – Keene; May 22 – Nashua; June 12 – Lebanon

MENTAL HEALTH: June 24: Life Up the Nite For Mental Health 5k run/walk Manchester, 6:00PM – a twilight 5K at Derryfield Park. Contact: Humberto Rodriguez 603-688-4114 x1422 humiskool@yahoo.com

MITOCHONDRIAL Disease: May 22 – Miles For Mito 5K Race & Walk Nashua, 10:00AM Stellos Stadium, 7 Riverside Drive. Contact Michael Amarello 603-429-8878; michael@3CRaceProductions.com

GENERAL FITNESS’ WALKS

May 1 – Angels 5K Fitness Walk/Run Penacook, NH 10:00AM Merrimack Valley High School; Contact: Danielle Varrill 603-798-4843 dvarrill@comcast.net

May 28 – Intergenerational Wellness 5K Walk Concord – 10:00AM State House ( statewide initiative focused on physical activity/health) Contact: Travis Home 603-224-7475x223 thome@nhlgc.org

May 29 – Annual North Country YMCA 5K Lilac Fun Run/Walk Lisbon- 9:00AM Intersection of US RT 302 and Lyman Rd. Contact: Walter Johnson 603-981-3734 or email: thecplaine@notzero.net

June 5 – 3rd Annual Keene NH Sports Medicine Center 5K Run or Walk & Kids Fun Run 9:00AM - Cheshire Medical Center, 580 Court St. (3.1 mile run or walk starting and finishing at the Cheshire Medical Center) Contact: Tate 603-354-5454 x3060 terckson@chesire-med.com

July 10 – Beech River 5K & Health Walk Center Osipspee—10:00AM Beech River Mill Contact: Vince Vaccaro 603-520-8268 vaccaro13@hotmail.com

FOR ADDITIONAL WALK or RACE EVENTS SEE WWW.COOLRUNNING.COM

SOME OTHER COMMUNITY HEALTH ORGANIZATIONS OFTEN LOOKING FOR NURSE VOLUNTEERS:

American Red Cross (blood drives, etc.)

www.concord-redcross.org www.nashuaredcross.org www.redcrossmanchester.org

Bone Marrow Registry: www.dkmsamericas.org 603-524-8284

Medical Reserve Corps: www.nhhealthcorps.org
Celebrate National Nurses Week with NHNA on May 10th
HOLIDAY INN - Concord, NH

The 3 R’s of Rejuvenation: RELEASE - REFOCUS - RECHARGE

12:30 p.m.  Registration and exhibit area open
1:00 - 2:15  Focused Not Fried! - Preventing Caregiver Burnout
2:30 - 3:45  Forgiveness - Empowering the Self; Healing the Workplace
4:00 - 5:15  The FiSH Philosophy™ - Creating a New Work Reality in Hospital Settings
5:15 - 7:00  Then - RELAX with colleagues for hors d’oeuvres, chair massage and surprises!

PLATINUM SPONSOR:

GOLD SPONSOR:

SILVER SPONSORS:

BRONZE SPONSOR:

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

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

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

Research: A Columbia University study found unhappy people were 22% more likely to have a heart attack or chronic chest pain, compared with those who are somewhat happy. Somewhat happy people also had a 22% higher risk than those who are moderately happy, researchers said. Happy was defined as the experience of pleasurable emotions, such as joy, happiness, excitement, enthusiasm and contentment on a five-point scale. People were followed for 10 years.

Reflection: Get out of work on time and do something to make yourself happy every day!

Research: A survey of 2,000 Americans found 50% said other people's health was "going in the wrong direction," while only 17% said the same of their own health. About 30% of participants gave themselves an A for managing their health and eating healthy, while 92% of physicians gave them a grade of C or lower.

Reflection: The grass seems to be greener in our own yard!

Research: A 1998 research paper that suggested a link between the measles, mumps and rubella vaccine and autism and bowel disease was formally retracted by The Lancet on Tuesday after the physician author was discredited. A British disciplinary panel said Dr. Andrew Wakefield was "irresponsible and dishonest" in the way he discredited. A British disciplinary panel said Dr. Andrew Wakefield was "irresponsible and dishonest" in the way he discredited.

Reflection: Perhaps they should have "No Talking" signs in operating rooms to speed up surgery and avoid the idle chit-chat between surgeon and anesthesia provider?

Research: The risk of getting a serious infection increases 10% each time a hospital patient in a shared room gets a new roommate, according to a Canadian study. Researchers said the risk could be substantial for patients with longer hospital stays that increase the likelihood of having multiple roommates.

Reflection: The results of this study support the trend to private rooms.

Research: There has been a steadily increase in registered nurses ages 23 to 25 entering the workforce since 2003, even though their colleagues ages 50 to 64 remain the fastest-growing segment of the workforce, according to nursing expert Peter Buerhaus. However, by 2025, the U.S. will face a shortage of 260,000 registered nurses, according to Buerhaus.

Reflection: Yes, the boomers are starting to hang up their scrubs!

Research: The so-called cough trick helps reduce the pain of vaccinations for children, according to a study in Pediatrics. Researchers said when children cough just as the needle is poked into their arm they feel less pain, and they added that this method is less hassle and cheaper than using TV, virtual reality goggles, bubble blowing or medicine to anesthetize the skin.

Reflection: Does this work with adults?

Research: For every 30-minute period between surgery incision and closing, the 30-day rate of infectious complications goes up by about 2.5%, research showed. The study found hospital lengths of stay also increased with operation times, about 6% for every 30 minutes.

Reflection: Perhaps they should have "No Talking" signs in operating rooms to speed up surgery and avoid the idle chit-chat between surgeon and anesthesia provider?

Research: The risk of getting a serious infection increases 10% each time a hospital patient in a shared room gets a new roommate, according to a Canadian study. Researchers said the risk could be substantial for patients with longer hospital stays that increase the likelihood of having multiple roommates.

Reflection: The results of this study support the trend to private rooms.

Reflection: Why did it take the Lancet so long?

Innovations

- A Delaware hospital has introduced bedside, flat-screen, touch-screen monitors to communicate with patients, educate children and families, and connect them to the Internet so they can be entertained and keep up with friends. Parents also can access their child's medical records through the system and e-mail their physicians.

Reflection: Isn't technology wonderful? Perhaps they can make the screen two-way, so the nurse can assess the patient's needs before entering the room.

- Some suburban hospitals are giving patients choices for care and reassurance by advertising their emergency department wait times online or even on highway billboards. The program allows people to register online for a small fee and hold their places in line at the hospital while they wait at home.

Reflection: This seems feasible as long as the patient doesn't get websites confused. You could end up booking concert tickets for your abdominal pain!

- A Veterans Affairs administrator’s idea to save money by sending unused prescription drugs home with discharged hospital patients was chosen by the White House as winner of an initiative to reduce bureaucracy. The innovation, to label bottles appropriately and let patients take them home will save an estimated $3.8 million when implemented next year at VA hospitals.

Reflection: Why can’t every hospital do this?

- Staff at an Alabama hospital are wearing special badges with wireless technology that can report whether they are washing their hands upon arriving and leaving patient rooms. Text messages and e-mails can be sent as reminders to staff who don’t comply with hospital rules on hand washing.

Reflection: The technology should be built into all stethoscopes, especially those worn by physicians.

Why Nurses Should Participate In The Political Process

There are three numbers which say all that you need to know about the New Hampshire legislature: 400, 24, and 2. 400 is the number of people in the New Hampshire House of Representatives. 24 is the number of people in the New Hampshire Senate. All of those legislators, like all other elected state officials, serve 2-year terms. This means that the New Hampshire legislature is a truly grass-roots organization. With a population of only about 1,000,000 citizens in this state, we have one representative to approximately every 3,000 people. To give a sense of proportion, if we had the same ratio of representation in the United States House of Representatives, there would be 92,000 members serving in the U.S. Capitol. As a result, the citizens of New Hampshire have a direct pipeline to their representatives in Concord. In contrast to the situation which exists in other states, New Hampshire citizens have easy access to their legislators because those legislators are the folks right up the street. The legislators reflect all walks of life, and they represent a cross-section of New Hampshire.

The legislature usually considers about 100 bills in any given year, and a substantial number of them concern healthcare. At a time when the state and federal governments increasingly have taken control of how healthcare is delivered—and anyone who has to fill out paperwork for the purpose of state inspections or Medicaid knows acutely what this is all about—it should come as no surprise that legislators play an important role in how providers perform their jobs and practice in New Hampshire.

This is why it is important for nurses to consider running for public office. Several nurses are serving right now in the state legislature, and the work that they have done in educating their fellow legislators concerning nurse practice and healthcare has been absolutely invaluable. For example, the participation of nurse legislators during the re-adoption of the Nurse Practice Act several years ago was an essential component of the positive outcome that was reached on that legislation. While lobbyists and members of the public can speak with legislators or testify at hearings, there is really no substitute for the input of one legislator to another.

Nurses are well-respected in Concord, just as they are in society at large. And in many ways the skills which make good nurses are exactly the same skills which make nurses good legislators: Assessment, planning, evaluating, listening, communicating, negotiating...it is endless.

So, if you want to shape the way that healthcare is delivered in New Hampshire, NHNA encourages you to seriously consider a run for public office. A patient’s side is not the only place that a nurse can serve the nursing profession.

Robert E. Dunn, Jr., Esquire
Shareholder, Devine, Millimet & Branch, PA

Ed Note: Bob Dunn has represented the nurses of New Hampshire as a paid health care lobbyist for the past 7 years.
Nurses as Frontline Risk Managers
Improving Patient Safety at the Point of Care

by June Fabre MBA, RN-BC

Preventable medical errors have continued to plague the healthcare industry despite the best efforts of individual professionals. The National Patient Safety Foundation and others attribute this crisis to the growing complexity of healthcare as well as to a failure to address systems problems. (www.npsf.org).

As frontline workers, nurses are ideally positioned to intercept medical errors but may lack the necessary power to intervene effectively. Positioning nurses to function differently, as frontline risk managers, can improve patient safety. Listen to the way that James M. Kouzes, author of The Leadership Challenge, describes his recommended path to organizational excellence, “The key to unleashing the organization’s potential to excel is putting the power in the hands of the people who perform the work.”

Empowering nurses to function as frontline risk managers requires leaders who are willing to make significant changes to their organizational cultures. Specifically, leaders must be willing to rethink the status of nurses, the communication that takes place within their organization, and how they can help frontline nurses prevent patients from being injured.

Consider the following evidence:
Researchers at Harvard found that nurses have a lower job satisfaction and how they can help frontline nurses prevent patients from being injured.

The Harvard researchers recommended the following practices to rectify this situation:

• Root cause removal must be an explicit part of a nurse’s job. Enough time must be allocated for them to resolve the problem.
• Nurses need frequent opportunities for communication with individuals who are responsible for supplying them with materials or information.
• When a nurse identifies a problem, managers must pay immediate attention to it. Often the best that the nurse can do is to merely raise the issue, but too often this runs the risk of being considered a complainer.

The Harvard researchers reported, “We did not observe any instances where the nurse contacted someone about a trivial or insignificant exception. In fact, we observed several occasions where we were surprised that a nurse did not raise awareness around a problem that we felt could have serious consequences” (Tucker et al., 2002)

Nurses need respect, appropriate tools, and leadership commitment to do their job. However, they often come face to face with polarization, overwork, and disruptive behavior.

A house divided
Too often, nurses and managers have an “us versus them” attitude. This consumes so much time and energy that there is little left for patient care. Polarization such as this does not have to happen; the best physicians and managers have become respectful of nurses. Consider these examples:

• A physician collaborates with nurses, and together they tirelessly respond to the needs of a critically injured patient.
• A nurse, contacting a physician-on-call about her concern for a patient, receives a timely and appreciative return call.
• A physician reviews the assessments of an observant nurse and modifies the patient’s treatment plan. (Fabre, 2008)

These exchanges are successful because they are based on mutual respect and courteous communication. In fact, communication has become such an important factor in patient safety that the Joint Commission has made a case for change in its Sentinel Alert # 40, “Behaviors that Undermine a Culture of Safety.” If you expect nurses to function as frontline risk managers, you will have to make sure that your organization values respect and courteous communication into practice.

The role of time management
Rechecking patient conditions thoroughly and often takes time as does solving the root causes of problems. It’s time consuming for a medication nurse to make a trip to the unit station and recheck the doctor’s orders. But, that final recheck might save someone’s life.

Making sure that frontline nurses have enough time to ensure patient safety does not necessarily require more staff. In many situations, leaders can reconfigure staffing by eliminating wasteful effort. Nurses often waste time as does solving the root causes of problems. It’s time consuming for a medication nurse to make a trip to the unit station and recheck the doctor’s orders. But, that final recheck might save someone’s life.

Visiting patient safety with a commitment to make system-wide changes is never simple. Shifting your basic culture to one of respectful communication and collaboration takes time. Although making these changes isn’t easy, making these changes is the right thing to do. It is right because our patients deserve to receive the safest and highest quality care that is humanly possible to provide.

June Fabre is author of Smart Nursing—Nurse retention and patient safety improvement strategies, 2nd edition. New York: Springer.

References:

As a 1987 Harlem teenager, Claireece “Precious” Jones (Gabourey Sidibe) is portrayed as and feels like a poor excuse for a human. Never mind the well known over-indulgent gen x-er teenagers you know. Precious is an obese, illiterate, still in the 8th grade sixteen year old child of a mother with Down’s syndrome (affectionately called “Mongo”), living in a slum of an apartment in Harlem; Ineffective Coping m/b eating a bucket of fried chicken to curb her anxiety, Risk for Compromised Human Security and love and belonging and look something like that somehow enhances that role. Well if Precious had a father was having sex with his daughter, and she got pregnant with her second child, and shows a gymnastics for this pathetic mother of a pathetic daughter and granddaughter.

I was disappointed to see the role of the nursing assistant who they call Nurse John (well played by Lenny Kravitz) portrayed. Once again the entertainment industry has taken a poetic license that borders on disrespectful to the profession. Not only is it inappropriate to call Nurse John a nurse when he isn’t one, but when Precious and her friends start fantasizing about John’s looks and he actually kisses Precious for this pathetic mother of a pathetic daughter and granddaughter.

The goal of these reviews is to find the pertinence to the role of today’s nurse and highlight it in such a way a genuine empathy for the role is not lost and is open to the current wretched situation in life is obvious as she fantasizes about a different life. Precious, the genius director of this film has uncannily put the viewer in the roller coaster seat. You actually feel like you are seeing everything through Precious’ eyes. Like when Precious is fantasizing about walking the red carpet, performing on stage, or more profoundly looking in the mirror to see a thin, attractive, white woman. And then her mother’s fist slams the side of her head.

When she discovers she is pregnant with her second child conceived with her father. Precious has the whore with all to try and find a way out of the hell she is living in. She enters herself into an alternative school “Each One, Teach One” where she needs to get and 8.0 or better to obtain her GED. There she finds herself surrounded by the comfort of other teenage girls trying to overcome the challenges of inner city life. They celebrate the birth of her baby with her and create camaraderie around mutual challenges, even if it is to out-do each other.

Precious’ mother Mary (pun intended) is nothing of the sort. In this Golden Globe and Screen Actors Guild award winning role, Mo’Nique has created a monster of a character to memorably play, as Hannah Lector, The dissonance created by this character presents the viewer with the ultimate challenge of feeling sympathy in a final scene where Mary tries to excuse her inexcusable behavior to Ms. Weiss (Mariah Carey) her social worker with the story of how she became the monster that she is. You see her boyfriend, the love of her life, and Precious’ father was having sex with his daughter, and she got violently (literally) jealous. The viewer is torn between a “boo, hoo, let’s call the waambulance” reaction, and a genuine sympathy for this pathetic mother of a pathetic daughter and granddaughter.

It took the jury less than an hour to return a not guilty verdict on February 11, 2010, for Anne Mitchell, RN, defendant in the criminal trial that has come to be known as the “Winkler County nurses” trial. Mitchell faced a third-degree felony charge in Texas of “misuse of official information,” for reporting a physician to the Texas Medical Board for what she believed was unsafe medical practices is non-negotiable,” said ANA President Rebecca M. Patton, RN, MSN, CNOR. As the nation’s largest nursing association, ANA joined forces with TNA, one of its constituent member associations, in July of 2009 to strongly criticize and raise the alarm about the criminal charges and the fact that the results from this case could have a lasting and negative impact on future nurse whistle blowers.

"ANA is relieved and satisfied that Anne Mitchell (RN) was vindicated and found not guilty on these outrageous criminal charges—and the verdict is a resounding win on behalf of patient safety in the U.S. Nurses play a critical, duty-bound role in acting as patient safety watch guards in our nation’s health care system. The message the jury sent is clear: the freedom for nurses to report a physician’s unsafe medical practices is non-negotiable,” said ANA President Rebecca M. Patton, RN, MSN, CNOR. “However, ANA remains shocked and deeply disappointed that this sort of blatant retaliation was allowed to take place and reach the trial stage—a different outcome could have endangered patient safety across the U.S., having a potential ‘chilling effect’ that would make nurses think twice before reporting shoddy medical practice. Nurse whistle blowers should never be fired and criminally charged for reporting questionable medical care."

"I was just doing my job,” relayed a jubilant Anne Mitchell, in a phone conversation with TNA immediately following the not guilty verdict, “but no one should have to go through this,” she said. “I would say to every nurse, if you witness bad care, you have a duty to your patient to report it, no matter the personal ramifications. This whole ordeal was really about patient care.”

Over $45,000 has been donated so far by individuals and organizations across the country to the TNA Legal Defense Fund as a way to support the defense of Anne Mitchell and former co-defendant Vicki Galle. “We didn’t have any support—emotional or financial—until TNA and ANA stepped in,” said Vicki Galle, RN, who also attended the trial in Andrews even though the prosecution had dismissed her indictment on February 1 as a co-defendant. “We could never have gotten through this without nursing’s support.”
Culturally Congruent at 35,000 Feet?

Sue Fetzer, RN

Nursing students and registered nurses alike who were born, raised and attending or attended school in New Hampshire tend to smile when the class discussion or mandatory in-service is on the topic of culturally congruent care. New Hampshire is a state with little ethnic diversity with over 90% of the state’s residents being of anglo Caucasian descent. I have often joked at our situation saying that in New Hampshire we think of someone from Maine or Vermont being from a different culture. Diversity is limited to the “large” cities like Concord, Manchester and Nashua. Nurses in the southern tier of the state have greater exposure to patients from “different” cultures as the Boston metropolitan border tends to inch closer to New Hampshire.

Nursing school and staff development educators have difficulty providing cultural experiences that are realistic or meaningful. Many nursing schools offer intensive immersion experiences with travel outside the US for small groups of students. And then there is a group of nurses who frequently question the merit and need for continuing education on cultural care. But you never know when you will need that piece of information on providing culturally congruent care, and it may make a difference.

In February I made my annual journey to Taiwan where I have been consulting with nursing faculty for the past ten years. It is a 29 hour plane trip, with the longest segment from Chicago to Hong Kong. As I was settling down 4 hours into the flight, in the middle of the first (of 4) movies, that dreaded call by the flight attendant overhead. “Would any doctor or EMT please identify themselves to a flight attendant?” Five years ago, on a long flight to Hawaii, I heard a similar call for help, and after the second call, offered my services. I learned, after doing CPR, that I am pretty quick at resuscitating a patient, and an emergency landing, that physicians tend not to volunteer. So, I got up and indicated to the flight attendant that I was a critical care nurse and might be able to help. She hurried me to the middle of the plane where I found a woman sitting with her husband. The passenger next to her had vacated the seat and I sat down and grabbed her wrist for a pulse. She was diaphoretic and had the look in her eyes that you see just before someone passes out. The pulse was weak and I helped her out of her overcoat. She had continued as 5 minutes had gone by and I was pretty sure she would not pass out. Yes, she had taken her pill this morning (it was now 12 noon) and no she had not gone to the bathroom since she had been on the plane. She had not had very much to drink.

And finally help arrives. A gentleman stopped to ask if I needed help, he was a retired paramedic. He looked about 70 and I thanked him for stopping, but the situation seemed to have stabilized. An Asian man in his mid-60’s interrupted my “interview” to state he was an oncologist. He wanted to listen to her heart and wanted to know if she was having chest pain. Grabbing the stethoscope he placed it over the 2 layers of clothes, listened for 10 seconds and then said he couldn’t hear anything. I informed him that she had recently been started on a diuretic and hadn't had anything to drink all day, nor had she moved from her seat. I suggested she was hypovolemic. He mumbled something and walked away.

Another blood pressure and it is up to 90 systolic. The diaphoresis is improved. I ask her if she can drink now and she says yes. I ask the flight attendant to get her a glass of warm water. He replied, “Doesn’t she want cold water?” No, warm water. At which point, not believing me, he asked her directly. “Do you want cold or warm water?” She answered warm, of course. Culturally congruent care.

After retrieving the water, I explained to the flight attendant that in the Asian cultures, when you are ill, the treatment is always warm liquids. Hospitals in Asia never provide ice water for patients. Ice machines are a rare entity, found only in the upscale hotels and restaurants that cater to Western tourists. My patient had been offered room temperature or cool liquids ever since she got on the plane, drinking neither. By offering warm water, culturally congruent care, she would comply and drink. After 20 more minutes, obtaining blood pressures over 100 systolic with a stronger pulse, she gave me a thumbs-up sign. I returned to my seat, satisfied that she would become rehydrated with some warm fluids. I checked on her every hour and got the thumbs-up sign, and 4 hours later both she and her husband were sleeping.

The rest of the flight was uneventful. Although I never realized that flight attendants had such a lot of paperwork to complete when an unexpected incident occurred. I was glad to have my nursing license with me as I documented my qualifications, assessment, interventions and findings on their “occurrence report”.

The next time you are attending an educational program on cultural values and practices I hope you will listen and learn. You never know when, or where you will need to practice culturally congruent nursing care!
New Hampshire Nurses’ Association Awards Program

The NH Nurses’ Association Annual Awards program has streamlined to FIVE key awards recognizing outstanding performance by registered and student nurses— as well as exceptional programs for the nursing profession. (Full document posted on our website.) Four award categories will be presented at the NHNA Annual Fall Convention and the Student award conveyed in the Spring during National Nurses’ Week.

1. Direct Care Nurse of the Year
2. Professional Advancement
3. Champion of Nursing (non-nurse recipient, individual, group or organization)
4. Student Nurse of the Year
5. President’s Award

Recipients of the first four awards are selected based on nominations submitted to the NHNA Commission on Nursing Practice. All award recipients are required in order to be eligible for nomination. Please consider nominating an outstanding nursing professional, aspiring professional or nursing champion today!

1. Direct Care Nurse of the Year Award

This award is given to a registered nurse who exemplifies strength and passion as a professional nurse in clinical practice using best practice standards, patient advocacy and community involvement. This nurse is highly regarded as a leader among peers.

Evidence required for submission of nomination:
1. A letter of recommendation from a peer identifying nursing leadership and involvement in the community with an exemplar(s) reflecting evidence of professionalism, best practice and patient advocacy.

2. Professional Advancement Award

This award is given to a registered nurse who has made a significant contribution towards developing or advancing the professional practice of individuals or groups, or the art and science of nursing. The contribution may be in one or more of the following categories:
- Education (academic setting, staff development or other)
- Nursing Research
- Evidence-Based Practice
- Mentoring
- Leadership

The ideal candidate for this award is highly regarded by nursing colleagues and/or students as someone whose contributions consistently exceed those normally expected in his or her role.

Evidence required for submission of nomination:
1. A letter of recommendation from a peer/student/ manager/nurse identifying nursing leadership with an exemplar(s) reflecting outstanding contributions for the advancement of the profession.

3. Champion of Nursing Award

This award will be given each year to an employer/institution or individual who has had a positive impact on the profession of nursing. This employer/institution or individual will have contributed by demonstrating characteristics and/or practices that support individual nurses or the nursing profession.

Evidence required for submission of nomination:
1. A letter of recommendation from a nurse or other individual identifying leadership and involvement in the nursing community.

4. Student Nurse of the Year Award

This award is given to a student nurse in an entry program who embodies all the finest qualities of nursing: caring, professionalism, advocacy, leadership and involvement.

Evidence required for submission of nomination:
1. A letter of recommendation from an instructor/ peer with an exemplar(s) identifying evidence of caring, professionalism, advocacy, leadership and involvement.

5. President’s Award

The New Hampshire Nurses’ Association President’s Award is given at the exclusive discretion of the President of the NHNA. The Office of the President of the NHNA provides a unique vantage point for identifying exceptional individuals who are worthy of recognition. The President is afforded absolute latitude in determining the criteria and qualifications for this award and may award more than one President’s Award each year.

New Hampshire Nurses’ Association Awards Program
Nomination Submission Form

Your Name:
How may we contact you?
Address:
Phone: Fax:
E-Mail:
Name of Nominee:
(Note: for the Champion of Nursing Award this is a non-nurse and may be an individual, group, facility or other entity)
Employer or School if applicable:
Address:
Phone: Fax:
E-Mail:
Award Category (Please select one):
- Direct Care Nurse of the Year*
- Professional Advancement*
- Champion of Nursing*
- Student Nurse of the Year*

*Submission deadline September 1. April 1 for Student Award—extended this year to April 15.

Each nomination must be accompanied by a signed letter of recommendation as specified in the award description. Submit to: NHNA, 210 N. State St. 1-A, Concord, NH 03301

On the Bookshelf
Joe Niemczuru
Plain View Press (May 15, 2009) Paperback, 260 pages Reviewed by Alex Armitage, BSc (Hons), MSc., RN, CNL

“Gentle reader: This book is not for the casual armchair traveler… so prefaces the journey of Joe Niemczuru, through his first encounter with the practice of nursing and medicine in Nepal. Joe, a nurse, a 30-year Maine veteran and post president of the Maine Nurses Association, relocates to Hawaii after a separation from his wife and the need for a clean break. Through a twist of fate and some contractual fine print, relocating to Hawaii means getting assigned to Pediatrics, more specifically, with pediatric burn patients. What was required to be spent on “international efforts” in nursing. In relocation he chooses to spend his funds in travelling—a glorified three month vacation is the image he paints in chapter 2 “I was going to Nepal more because it was cool.” United Missions to Nepal provided the official framework for this venture—the religious undertakings at the time were incidental.

Right from his arrival at the airport in Nepal, he becomes acutely aware that he is now in an impoverished nation, alone, with a wad of cash (in large bills) and unable to speak Nepalese. He discovers the reality of third-world illnesses which plague Nepal which not often seen in American practice. Such illnesses stem from lack of sanitation, lack of immunizations, poor nutrition and limited education: all preventable issues. Joe walks us along each hospital ward with him through his daily routine as he discovers the depth to which each one of these plagues compound Nepalese life. With each ward, each experience, each voyage we—the reader—see what he sees. As a seasoned nurse and educator, the medical insights he delivers are descriptively vivid. This is a frank and rare view into Christian-based health missions in Asia.

Like many healthcare professionals who offer their services internationally, Joe finds that he is required to have a broad practice range. A large part of his time in Nepal is spent in Pediatrics, more specifically, with pediatric burn patients. Acknowledging his discomfort, he notes that in the USA this is an area of practice that he would not naturally gravitate to. It is gut wrenching and emotive work, even for the most seasoned of nurses. From these tough areas which are so medically and emotionally disquieting, he poignantly describes the patients, the nurses and the establishment around him. He weaves us into the understanding that, as he teaches the Nepalese students, so too he is being taught. Concurrently we venture along these professional and personal paths of discovery with him. We see the struggle for human connection, for peace, for meaning and for life-purpose. In the true sense of the word, Joe collides with Nepal and neither is left unchanged.

The Hospital at the End of the World is a window into the disparities in medical resources between nations, and to the connectedness amongst healthcare professionals globally. Cultural differences are richly described. Serving by example, Joe emmeshes us as nurses and as educators of future nurses, into the intricacies of multicultural global healthcare. We, as readers, are allowed to vicariously “step outside the bubble” as he puts it; which is tantamount to unfolding a large world map, and then never really quite being able to fold it back up again along its original fold lines. Through his voyage, Joe leaves us a little changed, a little challenged and a little more aware of the world around us.

“In Tansen I saw some very smart people who worked hard to create miracles even though there were limited resources. Here in the US, I see some people who have all the resources in the world but fail to use them. I wonder why they settle for anything less than excellence, and it makes me a bit more willing to prod those around me into better performance.”

These concluding words still resound with me and have found meaning in my own nursing practice. This message of strength and excellence is both uplifting and supportive, a validation of sorts for raising-the-bar in all facets of nursing. As a patient advocate, in the striving for excellence, in developing a genuinely solid skill-set, in the willingness to take a stand we are what we claim to be: nurses.

Go. Do. Step outside your bubble. But be informed—first read this book.

Ed Note: Joe Niemczuru served as both President and Executive Director of the Maine Nurses Association and then ANA-Maine. Joe’s presence at ANA functions and his often long-winded Maine-themed sermons were always insightful if not entertaining. New England lost a good nurse when Joe relocated to Hawaii—even though we all thought he would be back! But after all, Joe was never predictable!
Recognizing NHNA Volunteers

Louise Smith-Cushing is recognized as departing President at our year-end Board meeting.

Denise Nies—also at our holiday meeting—with fellow Board members Peggy Lambert and Aleta Billadeau.

Lisa Thomka and Chandra Engelbert at their last Organizational Affairs meeting.

We would like to invite all nursing students and anyone else that would like to get involved in the organization to join us at our next meeting, Friday, April 23rd at 2pm at Manchester Community College or sign up for membership at www.NSNA.org.

If you have any questions or would like additional information, please contact Leila Volinsky (NH SNA President) at nhstudentnurses@yahoo.com, we can also be found on Facebook (NH Student Nurse Association) or www.nhsna.weebly.com.

Leila Volinsky, NHSNA President

In the fall of 2009, several students at Manchester Community College began working on the re-establishment of the NH chapter of NSNA. The chapter has been inactive since 2005, but with all of the nursing activities, programs and amazing students it seemed like the perfect time to bring attention to the state and provide nursing students with the resources for networking.

NH SNA is a pre-professional association for nursing students. Involvement in the association prepares students for involvement in professional associations and leadership positions after graduation. We are composed of and governed by nursing students. The organization seeks to have direct input into the standards of nursing education and influence the educational process; to influence health care, nursing education and practice through legislative activities; and to promote and encourage participation in community affairs and activities towards improved health care and the resolution of related social issues.

As part of our efforts to re-activate the chapter, the president, vice-president/secretary and treasurer will be traveling to the NSNA Annual Convention in Orlando. During the convention, our representatives will be attending the House of Delegate planning sessions, networking with fellow nursing students from across the country and representing NH nursing activities. We welcome any and all input from nursing students, faculty and other healthcare professionals on issues that should be brought to the attention of the delegation.

NH SNA is really excited about some of the events that we have been working on and are planning to offer to all nursing students in NH. First, we are holding a drawing for a seat at the NCLEX Review featuring Judy Miller, which is being held by Manchester Community College, March 26th-28th. This drawing is open to current members of NSNA and winners will be announced.

Second, we have been working with several companies to offer seminars/workshops for students on topics of interest, including: pharmacology, diabetes and much more. We would love to have feedback from anyone interested in attending with additional suggestions for topics. Finally, plans are in the works for a Walk for Nurses this spring. Come show your support for nursing students and nurses, meet fellow healthcare professionals in the state and enjoy the lovely springtime weather, more information to come.

Alicia David, NHSNA Associate Member, Kara Dubosh, MCC NSNA Co-President, Karen Parr-Day, NHSNA Faculty Advisor, Sharon Hatch, MCC NSNA Co-President, John Cody, NHSNA Treasurer, Charlene Wolfe-Stepro, Jessica Price and Lyn Michlovich, MCC NSNA Faculty Advisor.

April, May, June 2010

New Hampshire Nursing News • Page 17

We would like to recognize the following volunteers who completed their position commitments in 2009 and thank them for their invaluable service. (See our last issue for newly elected members.)

BOARD of DIRECTORS: Louise Smith-Cushing completed her term as NHNA President but remains with us as immediate Past President. Lori Brown, RNC and Elizabeth Hale-Campoli, RN, MSN, BSN, OCN completed their terms as “Director at Large”. Denise Nies, BC, MSN completed her Board term as Chair of Nursing Practice and has now moved to Continuing Education. Heidi Squires, BSN completed her Board term as Chair of Organizational Affairs but thankfully remains working with that busy Commission.

Continuing Education Commission: Judy Evans, BSN, MSN, EdD and Marilyn Ireland, CEN, BC, RN, MS

Govt Affairs Commission: Susan Cuddy, CCRN, RN, MSN, EdD and Marilyn Ireland, CEN, BC, RN, MS

Nursing Practice Commission: Kimberlee Munroe-Swift, RN, BSN

Organizational Affairs / Event Planning: Deborah Beck, RN; Chandra Engelbert, RN, BSN, MBA, and Lisa Thomka RN, PhD.

Aleta Billadeau.

Recognizing NHNA Volunteers

Louise Smith-Cushing completed her term as NHNA President but remains with us as immediate Past President. Lori Brown, RNC and Elizabeth Hale-Campoli, RN, MSN, BSN, OCN completed their terms as “Director at Large”. Denise Nies, BC, MSN completed her Board term as Chair of Nursing Practice and has now moved to Continuing Education. Heidi Squires, BSN completed her Board term as Chair of Organizational Affairs but thankfully remains working with that busy Commission.

Continuing Education Commission: Judy Evans, BSN, MSN, EdD and Marilyn Ireland, CEN, BC, RN, MS

Govt Affairs Commission: Susan Cuddy, CCRN, RN, BSN and Doris Nuttelman, RN, EdD–

Also- Amanda Callahan, RN, BSN,

We would like to recognize the following volunteers who completed their position commitments in 2009 and thank them for their invaluable service. (See our last issue for newly elected members.)

BOARD of DIRECTORS: Louise Smith-Cushing completed her term as NHNA President but remains with us as immediate Past President. Lori Brown, RNC and Elizabeth Hale-Campoli, RN, MSN, BSN, OCN completed their terms as “Director at Large”. Denise Nies, BC, MSN completed her Board term as Chair of Nursing Practice and has now moved to Continuing Education. Heidi Squires, BSN completed her Board term as Chair of Organizational Affairs but thankfully remains working with that busy Commission.

Continuing Education Commission: Judy Evans, BSN, MSN, EdD and Marilyn Ireland, CEN, BC, RN, MS

Govt Affairs Commission: Susan Cuddy, CCRN, RN, BSN and Doris Nuttelman, RN, EdD–

Also- Amanda Callahan, RN, BSN,

We would like to recognize the following volunteers who completed their position commitments in 2009 and thank them for their invaluable service. (See our last issue for newly elected members.)

BOARD of DIRECTORS: Louise Smith-Cushing completed her term as NHNA President but remains with us as immediate Past President. Lori Brown, RNC and Elizabeth Hale-Campoli, RN, MSN, BSN, OCN completed their terms as “Director at Large”. Denise Nies, BC, MSN completed her Board term as Chair of Nursing Practice and has now moved to Continuing Education. Heidi Squires, BSN completed her Board term as Chair of Organizational Affairs but thankfully remains working with that busy Commission.

Continuing Education Commission: Judy Evans, BSN, MSN, EdD and Marilyn Ireland, CEN, BC, RN, MS

Govt Affairs Commission: Susan Cuddy, CCRN, RN, MSN, EdD and Marilyn Ireland, CEN, BC, RN, MS

Nursing Practice Commission: Kimberlee Munroe-Swift, RN, BSN

Organizational Affairs / Event Planning: Deborah Beck, RN; Chandra Engelbert, RN, BSN, MBA, and Lisa Thomka RN, PhD. Also- Amanda Callahan, RN, BSN, BSN, OCN have moved into new responsibilities as Directors at Large.

New Hampshire Nursing News • Page 17

Recognizing NHNA Volunteers

Louise Smith-Cushing is recognized as departing President at our year-end Board meeting.

Denise Nies—also at our holiday meeting—with fellow Board members Peggy Lambert and Aleta Billadeau.

Lisa Thomka and Chandra Engelbert at their last Organizational Affairs meeting.

We would like to invite all nursing students and anyone else that would like to get involved in the organization to join us at our next meeting, Friday, April 23rd at 2pm at Manchester Community College or sign up for membership at www.NSNA.org.

If you have any questions or would like additional information, please contact Leila Volinsky (NH SNA President) at nhstudentnurses@yahoo.com, we can also be found on Facebook (NH Student Nurse Association) or www.nhsna.weebly.com.

Leila Volinsky, NHSNA President

In the fall of 2009, several students at Manchester Community College began working on the re-establishment of the NH chapter of NSNA. The chapter has been inactive since 2005, but with all of the nursing activities, programs and amazing students it seemed like the perfect time to bring attention to the state and provide nursing students with the resources for networking.

NH SNA is a pre-professional association for nursing students. Involvement in the association prepares students for involvement in professional associations and leadership positions after graduation. We are composed of and governed by nursing students. The organization seeks to have direct input into the standards of nursing education and influence the educational process; to influence health care, nursing education and practice through legislative activities; and to promote and encourage participation in community affairs and activities towards improved health care and the resolution of related social issues.

As part of our efforts to re-activate the chapter, the president, vice-president/secretary and treasurer will be traveling to the NSNA Annual Convention in Orlando. During the convention, our representatives will be attending the House of Delegate planning sessions, networking with fellow nursing students from across the country and representing NH nursing activities. We welcome any and all input from nursing students, faculty and other healthcare professionals on issues that should be brought to the attention of the delegation.

NH SNA is really excited about some of the events that we have been working on and are planning to offer to all nursing students in NH. First, we are holding a drawing for a seat at the NCLEX Review featuring Judy Miller, which is being held by Manchester Community College, March 26th-28th. This drawing is open to current members of NSNA and winners will be announced.

Second, we have been working with several companies to offer seminars/workshops for students on topics of interest, including: pharmacology, diabetes and much more. We would love to have feedback from anyone interested in attending with additional suggestions for topics. Finally, plans are in the works for a Walk for Nurses this spring. Come show your support for nursing students and nurses, meet fellow healthcare professionals in the state and enjoy the lovely springtime weather, more information to come.

Alicia David, NHSNA Associate Member, Kara Dubosh, MCC NSNA Co-President, Karen Parr-Day, NHSNA Faculty Advisor, Sharon Hatch, MCC NSNA Co-President, John Cody, NHSNA Treasurer, Charlene Wolfe-Stepro, Jessica Price and Lyn Michlovich, MCC NSNA Faculty Advisor.
Pediatric Nurse

Linda Stickney Mathewson, 69, died September 9, 2009 from complications of kidney disease. After graduating with her nursing degree from the University of Vermont, she relocated to Hancock NH where she assisted her husband establish the first pediatric practice at Monadnock Community Hospital in 1971.

50+ year career

Gladys C. Bean Howe, 99 died December 18, 2009, two months shy of her 100th birthday, in Laconia. She received her diploma from the Salem (Mass.) Hospital School of Nursing and a degree in dental nursing from the Boston School of dental nursing. She practiced in hospitals across New England and Pennsylvania. She was a nurse at the Gale Home and Women’s Aid Home in Manchester, NH, Speare Memorial in Plymouth, NH and retired in 1980, after over 50 years of practice from the Centennial Home in Concord, NH. She received a 40 year service pin as nurse for Camp Sentinel.

Nurse for State of New Hampshire

Emily Bartlett Patterson, 81, died December 20, 2009 in California. Graduating from Newton-Wellesley Hospital School of Nursing she started her nursing career in California, and then relocated to New Hampshire where she worked for the State of New Hampshire. Her passion was supporting unwed teens, and for a while she owned and operated a home for unwed teen mothers. She actively sought legislative support for teen programs.

Sacred Heart Grad

Marie Painchaud Aulet, died December 24, 2009 at 87. A graduate of the Sacred Heart School of Nursing in Manchester, she spent her nursing career in Concord.

Ortho Nurse

Helen Tittenmore West, 85, died January 4, 2010 at Dartmouth Hitchcock in Lebanon. After attending Concord Hospital School of Nursing she joined the Army Cadet Nurse Corps. She returned to Concord, practicing as an orthopedic nurse at Concord Hospital.

Notre Dame Alum

Irene Messier Provencher, 92, died January 23, 2010 in Manchester. A Manchester native she earned her nursing diploma from the Notre Dame School of Nursing in Manchester in 1939. She completed advanced study in operating and emergency room nursing at the University of Pennsylvania. She was a member of the ANA and the National Council of Catholic Nurses. She had a lifetime membership in the Notre Dame de Lourdes Hospital Nurses Alumnai.

Outstanding New Hampshire Nurse Leader

Marilyn Perkins Prouty, 84, died January 26, 2010. Born in Massachusetts, she received a Bachelors degree from Colby College in Maine in 1949 and worked at Massachusetts General Hospital. She obtained her diploma in nursing from Mass General in 1956. In 1964 she obtained a Masters in Nursing from Boston University and soon became the Associate Director of Nursing at Newton-Wellesley Hospital. She then accepted a position as the Director of Nursing of the Boston Hospital for Women which is now Brigham and Women’s Hospital. She moved to New Hampshire in 1972 and started a long career at the then Mary Hitchcock Memorial Hospital. She retired as the Vice President of Nursing in 1988.

Prouty introduced “participatory nursing” as well as the concept of the clinical nurse specialist—a nurse with an advanced degree who is an expert in a specialty. In 1974, she led a future-of-nursing-education conference, which produced a report—endorsed by the Mary Hitchcock School of Nursing and Hospital officials—that recommended the diploma school be phased out. In 1977, the MHMH Trustees added their endorsement. In 1980, just a few days before the final school of nursing graduation ceremony, Prouty and other administrators talked about the closing on a local radio show. “We’re the only profession on the health-care team which does not require a baccalaureate degree to start,” Prouty explained. “We are feeling that this is really essential. The nurses have to make so many decisions now... They’re not any more following orders blindly as they maybe did in the past... They make many very, very important decisions.” Prouty was instrumental in starting the Colby-Sawyer College Nursing Program in New London in 1981. She was a member of the American Nurses Association and the New Hampshire Nurses Association, and honored with the Outstanding Nurse of the Year award.

School Nurse

Ruth M. Bowen, 83, died February 7, 2010 in Connecticut. Before her retirement, Mrs. Bowen was a school nurse. She lived in Westmorland, N.H. for many years but returned to Connecticut in 1996.

Captain, US Army

Pauline H. Woods, 92, died February 10, 2010 in Nashua, NH. She was a graduate of the St. Joseph’s Nursing School, Nashua, NH, Class of 1941. She enlisted in the US Army Nurse Corps during World War II and was head nurse of the operating room at Grenier Field in Manchester, NH and was later stationed at Camp Kilmer in New Jersey as head nurse. Captain Woods was honorably discharged from active duty in 1947 and transferred to the Army Reserve. Following her military service, she had been employed as a district school nurse in the Milford and Amherst area.

St. A’s Grad


Night Supervisor

Elizabeth Ann Westholm, 62, died November 30, 2009 after a brief illness. A Massachusetts native she graduated in 1968 from Cape Cod Community College with an assoc. of Arts degree. She obtained her diploma in nursing in 1978 from Lawrence Memorial Hospital School of Nursing, in Medford, MA. In 1988, she graduated from the Mass. College of Pharmacy with her Bachelor of Science Degree in Nursing, and in 1999, she received her Masters Degree in Nursing at Rivier College in Nashua. After graduation she practiced as a critical care nurse and later as a family nurse practitioner. She had practiced at Southern New Hampshire Medical Center since 2004, most recently as a night supervisor.
**VOICE & VISIBILITY**

Add your voice to Our Voice! Join NHNA Today

**MEMBERSHIP**

- **NHNA Membership** $125/yr or [ ] $10.92/mo (State only - no ANA benefits or voting rights)
- **ANA Membership** $171/yr (Membership in ANA only - no NHNA voting rights or ability to hold office)

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

- **Full Membership** $249/yr or [ ] $21.25/mo (RN's only - employed full or part time)
- **Reduced Membership** $124.50/yr (Nursing Students, New Graduates, or RN's not employed)
- **Special Membership** $62.25/yr (Retired or Disabled RN's)

**NHNA ASSOCIATE MEMBERSHIP** (Non-voting status with limited benefits)

- **Associate Membership** $45.00/yr (LPN, LNAS, healthcare professionals, and friends of nursing)
- **Student Associate Membership** $25.00/yr (Nursing Students who are also a members of NHNA)

<table>
<thead>
<tr>
<th>NHNA Membership Application</th>
<th>[ ] New</th>
<th>[ ] Renewal</th>
<th>Date:<strong>/</strong>/__</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td></td>
<td>First Name</td>
<td>Member Type</td>
</tr>
<tr>
<td>NH License Number &amp; State</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN License Number &amp; State</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer Name</td>
<td></td>
<td></td>
<td>Email Address</td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Work Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Work Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home City</td>
<td></td>
<td></td>
<td>Home Address</td>
</tr>
<tr>
<td>Home State</td>
<td></td>
<td></td>
<td>Home Zip</td>
</tr>
</tbody>
</table>

- [ ] Check enclosed for $____ payable to the New Hampshire Nurses Association
- [ ] Charge to: [ ] MasterCard [ ] Visa [ ] Diner’s [ ] American Express [ ] Discover

By signing this Monthly Electronic Payment Authorization, you are authorizing ANA to either charge the credit card indicated or deduct the monthly payment from your checking account as designated above.

- [ ] Automated Annual Renewal: authorizes the automatic continuation of this Electronic Payment Authorization until cancelled by written notice at termination - thirty (30) days prior to scheduled renewal.

MAIL APPLICATION TO: ANA Customer and Member Billing PO Box 504345 St. Louis, MO 63150-4345

Keep a copy for your own records. Call the NHNA office with any questions: 603-225-3783

---

Join NHNA Today!

Heidi Barton, Alton  
Suzanne Brown, Claremont  
Paula Byrson Johnson, Lebanon  
Angela Carter, Concord  
Matthew Case, New Ipswich  
Diana Cassidy, Lyndeborough  
Cynthia Cohen, Windham  
Elizabeth Connelly, New Hampton  
Rosemary Costanzo, Concord  
Kristine Day, Alexandria  
Kellie Decalergo, Merrimack  
Robert Duhaime, Manchester  
Cheryl Garand, Rochester  
Alicia Hughes, Durham  
Diane Ketchum, Manchester  
Jennifer Knits, Londonderry  
Carol Lindsay Menard, Rye  
Susan Moreau, Bedford  
Marissa Morse, Marlborough  
Lori Nerbonne, Bow  
Susan Nieder, Concord  
Karen Norris, Elyseworth  
Judi O’Hara, Lowell, MA  
Phelister Bonareri Ongwae, Manchester  
Kathleen Reinig, Hudson  
Emily Richards, Hartford, VT  
Sarah Scott, Rye  
Margaret Shea, Hampstead  
Amy Shields, Merrimack  
Hilda Shortall, Bow  
Danielle Simmons, Westmoreland  
Sherry Stevens, Littleton  
Jennifer Torosian, Nashua  
Holly Wentworth, Tilton  
Justyn Wurtele, Hooksett