The Oklahoma Nurse

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ONA OKLAHOMA NURSES ASSOCIATION **More inside...**

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President's Message

Christine Weigel

Every 365 days we start the New Year off with making a resolution regarding change which varies according to where we are currently in our lives. Some resolutions might be related to spending more time with our family and friends, taming the bulge, fitting in fitness, quitting smoking, getting out of debt or maybe just getting organized. Regardless of which resolution you may have chosen it takes commitment to achieve or is not worthwhile.

As we set our resolutions we need to remember a few simple tips. Be realistic by setting achievable goals. Winning the lottery is probably not going to happen. Describe your resolutions in specific terms, like exercise 3 times a week. Third, be sure to break down large goals into smaller ones. Unless you participate in the Biggest Loser, you probably won't lose 20 pounds in a week but 2 to 3 months is probably realistic. Find alternatives to a behavior that you want to change and make them part of the resolution plan. If you smoke as a form of relaxation, then find a relaxing replacement. Last and above all, aim for things that are truly important to you, not what you think you ought to do or what others expect of you.

One resolution that I have made myself involves increased involvement in nursing's legislative 2010 priorities. Many times I have heard Vickie White Rankin, ONA lobbyist, discuss ways that individuals and groups can engage in advocacy. One of the most important aspects for groups, such as nursing, is the power of grassroots action. Advocacy is about connectivity and the commitment of each member of our profession becoming involved. As one of the ANA representatives says "if you are not at the table, then you are on the menu." Nursing needs to stay knowledgeable about the current issues facing our profession. Below is a list of ONA legislative priorities for 2010.

- Preservation of the Board of Nursing and its oversight and regulation of nursing practice.
- Uphold the RN and APRN scope of practice
- Support legislation on Oklahoma health status
- Health insurance coverage for all Oklahomans
- Support nursing education and faculty
- Access and maintain funding for Behavioral Health
- Health and Safety issue support

Several web sites that can help you stay connected to the issues are www.ok.gov, www.okhouse.gov and www.oksenate.gov. The fist web site listed is especially helpful in relation to bill tracking, the governor's state of the state as well as the governor's action on bills. The above listed issues can affect each and every one of us as well as our families and the lives of our patients. Please get involved and come join us at Legislative Day for Nurses at the Capitol on February 23, 2010. Nursing needs your involvement!

Executive Director's Report

Isn't it Time You Got Involved!

Jane Nelson, CAE
Executive Director
Oklahoma Nurses Association

Jane Nelson

In nursing school you learned about the nurse practice act and how it was important to make sure that you practiced within the realm of your nursing license. You probably walked away from the discussion feeling secure about the practice of nursing. You may have thought that nurses own the nurse practice act, and that nurses or the Oklahoma Board of Nursing would be the only ones able to change it.

The perception that nurses are the only group to be able to open the nurse practice act is far from reality. Any Legislator, individual, or group out there can propose changes to the "nurse practice act."

Ask yourself this: "What individual or organization is out there protecting the nurse practice act?"

The answer is the Oklahoma Nurses Association (ONA). ONA has two registered lobbyists, one on staff and one on contract. Two other nursing groups: Oklahoma Nurse Practitioners and the Oklahoma Association of Nurse Anesthetists contract with lobbyists. These two groups tend to only focus on issues that pertain to practice issues specific to them.

ONA works on issues for all nurses including funding for health care, access to health and behavioral health care, nursing workforce, safety issues and many more issues. What if ONA weren't around because nurses—you included—didn't join… who would do this for the nursing profession? Who would protect and advance nursing practice? Who would look out legislatively for patients? Think about it. Without your membership, ONA is nothing.

ONA can't do this alone…it takes the members of the Oklahoma Nurses Association to get involved by contacting legislators, serving as Nurse of the Day and coming to the our day at the Capitol. As a nurse it is your job to practice nursing in whatever setting you have chosen and it is ONA's job is to represent you at Table—be it the Capitol or the other entities.

By joining ONA and getting involved in it, you will have a voice to improve health care outcomes in Oklahoma ranging from health care in our schools to safety procedures in our hospitals, nursing homes and other healthcare settings. Now is time to get involved! Involved with your professional organization, your nursing practice and your community.

What are you waiting for!!!

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

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

ONA Mission Statement

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

Oklahoma Nurse Editorial Guidelines and Due Dates Submittal Information

Materials Due Date to Editor:	Oklahoma Nurse Issue Date:
April 16, 2010	June 2010 Issue

1. Manuscripts should be word processed and double-spaced on one side of 8 1/2 x 11 inch white paper. Manuscripts should be emailed to Editor at ona@oklahomanurses.org.
   - Manuscripts should include a cover page with the author's name, credentials, present position, address and telephone number. In case of multiple authors, list the names in order in which they should appear.
   - Style must conform to the Publication Manual of the APA, 4th edition, 1995.
   - The Oklahoma Nurse reserves one-time publication rights. Articles for reprint will be accepted if accompanied with written permission.
   - The Oklahoma Nurse reserves the right to edit manuscripts to meet style and space limitations.
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The Arthur L. Davis Publishing Agency, Inc. proudly announces a $1000 award to be awarded to the ONA Member who submits the 'most excellent' manuscript for publication in The Oklahoma Nurse. This Award is offered in celebration of the agency's 26 successful years in publishing and to affirm nursing. The award will be presented at the Awards Banquet and the manuscript printed in a future issue of *The Oklahoma Nurse.*

Manuscript Submission Guidelines:

1. The manuscript must be an original, scholarly work addressing topics of interest to readers of The Oklahoma Nurse. Examples of topics: Integrative literature reviews, clinical topics, evolving/emerging professional issues, and analysis of trends influencing nurses and nursing in Oklahoma.
2. Manuscripts must not exceed 15 double spaced pages and must conform to APA guidelines.
3. Manuscripts must be received in an email or diskette as Word Documents by September 1, 2010 to be considered. A cover sheet listing author (s) name, credentials, address, and work and residence telephone numbers and email address must be included. The author (s) name must not appear anywhere else on the submission.
4. The topic must be relevant to nurses/nursing in Oklahoma and provide new insights and/or a contrarian view to promote debate and discussion.
5. Ideas must be supported with sound rationale and adequate documentation.
6. If the manuscript describes a research project, quality initiative, or organizational change process, methods must be appropriate and participant confidentiality protected (as indicated).
7. The manuscript must be grammatically correct, organized, and submitted according to guidelines to be considered.

Manuscripts must be accompanied by a statement signed by each author indicating 1) the manuscript is NOT being considered for publication in any other journal; 2) the manuscript WILL NOT be submitted to another journal until notification of acceptance or rejection is received from the Oklahoma Nurses Association; and 3) willingness to sign a copyright release form upon publication of the manuscript in *The Oklahoma Nurse*.

Submit Manuscripts to the Oklahoma Nurses Association, 6414 N Santa Fe, Ste. A, Oklahoma City, OK 73119 or via email at ona@oknurses.com.

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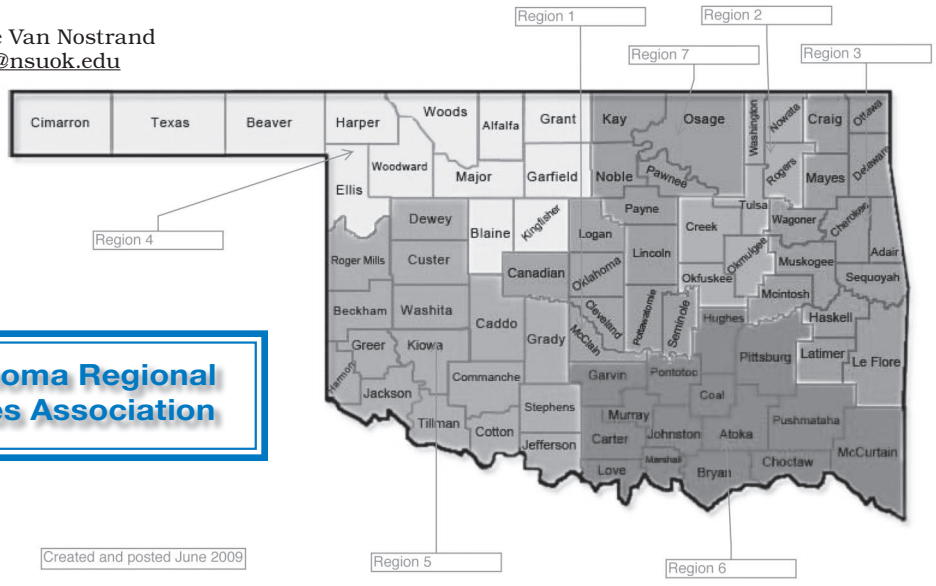

Oklahoma Regional Nurses Association

"Have you experienced stress in your LPN training, RN education, or practice as an LPN or RN?

If yes, would you be willing to participate in a research study that provides you an opportunity to share about your stress?

Please take a short survey online: https://frontpage.okstate.edu/coe/gaylaanderson"

OLN News

Submitted by Thea Clark MS, RN
President of the Oklahoma League for Nursing
ONA Member

Oklahoma League for Nursing
An affiliate of the National League for Nursing

NLN

2009-10 Oklahoma League for Nursing

The Oklahoma League for Nursing (OLN) is a constituent affiliate of the National League for Nursing, and has continued affiliate status with the Oklahoma Nurses Association. The OLN focuses on nursing education at all levels and practices, e.g., formal and continuing education, and staff development.

Thea Clark, President, represented OLN at the ONA convention and the NLN 2009 Education Summit. As of September 30, 2009 there are 71 educators in Oklahoma that have been awarded the Certified Nurse Educator (CNE) designator. Oklahoma is one of the leaders in numbers of CNE.

Four awards were given to an NLN affiliated school from each level of education. These awards were to be used for faculty development, preferably using NLN services or products. The awards were given to Oklahoma City University Kramer School of Nursing, Graduate Program, The University of Tulsa School of Nursing, Oklahoma City Community College School of Nursing and Central Technology Center School of Practical Nursing.

Elections held in October 2009 resulted in the following: Linda Lyons Coyle was elected President-Elect. Emma Kientz was elected to join Marsha Green, Joyce Van Nostrand and Kim Bruce as a non-officer member at large. Thea Clark continues as President, Marie Ahrens as treasurer and Anne Davis as secretary.

All Oklahoma nurses are invited to join OLN for only $15 per year. Funds directly support the co-sponsored continuing education offerings and educational awards to affiliated schools.

The Magnet Difference

Congratulations

to St. John Medical Center, Tulsa, Oklahoma on their recent designation as a Magnet hospital. They are the third to receive the designation in the State of Oklahoma.

Oklahoma Nurses Association

St. John Medical Center Receives Magnet Designation

Jessie Drago
ONA Member

Jessie Dragoo

I wanted to be sure I'd heard it right. A call on the afternoon of January 14 from the American Nurses Credentialing Center asked me to pick a date for a special announcement which seemed to confirm that St. John Medical Center in Tulsa would join the rank of hospitals with Magnet designation.

I chose the morning of January 20 and began work to gather nurses for the announcement. But I was nervous. After I selected that date, I called the ANCC back. "I'm not gathering my staff and receiving bad news," I told them. No, confirmed the voice on the other end of the line, it won't be bad news.

The Magnet Recognition Program identifies health care organizations that demonstrate sustained nursing care excellence in management, philosophy and nursing practices, among other criteria. Gaining Magnet designation requires tenacity and preparation, with extensive documentation (in St. John's case, 2,000 electronic file pages worth), and a four-day site visit by ANCC surveyors. With the announcement, St. John became the only medical center in northeast Oklahoma, and one of three in the state, to hold Magnet status. Nationally, only 353 hospitals—about 6 percent—are Magnet facilities.

The process of making St. John a Magnet facility began in 2004, when I began in earnest to review and plan what it would take to achieve that goal, essentially, changing the culture of the environment where the nurses practice, and empowering the nurses at the bedside to make decisions that bring about positive patient outcomes.

Magnet designation is not so much an end as it is a marker on a long quest. It's a journey; you get the Magnet designation, but you have to stay, as my father would say, *en pointe*.

To that end, we have overseen a remarkable transformation among the nursing corps. Only about 12 nurses at St. John were nationally certified when the Magnet process began six years ago. Now there are more than 200. Most nursing directors and many managers are advanced certified in nursing administration. Sixteen nurses are presently working on their master's degree in nursing.

It wasn't because we were perfect that St. John became a Magnet hospital. We got the award because they saw where we had been and where we have made improvements, and are still improving. A journey, not a destination.

And now, as a Magnet facility, St. John is in a position to pay it forward. It is really our job to help other hospitals become Magnet hospitals. Mercy Health Center in Oklahoma City helped us with our process, and we will do likewise.

That's part of being a Magnet hospital. You share your journey with others.

Crowd reaction to the surprise call from ANCC.

Sister M. Therese Gottschalk, CEO of St. John Health System congratulating Valinda Jones, Director Clinical Resource Center.

Nurses celebrating the announcement (left to right): Sharon Pollock, Kathryn Mears, Susan Reeder.

Mercy Health Center

Linda Fanning
ONA President-Elect
CNO Mercy Health Center

Linda Fanning

It was a year of honors at Mercy. We were awarded best medical facility by the readers of *The Oklahoman* and *The Edmond Sun*. We also garnered the consumer choice award for best medical facility from the National Research Corporation, a group who talks directly with consumers in the Oklahoma City area. And those awards meant a lot because they came from the people we serve. Then this fall we also won the best of the best in Oklahoma for environment excellence from Keep Oklahoma Beautiful for achievements made with nurses in the lead.

However, the most exciting award we received on December 14. We finally got a phone call from the American Nurses Credentialing Center and they told us we had earned the Magnet award again. After a very rigorous process of collecting all our data, submitting the application and hosting Magnet appraisers for three days, we got the news we were worthy of the award for another four years. Earning the award the first time was quite a feat, but most will tell you that earning the second time is even more difficult.

Needless to say, I've been thinking about Magnet a lot over the past few months. There has been plenty of time to reflect on what it means to be Magnet and how it impacts us, as nurses. I truly believe Magnet is more than just an award for good nursing. It recognizes the culture and model of care within a hospital allowing nurses, and ancillary departments, to provide the very best, compassionate care they can.

Achieving a culture of patient-centered care doesn't happen overnight. It happens through a constant pursuit of perfection in everything we do, specifically in building relationships with those who work side by side every day. Whether it's a direct care nurse who thinks of a solution to a problem or collaboration between nursing and other departments within the hospital, every co-worker should have the opportunity and tools they need to have their voices heard.

At Mercy, our work daily focuses on how we can support our nurses in their pursuit of perfection for their own careers. Providing mentors for our new nurses or encouraging seasoned nurses to dig into research are important efforts in recruiting and retaining nurses.

In the end, it's my job as chief nursing officer to make sure nurses have a place where they can focus on providing the best care for patients. Every nurse has the ability to be a Magnet nurse, regardless of the role they are in and that's what makes a hospital a Magnet hospital.

OONE News

Persuasion: An essential Competency for the Nurse Leader

Betty R. Kupperschmidt, EdD,RN.NEA-BC
Director and Faculty
Nursing Administration Pathway
University of Oklahoma College of Nursing
ONA Member

Introduction

Persuasion is an integral part of our lives. Many Nurse Leaders are working in collaboration with the leadership team to persuade nurses to embrace evidence-based practice. In this column, persuasion is presented as an essential competency for Nurse Leaders using Jay Conger's Model.

Conger's Model of Persuasion

Conger (1998), the recognized persuasion guru, views persuasion as a competency, the process of negotiating and learning. It is a process that demands discovery, preparation and dialogue. Thus, fours ways NOT to persuade are 1) try to persuade with an up-front hard sell style; 2) resist compromise; 3) think that the secret of persuasion lies in presenting great arguments; and 4) assume persuasion is a one-shot effort.

Conger (1998) develops four distinct and essentials steps to effective persuasion as follows.

- Establish credibility
- Frame goals in a way that identifies common ground with audience
- Reinforce position, using vivid language and compelling evidence
- Connect emotionally with audience

Credibility—Establishing credibility is the first hurdle the Nurse Leader must overcome. In Conger's (1998) model, credibility grows out of expertise and relationships. On the expertise side, a history of sound judgment and being well informed about the proposed initiative enhances credibility. On the relationship side, the Nurse Leader must have demonstrated that they can be trusted to listen and to work in the best interests of others.

Frame goals—Even if one's credibility is high, the proposed initiative still must be framed to appeal to the people one is trying to persuade. Framing goals is the process of identifying shared and tangible benefits. At the heart of framing goals is a solid understanding of one's audience. For example, assure that staff nurses can connect the benefit of a proposed evidence-based practice change to their professional practice and to patient care.

Compelling evidence—With credibility and goals established, persuasion becomes a process of developing and presenting compelling evidence, of unleashing the power of language by supplementing data with examples, stories, metaphors, and analogies to make the proposed initiative come to life!

Connect emotionally—Nurse Leaders who develop and use the competency of effective persuasion capture the power of emotions in two ways.

- They show their own emotional commitment to the initiative they are advocating
- They perceive and use an accurate sense of the audience's emotional state to adjust the tone of their persuasion

Conger (1998) notes Nurse Leaders must connect and feel their commitment in their heart and gut as well as in their mind. Sometimes they may need to make forceful points, other times they should use a softer tone, matching their tone to what the staff are already feeling or expecting. He stresses the importance of interacting with key staff members to get a sense of how they are interpreting past initiatives and how they may react to another seemingly overwhelming initiative.

Steven's Adaptation of Conger's Model

Stevenson (2001) uses Conger's model to propose strategies for 'managing up.' Managing up involves the use of relationships built on respect, understanding, and effective communication. He asserts that persuasion is not manipulative, as some leaders believe, but using the skills of persuasion to manage up is simply a process that facilities key people to understand the proposed initiative and thus makes it easy for them to say "Yes."

The ability to speak with candor and field questions with clarity is essential for effective persuasion. The competency of candor will be discussed in a later OONE Column.

Summary

Conger (1998) notes that the competency of persuasion may confuse and even mystify some Nurse Leaders because it is so dangerous when mishandled that many try to avoid it altogether. However, he presents compelling evidence, including many pertinent examples beyond the scope of this column, demonstrating that persuasion is an essential competency for today's Nurse Leaders.

Shirey (2006) supports Conger's contention that persuasion is an important aspect of any change. In a must-read article, Shirey masterfully develops the competency of persuasion in Stage 2 of Roger's Theory of Innovative as essential if Nurse Leaders are to facilitate evidence-based practice. I strongly encourage Nurse Leaders to read both Conger and Shirey's work.

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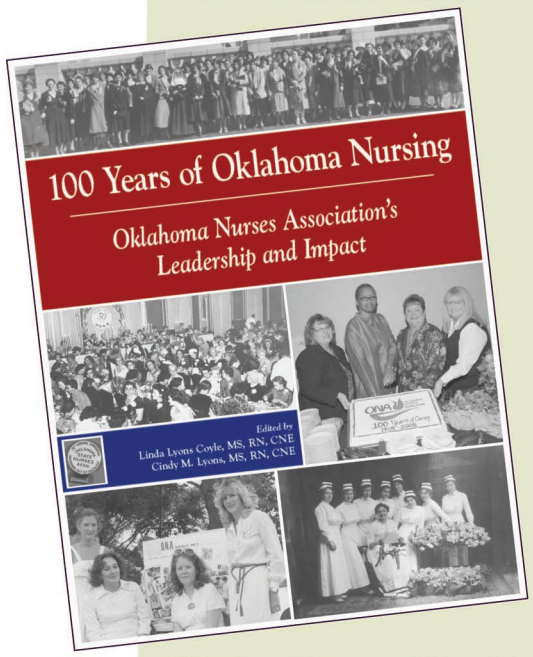
ONA Centennial Publication



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2008 marked a monumental celebration for nurses in Oklahoma–the 100th anniversary of the Oklahoma Nurses Association (ONA)! In recognition of the occasion, this publication has been written to share a historical perspective of the pioneering spirit of Oklahoma nurses and their professional Association, ONA.

Editors and authors of ***100 Years of Oklahoma Nursing*** developed this commemorative book from interviews and the ONA archives. It is a snapshot of the ONA story and nursing in Oklahoma from 1908-2008. The transformation of nursing through the last 100 years is highlighted through themes of leadership, political advocacy, collaboration, service and education. Included is ONA's response to major events such as wars, pandemics and diseases, economic depressions, women's suffrage and liberation movement, civil rights, and terrorism.

This is an unfinished story of Oklahoma nursing. We entrust the current and future generations of Oklahoma pioneer nurses to continue to capture and share nursing's history along their journey.

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Save the Date!

Oklahoma Nurses Association

ONA Oklahoma Nurses Association

Annual Convention
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Tulsa, Oklahoma
Details coming soon
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We want to review your abstract!
Please submit your proposal to present at the annual Oklahoma Nurses Association Convention
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Oklahoma Nurses Association's Nurse of the Day program serves as an effective advocacy tool for nurses across the state to talk one on one with Legislators. Every day of the legislative session a registered nurse has the opportunity to actively participate in the legislative process. The Nurse of the Day has the opportunity to visit with legislators, attend various committee meetings and assist in the First Aid station at the Capitol. So that those participating in the Nurse of the Day or Doctor of the Day program are not tied to the First Aid station, there is a paid ER Nurse that oversees the care provided. The program allows nurses to voice their thoughts and opinions on currently legislation that affects nurses and healthcare.

Learn more online:
www.oklahomanurses.org

Polar Bear Alert!

Sarah Jensen, MS, RN
Faculty, University of Oklahoma-Tulsa
College of Nursing
ONA Member

Be on the look out for this polar bear, disguised in a heavy white coat. On at least 13 occasions, during the past 4-5 years, I have seen him lurking around very sick hospital patients, whom physicians were unable to determine the cause of their illness. Have you seen the polar bear?

The patient is extremely ill with severe abdominal pain, intractable nausea & vomiting, diarrhea, and a sore, swollen throat. In addition, the patient complains of feeling weak, lethargic with no energy, not being able to eat, and states he, "doesn't have any appetite for food." He says "nothing tastes good." One patient even had a PEG tube placed. Do you see the polar bear?

The patient is unable to sleep through the night. He may cough, complain of not being able to breathe adequately and claim that his nose is stuffy with congestion. The patient presents in the emergency department or in a hospital room with nausea, vomiting, diarrhea, weakness, lethargy, & dehydration, and states that he "can't go on much longer." The patient feels like vomiting, but "nothing comes up." The patient "looks very ill;" in fact, the nurse wonders if the patient will be able to survive. Can you see the polar bear?

The nurse finds that an IV site is difficult to establish. Lab tests show that the patient's potassium is low, between 2.2 and 3. The CT-scan is normal and all other testing is within normal limits. The physician orders a liter bolus of Normal Saline to run wide open, Zofran or Phenergan for the nausea and abdominal pain, and oral Potassium for the hypokalemia, thus preparing the patient for discharge. The physician diagnoses the patient with acute gastroenteritis and recommends clear liquids for 24-48 hours, meds for nausea & vomiting, rest, a potassium supplement, and a follow-up visit with the patient's physician in 1–2 days. Have you spotted the polar bear?

Armed with prescriptions, discharge instructions, and a follow-up visit scheduled with his PCP on Monday, the patient is "ready to leave." The nurse wonders how this very weak patient can get into a wheelchair to go home, and how the family will assist the patient out of the car at home, since the patient can barely sit up.

During discharge teaching, the patient says, "I just don't feel any better than before being treated. I really felt fine until I had that UTI a couple months ago". Watch for the polar bear, he's getting closer! The nurse has now learned that the patient was ill 2 months ago and was on antibiotics for 2 weeks to treat the UTI. Can you hear, smell, or taste the polar bear?

On a "gut feeling," the nurse asks the patient to stick out his tongue and says, "Well, look at that, sure looks like a polar bear to me!" The white coat, yellowing around the edges, is hiding on the patient's tongue. The patient blames the white tongue on Maalox he's been taking for his upset stomach, but the alert nurse notifies the physician, suspecting that it's the Polar Bear tongue. What does the alert nurse suspect?

Literature is well documented with descriptions of this problem, but have you ever seen this polar bear? *

The white coating on the tongue belongs to the Candida albicans family of yeasts. This yeast is commonly found in our digestive system, throat, and vaginal mucosa, and develops following exposure to antibiotics, birth control pills, corticosteroids, prednisone, or anti-depressants. In babies, we recognize this condition as thrush.

Literature indicates possible pathophysiological explanations, including how normal bacterial flora, that reside in our bodies, are eliminated and how the candida organisms flourish as a secondary infection. Growing rapidly, the candida yeast may change into a fungal form, becoming invasive and developing rhizoids, which burrow into the intestinal wall. Microscopic holes surface in the intestinal wall, which allows toxins in the form of undigested food particles, bacteria and yeast to enter into the blood stream. *

When this condition occurs, the overgrowth is called Candidiasis or a systemic yeast infection. A common manifestation of a systemic yeast infection is a white coated tongue. Persons at risk for candidiasis include patients who have poor immune systems, cancer, diabetes mellitus, hypothyroidism, hypoadrenalism, Sjogren's syndrome (reduced saliva). Have you seen a polar bear lately? **

How often do nurses thoroughly assess the tongues of our sickest patients? Oral thrush can be easily diagnosed and treated by excellent assessment technique; swabbing a sample of the affected tissue on the patient's tongue; and obtaining a physician's order for oral Fluconazole or Nystatin "swish and swallow" suspension. This treatment may need to be repeated several times to clear the yeast infection and may damage the liver. According to the literature, persistent treatment and follow-up will increase success of the oral anti-fungal medication.

Nurses, while you're looking at oral cavities, check those dentures. Black coloration on the dentures may indicate that the fungus has attached and become embedded into the denture material, causing the patient to re-infect himself following treatment. Be sure that dentures are being properly cleaned, perhaps with a very weak solution of Chlorox.

Preventative measures, including adequate oral hygiene, limiting high sugar/yeast containing foods, smoking elimination, and visiting a dentist regularly can also be useful. ** Watch for the polar bear tongue! You may save a life.

Online References

* http://www.mayoclinic.com/health/oral-thrush/DS00408

** http://www.medicinenet.com/thrush/article.htm

http://candidapage.com/

http://www.colonhealth.net/free_reports/candirpt.htm

http://www.healthscout.com/ency/68/312/main.html

Purpose of this manuscript is to call attention to a preventable condition, which can be found during assessment, and treated. Without proper prevention, assessment, or treatment, this condition can result in a fatal outcome.

Signs of Humor

C Humor

Diane Sears, RN, MS, ONC
ONA Member

C is for coping creatively with craziness to combat cancer. I have not experienced cancer myself, yet, however I have lived it with family, friends and patients. Promoting humor, while living with cancer is a very powerful tool to helping conquer cancer. Give someone a funny joke, video, CD, card, drawing, picture, story, phone call, song, or whatever, to support their spirits and immune system. Individualize to their personal style of humor, situations, and hobbies to increase the mirth response level. Recipients will tell you what a difference this "magic" can make in their day to day emotional roller coasters. "Laughter rises out of tragedy when you need it the most and rewards you for your courage." (Erma Bombeck)

A grandma was changing clothes in front of her young granddaughter, when with wide eyes the little one exclaimed, "Grandma, I didn't know you could take your boob off!" She gently explained about her breast cancer. Later while preparing for bed during tooth brushing time, her grandson ran to the door, shouting to his sibling, "Come here quick, she can take her teeth off too!!"

Cancer Survivor, Christine Clifford, Cartoons

"I haven't had a mosquito land on me all summer… it's gotta be the 'chemo'.

Looking in a mirror, while hairless, imagining former self with hair: "Gray hair wasn't so bad after all.

I remember when port referred to a type of wine.

Not now… I'm having a no hair day!

It's funny how I've gained a greater appreciation for the follicly impaired.

Son pleading to bald mom on behalf of his inquisitive friends: "They wanna' know if they can autograph your head?"

Yes, the doctor did say 'no alcohol 48 hours before cancer surgery'…so what's it going to do, kill me?

There's radiation therapy…chemotherapy…and then there's retail therapy!

Mom…more flowers for your breast.

I've chosen a woman surgeon…a Korean radiologist…a Jewish oncologist…an Afro-American plastic surgeon…if I get a male nurse, I will have achieved total diversity in the 90's!

The Damned Cancer Song (To the tune of "Bye-Bye Love") by Kristie Chilcote

Bye-bye Cytoxan, bye-bye Adriamcin, hello life again, I know that I'll survive.

There goes my cancer, right out the door. It sure is ugly, I sure am sore.

But there's a reason why I'm so free. That fricking cancer is out of me.

Bye-bye Zofran, bye-bye nausea, hello tamoxifen. I know that I'll survive.

There goes my hair, it feels so odd. Look in the mirror and I am bald.

But there's a reason that I'm so free. My cancer group right with me.

Bye-bye Cytoxan, bye-bye red pee, hello hair again. I know that I'll survive.

I'm through with cancer, I'm through with drugs. I'm still real thankful I've got two jugs.

And there's no reason to feel despair 'cause soon I'll grow body hair.

Bye-bye cancer, bye-bye no appetite, hello world again. Watch as I start to thrive.

Goodbye cancer, goodbye."

Doctor speaking to chicken patient: "I don't think breast implants are such a good idea." (Cartoon, Pete Mueller)

Three elderly women met at the coffee shop every week without fail for coffee, cigarettes, and conversation. One Saturday, Doris announced she was giving up smoking for her health. "I survived cancer of the uterus," she said, "and I'm not taking any more chances." Despite Doris's revelation, Edith lit up a cigarette. "Aren't you afraid of getting cancer of the uterus?" asked Hazel. "Oh no dear," Edith replied, without batting an eye. "I don't inhale that far down." (Nurse's Calendar)

"Smoker's Hindsight…R.I.P. Being 10 pound shevier doesn't seem like a bad alternative anymore." ("Non-Sequitur," cartoon, Wiley)

Slogans that belong on colostomy bags

My other bag's a Prada.

Is your colostomy bag full, or are you just happy to see me?

If you think this bag is full of crap, you should meet my brother-in-law.

The Lord is my ostomy nurse!

Colostomy? Coloso-Y OU! (Nurse's Calendar)

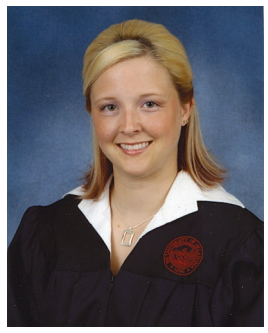
The NT noticed that her patient seemed a little down and asked if there was anything troubling him. "Oh, I've just had abdominal surgery and I have a history of cancer too." "Where was the cancer?" she asked. "In my phosphate," he replied. (Nurse's Calendar)

Prisoner: Look here doctor! You've already removed my spleen, tonsils, adenoids, and one of my kidneys. I only came to see if you could get me out of this place! Doctor: I am, bit by bit. (Nurse's Calendar)

There is no cancer… of the funny bone.

Mental Gymnastics

Crystal Jones-Gandy, RN



Crystal Jones-Gandy

Welcome everyone to 2010! Hope the New Year has greeted you as well as it has me. Those of you who read my last article know that I was in a whirlwind of anxiety, stress, and general craziness as I prepared for the NCLEX and was on the job hunt. Update, I passed the NCLEX and found a job in the exact field I was hoping for: critical care.

I am truly enjoying my new job. The number one thing that I have realized, though, is that in nursing school, you only learned how to do no harm. You learned the basics, and learned to be able to realize when something is not right. It is in the job where you learn to be a nurse.

I have just completed my 12 weeks of orientation and this last week was my first week on my own. I have to say, out of all the nerve-racking events that occur in nursing school, taking the NCLEX, and starting a new job, that first night by myself truly was the most stressful of all. I did well though and now I am feeling much more comfortable. I simply do my best and don't hesitate to ask questions.

It has been a total of 14 weeks for me and the only thing I have yet to get used to is the night shift schedule but they say it takes a long time to get used to. I like it though.

I hope everyone has a great year: take each day at a time, make the most of everything, spend more time with your families, and don't stress the small stuff!

Until next time, do some mental gymnastics! Try to look at it from a different perspective.

Healing a Non-healing 10 Year Diabetic Foot Ulcer with Bilayer Cell Therapy: A Success Story

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A middle aged female presented to our Wound Management Clinic with a non-healing diabetic foot ulcer that had been present for ten years. Patient history and wound assessment were completed. The initial wound measurements: 3.2cmX3.5cmX1.2cm. Previous wound treatments had included gauze, silver, and alginate dressings. In addition, the patient had been initially treated with an antibiotic and cadexomer iodine to battle infection.

At our Clinic, aggressive debridement of the peri-wound callous was consistently performed throughout her treatment. When the infection was resolved, a total contact cast was applied (from below the knee to just above the toes) to offload the wound bed. After the contact cast was removed, a bilayered cell graft was placed onto the wound bed. At this stage of the wound management treatment, the wound measurement on application date: 2cmX1.5cm with surface depth. Within one week of placement of the cast, wound measurements were: 1.8cmX1.4cm and at two week follow-up 1.1cmX1.1cm. Subsequently another bilayer cell graft was placed. Wound measurements at this time were 0.3cmX0.3cm with new epithelial tissue present.

Subsequently, the patient achieved wound healing within 10 days following the second graft placement. The patient and staff were elated with the success of this fairly new wound treatment!

Metaphorically Speaking: I am a ?

by Sandra A. Weiland, M.Sc., ARNP, FNP-C
ONA Member

Introduction

Exploring my own metaphor as a nurse and a teacher was not an easy task. At first I thought to be a gardener with all the ramifications of providing ideal growth conditions, caring, and nurturing. Somehow, though, being a gardener just didn't seem to say it all for me. So, I took a different position, and decided it wasn't a metaphor so much that I should be striving to determine, but rather what I wanted to say about me. From my earliest recollections as a child I have questioned everything; and, as a nurse and a teacher I continue to question. Therefore, metaphorically speaking, I have to say—I am a question mark because questions guide me, my clients, and my students to explore further.

According to Wikipedia (2007) a question mark is a punctuation mark that replaces the full stop at the end of an interrogative sentence and is often used in place of unknown or missing data. The question mark, then, functions to question what is known or unknown, to query, and to interrogate. The question mark is also an interesting shape: a half circle straightens to form a line and is balanced on top of a point. In its incompleteness, **?** begs to question—seeking for itself completion as a *Q*. Hence, questioning unseats the status quo, and sheds light on unknown ground simply by posing the question?

For me personally, questioning has led to the conviction that the power differential of one group over another robs one of dignity and integrity. Hence, questioning unseats the status quo to understand the why better. Questions also form the basis of all nursing assessments. Are you comfortable? How can I help? What are the symptoms? When did your symptoms begin? How did they begin? Where is the pain? Can you tell me more? The question mark can be a look, a raised eyebrow, and can dangle uneasily. Although no words may be spoken because it may be unsafe to reveal, a question mark can sometimes quietly guide the client to discovering their own solutions to their problems rather than passively accepting a solution that another thinks best. In this sense, a question mark can be a powerful tool that leads to knowledge that helps, and knowledge that liberates from both external and internal barriers to one's own becoming.

The question mark seeks to unhinge infallibility as a teacher and the guilt that ensues when one's own expectations are unmet. Thus, it positions the teacher as a learner, too, and not just as the all-knowing expert. It guides the teacher to plan lessons that build a community of learning by turning the text into a small piece of the puzzle for inquiry. Therefore, the question mark symbolizes a learning environment engendering a mutual quest of wanting to know more. In such an environment, mutual questioning turns authority into leadership. In such an environment, the question mark electrifies the learners as looks of puzzlement give way to the looks of understanding. Through these eyes the question mark becomes a mirror image and forms the missing link to complete the *Q* and things previously unseen are now clearly seen!

My metaphor makes the assumption there is much that is not known, and it could be construed to assume questioning leads to problem solving. However, as a question mark I bring more than problem solving, rather, it is as Palmer (1998) describes: a way of learning so that students (or clients) can see for themselves. I lead others to creating for themselves the whole picture. That is, by bringing into the circle of practice one small piece of information and placing a question mark at the end of the sentence the traditional practice of passive learning (i.e., transferring information from teacher to learner) is transformed into an inquiry wherein learning becomes active. Furthermore, a question mark opens up what both Palmer (1998) and hooks (1994) describe as space, that is, an environment that is open to learning. By asking questions, the question mark also invites further questions. Therefore, imbedded in this space is the freedom to question others.

In conclusion, a question mark symbolizes a challenge to the teacher inside to create an atmosphere of open, unencumbered inquiry, and for the student, or learner, inside not to accept, but to question. Professionally, it challenges the nurse as a provider to deeper understanding, not only of others in the endeavor to help, or to care; but also of the self. Because, after all, questioning the self is requisite to knowing the question? that begs to be known, that begs to be the whole *Q*!

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Is Your Unit Student Ready?

Lisa Lee, MS, RN, Faculty, University of Oklahoma College of Nursing (ONA Region 2)

Every year they invade your unit…some with bright and eager faces and others with faces lined of fear, stress and anxiety. They come in groups of eight with brightly colored scrubs, new stethoscopes and huge books in the new backpack. They bring questions, evidence based practice and helpful hands. By now you should now that I am talking about the nursing student.

The clinical setting is one of the most critical areas of transition from the classroom to nursing at the bedside. It can be very rewarding or it can be one of the most terrifying, anxiety and stress provoking environments. Factors that influence this stress and anxiety include the fact that this may be one of their first clinical experiences; the fear of making mistakes when they perform clinical skills and the lack of support from the nursing staff (Moscaritolo, 2009). Having a clinical environment that is open to student learning is crucial if students are to experience each clinical experience as positive steps toward becoming a professional colleague.

Nursing students often see themselves as more than "just" students: They see themselves as nurses in the process of becoming! So how do you make your unit ready and open to this process of learning and becoming, of transitioning to professional nurses (Duchscher, 2008)? Below are simple yet essential strategies for facilitating an optimal learning environment.

- Experienced, competent professional nurses must be prepared to and willing to be role models.
- Experienced, competent professional nurses must be prepared to and willing to share information with the student about their professional failures and successes.
- Develop strategies to help students bridge "the gap" between how they learn skills taught in the lab and those skills that are practiced at the bedside.
- Affirmation for students when they are using critical thinking and performing skills correctly as they give care and learn.
- Professional socialization and encourage conversation and collaboration with other disciplines.
- Take students to lunch and share breaks with them.
- Assist the student in defining belief systems, values and moral reasoning.

We are all social beings. Experienced nurses as well as students strive to be accepted by our peers, the nursing staff and the facility. Implementing the above strategies should assure the clinical environment is a more positive experience for students.

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Extermination: Utilizing Risk Management to Quash "Super Bugs"

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When I purchased my home, I was required to have a termite inspection. Even though it seemed there were no bugs eating away at the beams in my attic, I was surprised to learn that they did live in my home, in places I would have never looked. An unwanted inspection turned out to be an opportunity to improve how I maintained my home and the overall safety for years to come.

Health Care Systems, as well as health care clinicians, should be able to seek and destroy potential sources of infestations like pest exterminators seek and destroy nests of termites in the home. Multi Drug Resistant Organisms (MDRO's) not only compromise patient outcomes but financially impact organizations. The Department of Health and Human Services (2007) estimates that MDRO treatment can cost $6,000-$30,000 per episode. MDRO's also lead to complications of care and extended hospital stays. Hospitals must adopt strategies to "exterminate" MDRO's in their facilities. First, hospitals should employ a risk based approach to preventing MDRO's. Identifying gaps in care and practice is imperative so that hospitals can quickly eliminate potential portals of entry for MDRO's. Second, hospitals should develop a plan to address any under performing areas identified in the risk assessment. Finally, hospitals should follow a guided prioritized plan to eliminate the opportunities for MDRO's to be acquired during a patient's hospital stay.

The most common and most pervasive MDRO is MRSA. Methicillin resistant staphylococcus aureus (MRSA) is bacteria that lives on that has now resists antibiotic administration. MRSA was initially identified in 1961 in the United Kingdom and quickly spread throughout the globe. By 1974, 2% of all staph infections in the United States were methicillin resistant (Rubin et al, 2007). MRSA infections increased in lab identified events to 22% in 1995 and by 2004 63% for reported staph infections that were antibiotic resistant (Rubin et al 2007). According to Larson (2010), MRSA because of its ability to be transmitted by direct and indirect contact is a good gauge of how well a hospital has implemented it's MDRO program.

Hospitals should utilize MRSA as a good tool to develop their risk management plan. Just like with terminates, the best method of reducing these bugs is prevention. Preventing termites or super bugs like MRSA from ever entering your structure is the most effective method of dealing with infestations. It's a lot harder to get a bug out once it's in than stopping the bug from invading in the first place. By using MRSA hospital and community acquired rates health care systems can gauge their compliance rate with MDRO best practice. They can find the bugs eating away at the foundation of their structure and quash these superbugs with their proactive plan of prevention!

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ANA News

ANCC's Pathway to Excellence Program

Ellen Swartwout, RN, MSN, NEA-BC

Introducing the Pathway to Excellence® Program

The American Nurses Credentialing Center's (ANCC) Pathway to Excellence® credential is granted to healthcare organizations that create work environments where nurses can flourish. The designation supports the professional satisfaction of nurses and identifies best places to work.

To earn Pathway to Excellence status, an organization must integrate specific Pathway to Excellence standards into its operating policies, procedures, and management practices. These standards are foundational to an ideal nursing practice environment with a positive impact on nurse job satisfaction and retention. Pathway to Excellence designation confirms to the community that the healthcare organization is committed to nurses, recognizes what is important to nursing practice, and values nurses' contributions in the workplace. Nurses know their efforts are supported. They invite other nurses to join them in this desirable and nurturing environment.

ANCC grants Pathway to Excellence designation for three years. Any healthcare organization, regardless of its size, setting, or location, may apply for this mark of excellence.

Program History

In 2003, the Texas Nurses Association (TNA) established its Nurse-Friendly™ hospital program to improve the workplace and positively impact nurse retention. With the help of a five-year funding grant from the U.S. Health Resources and Services Administration (HRSA), the program sought to enhance both the quality of patient care and professional satisfaction of nurses working in rural and small hospitals in Texas. TNA designated its first Nurse-Friendly facility in 2005[13,14].

The program attracted many inquiries from other states about possible expansion. Texas Nurse- Friendly sought to transfer their program to a robust, collegial organization that could build on this success, while assuring the program's integrity as it expanded nationwide. ANCC was able to facilitate the expansion of the Texas Nurse-Friendly program into a national program and expand the high quality and superb reputation of the TNA Nurse-Friendly hospital program into ANCC's existing portfolio of credentialing activities. ANCC acquired the program in 2007.

In re-launching the Nurse-Friendly hospital designation to a national audience, ANCC renamed the program Pathway to Excellence®.

Healthy Work Environments Make a Difference

The impact of healthy work environments on nurse satisfaction and retention is evident in the literature[2,6,9]. In addition, many studies have indicated a strong impact of a positive work environment on patient safety, patient satisfaction and quality care[1,3,4].

Research has shown the nurse practice environment greatly influences many factors that affect both the nurse and patient. One key priority in healthcare is the safe delivery of nursing care. The Institute of Medicine's (IOM) report indicated that between 44,000 to 98,000 deaths occur annually due to medical errors[5]. Nurses are among the healthcare professionals who practice in a complex environment and can impact patient safety through their clinical practice.

At the core of the Pathway to Excellence program is a nursing practice environment that supports shared governance, interdisciplinary collaboration, leadership, quality, safety, professional development and work-life balance. Tested in Magnet environments, similar characteristics have translated into better patient outcomes, nurse satisfaction and quality care[1,10,11].

The ability for nurses to problem solve, collaborate with other disciplines and handle conflict is critical to quality patient care. In a study by Siu, Laschinger & Finegan (2008), positive work environments enhance nurses' conflict management skills, thus influencing the unit effectiveness.

Work-life balance and recognition for one's contributions in the workplace are important factors in the prevention of burnout. In a study that tested the Nursing Worklife Model, which measured the relationship between the nurse work environment and patient safety outcomes, it was demonstrated that the quality of the nurses' work environment mediated with burnout and engagement, influenced patient safety outcomes[7]. Another study of the Nursing Worklife Model, indicated that a professional practice environment had an impact on predicting nurse burnout[8].

Each Pathway to Excellence practice standard supports the essential components of a healthy work environment. The evidence indicates that organizations that embrace the elements of a positive nursing practice environment have a great impact on nurse satisfaction and retention, a key component of a Pathway to Excellence designation. Results have also demonstrated an influence on patient safety and quality care as well. It is evident that a healthy work environment does indeed matter for both nurses and patients.

The Vision for the Pathway to Excellence Program

A vision is a statement about the desired future. When thinking about the future, Pathway to Excellence healthcare organizations will be known for creating work environments where nurses can flourish. They will be places identified as nursing practice settings where a collaborative atmosphere prevails with a positive impact on nurse job satisfaction and retention. They will be seen as best places to work because a balanced lifestyle is encouraged, where nurses feel their contributions are valued as patient care partners in health care to the community.

Pathway to Excellence Standards

Based on evidence and expert nurse input, the Pathway to Excellence Practice Standards represent qualities that both nurses and researchers agree are critical to high quality nursing practice, professional development, and job satisfaction. ANCC encourages the use of these standards in all nursing practice environments. The Pathway to Excellence practice standards are:

1. Nurses Control the Practice of Nursing
2. The Work Environment is Safe and Healthy
3. Systems are in Place to Address Patient Care and Practice Concerns
4. Orientation Prepares New Nurses
5. The Chief Nursing Officer is Qualified and Participates in all Levels
6. Professional Development is Provided and Utilized
7. Competitive Wages/Salaries are in Place
8. Nurses are Recognized for Achievements
9. A Balanced Lifestyle is Encouraged
10. Collaborative Interdisciplinary Relationships are Valued and Supported
11. Nurse Managers are Competent and Accountable
12. A Quality Program and Evidence-Based Practices are Utilized

What Makes this Program Unique?

ANCC's Pathway to Excellence Program® recognizes the *foundational elements of an ideal nursing practice environment* whereas, the Magnet Recognition Program® *recognizes excellence in nursing and patient care*. Pathway to Excellence standards focus on the workplace, a balanced lifestyle for nurses, and policies and procedures that support nurses on the job. Written documentation and a confidential, online nurse survey confirm the standards are met.

Is Your Organization Ready?

Use the Pathway to Excellence self-assessment tool at www.nursecredentialing.org to determine if your organization is ready to begin the application process.

E-mail the Pathway to Excellence Program Office at pathwayinfo@ana.org if you have questions.

Learn More

Watch for upcoming articles with more information about the Pathway to Excellence program. Topics include:

- The Many Benefits of Pathway to Excellence Designation
- Getting Started: Organizational Assessment and Gap Analysis
- The 12 Practice Standards and Elements of Performance
- How to Apply for Pathway to Excellence Designation
- The Pathway to Excellence Designation Evaluation Process
- Case Study: A Pathway to Excellence Facility

About the American Nurses Credentialing Center

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), provides individuals and organizations throughout the nursing profession with the resources they need to achieve practice excellence. ANCC's internationally renowned credentialing programs certify nurses in specialty practice areas; recognize healthcare organizations for promoting safe, positive work environments through the Magnet Recognition Program® and the Pathway to Excellence® Program; and accredit providers of continuing nursing education. In addition, ANCC's Institute for Credentialing Innovation provides leading-edge information and education services and products to support its core credentialing programs.

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ANA News

RNs Hope Nurses 'float' at Rose Parade

by Susan Trossman

Every year, millions of people around the world witness southern Californiaís Rose Parade—replete with spectacular floats, marching bands, and equestrian pageantry. But in 2013, a group of nurses are hoping for more: to see a float honoring nurses make its way down the traditional parade route and into the international spotlight.

"Our mission for the float is to honor nurses worldwide and remind everyone how important nurses are to individual patients and to the health of their communities," said Suzanne Ward, MN, MA, RN, CNOR, an American Nurses Association-California (ANA\C) member and treasurer of the non-profit organization Bare Root, Inc., which is planning the float. "We also see the float as a way to recruit people into the profession by highlighting what we do. Sally is an excellent role model and someone whose had a wonderful career in nursing."

That's "Sally" as in Sally Bixby, MS, RN, CNOR, an ANA\C member, director of surgical services at the City of Hope National Medical Center in Duarte, CA, and a future president of the Tournament of Roses. Bixby is the first nurse and only the second woman named to this top role. Her term will run from Jan. 19, 2012 through the final events of the Tournament of Roses on Jan. 17, 2013.

"Having a float is such a fabulous opportunity to get worldwide exposure for nursing, and to get nurses and other people excited about the profession," Bixby said. "I'm totally thrilled and honored that my colleagues are promoting nursing during my tenure as tournament president."

Roses and Bare Root

Traditionally held on New Year's Day, the Tournament of Roses has two major televised events. The Rose Parade, which debuted in 1890, highlights floats made of flowers and other natural materials, such as seeds, leaves, or bark, according to the tournament Web site. The Rose Bowl Game pits the winners of the Pac-10 college football conference against the winners of the Big Ten conference. Since 1895, the festivities have been run by the Tournament of Roses Association, which now comprises 935 volunteer members. And Bixby has been active in the event planning and operations for more than 20 years.

"I've known Sally professionally since the 1970s, and I always knew about her tournament involvement," said Ward, whose 38-year career as a nurse included the roles of staff nurse, educator, nurse manager, and director of surgical services. "But we usually talked about nursing things."

In 2006, however, Ward and four other California nurses who now serve as the Bare Root board of directors learned that Bixby had been named tournament president for the 2012-13 term.

"We felt it's a historic event for women and for nursing," Ward said. So the group decided a float was in order. They formed Bare Root, a 501(c) 3 non-profit organization, and launched their "Flowers 4 the Float" campaign to raise funds to design, build, and decorate the float; maintain the organization's Web site; and cover other related costs. (The name "Bare Root" refers to the root of a rosebush or tree before it is planted and leafs out.)

"We're not experienced fund-raisers, but our goal is to make this happen," Ward said. "And as nurses, we're used to public speaking, teamwork, and working on committees to get things done." So she, her board colleagues, and now a growing number of nurses have rolled up their sleeves to do just that.

Their first goal is to raise $500,000 by December 2011, one of several deadlines for potential float participants.

"There are millions of people whose lives have been touched in a positive way by nurses," said Monica Weisbrich, RN, president of Bare Root and a member of the ANA\C board of directors. "We encourage nurses and those who have been helped by nurses to go to our Web site and contribute to help us meet our goal."

Rose Parade floats are extremely complicated structures to build, and natural materials can be quite expensive. However, Ward added that any money remaining after the float is built will go toward scholarships and grants to qualifying organizations.

The group also is trying to promote its campaign through other venues. They've already had several articles published in nursing publications, and they speak at every nursing event possible. Their constant effort thus far has yielded the cooperation of several organizations, including the Association of California Nurse Leaders, the California Student Nurses Association, ANA\C, and individual nurses. ANA has promoted the effort through listservs and its publications.

To illustrate the difference one nurse can make, Ward pointed to Sylvia Estrada, RN, WHCNP, who works at a Los Angeles hospital and is actively involved in three separate nurse organizations—Greater Los Angeles Chapter of the Oncology Nursing Society, California Association of Nurse Practitioners Chapter 17, and the National Association of Hispanic Nurses-Los Angeles Chapter. She has encouraged all three groups to have a monthly raffle to support the nurses float. And the nurse practitioners group has created a rose pin to sell and will share the profits with the float project.

And then there is the work around the float itself. The group has to develop a solid theme and hire a float designer who can bring the nurses' vision to life.

"We really want to celebrate nursing and show its diversity—in both the roles nurses can have and where we come from," said Ward, who was encouraged to go into nursing by her mother and a nursing home charge nurse with whom she worked as a young girl.

A nurse and event-planner

Bixby was born and raised in Pasadena and started going to the Rose Parade as a small child. When she was in high school, her family moved to a house that was at the end of the parade route.

"When we started to hear the (marching) bands, we put up a couple of ladders with a plank in between and watched the entire parade," Bixby said. "The parades always were wonderfully entertaining."

In 1988, Bixby became officially involved in the tournament association by volunteering and being assigned to one of the "big three" committees. Her first role was on the formation committee, in which she helped secure the area around the floats, bands, and equestrians prior to and during the parade. After that two-year stint, she was assigned to parade operations, which stages the event, and then the post-parade committee, which oversees generally two days of public viewing of the floats. Other volunteer work had her pitching in on activities involving decorating sites, queen and court, and hosting tournament guests. She currently is tournament secretary.

When she assumes the tournament presidency, Bixby will oversee the entire parade, including such duties as selecting the theme and appointing the grand marshal. (Previous grand marshals have included Shirley Temple in 1939, President Dwight D. Eisenhower in 1964, and Tom Brokaw in 2001.) She and her tournament officers also will make final decisions on marching bands, float entrants, and other key components. Additionally, she will travel around the country to honor selected marching bands (13 selected from roughly 50 entrants each year) and for promotional engagements.

Bixby said her nursing career definitely has prepared her for the role of tournament president.

"As a surgical nurse all my life, I have worked with many surgeons, nurses, and staff in other departments," she said. "Those interactions have allowed me to build strong interpersonal and communications skills. As a manager, I've learned other important business skills, including being able to handle a very large budget."

Bixby added that she started as a scrub nurse more than 30 years ago and has always been happy with her career choice.

Said Bixby, "Nursing has really been a perfect fit for me, and having a nurses float is just a great way to highlight the different opportunities available in nursing."

For more information, go to www.flowers4thefloat.org.

Susan Trossman is the senior reporter for ***The American Nurse****.*

Medication Errors: Reduce Your Risk

Experts estimate that nearly 98,000 people die in any given year from medical errors. A significant number of those deaths are due to medication errors.[1]

The National Coordinating Council for Medication Error and Prevention defines a medication error as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer."

Mistakes can happen

As a nurse, you dispense medication to your patients on a regular basis. Consequently, you're charged with knowing the "five rights" in administering medication—right patient, right drug, right dose, right time, and right route. And while you take every precaution to avoid making errors that may put your patients at risk, mistakes can happen.

Common reasons for mistakes include distractions and interruptions during medication administration, inadequate staffing, illegible medication orders, and sound-alike drug names and packaging.

Reduce your risk

To reduce your risk of liability, take the time to read medication labels—especially those that you're not familiar with. It is also your responsibility to know the drug's dosage range, possible adverse effects, toxicity levels, indications and contraindications. Understand the medications you administer and don't hesitate to ask questions. Consult your nurse drug guide, the physician, a pharmacist or your supervisor if you have any questions.

Further protect yourself and your career with an individual liability coverage policy. Professional Liability Insurance protects you against real or alleged malpractice claims you may encounter from your professional duties as a nurse.

Even if you have Professional Liability coverage through your current employer, it may not be enough. That coverage may have some serious gaps, including:

- Policy limits may not be high enough to protect you and all of your co-workers
- You may not be provided with coverage for approved lost wage reimbursement, licensing board hearing reimbursement defense reimbursement.
- You may not be covered outside of the workplace, such as when you engage in volunteer or part-time work
- You may not be covered for suits filed after you have terminated your employment

In the event of a lawsuit, your own Professional Liability Insurance policy would:

- Provide you with your own attorney
- Pay all approved and reasonable costs incurred in the defense or investigation of a covered claim
- Pay for approved lost wages up to the limits of the policy
- Provide reimbursement of defense costs if licensing board investigations are involved
- Pay approved court costs and settlements in addition to the limits of liability, in accordance with the policy.

Arm yourself with the protection you need so you can focus on providing excellent patient care and reduce your exposure to liability.

For more information about Professional Liability Insurance, visit www.proliability.com.

This article contains a summary of the insurance certificate provisions. In the instance of conflict between this article and the actual certificate, the insurance certificate language will prevail and control.

SOURCE: The Professional Liability Insurance Plan is underwritten by Chicago Insurance Company, a member company of the Fireman's Fund Insurance Companies.

[1]www.nccmerp.or

Making the Dream a Reality

Authors: Helen Southerland, Manager of Business Development and Cheree Belt, Marketing Representative for Hospice of Oklahoma County, Inc.

ONA membership status: INTEGRIS Health is a member

Two decades ago, the physicians of the Oklahoma County Medical Society established Hospice of Oklahoma County, Inc. to serve the terminally ill in the local community. In 1996, Hospice of Oklahoma County was serving portions of nine counties in Oklahoma and had an opportunity to grow and develop the hospice program further by affiliating with INTEGRIS Health.

In 1998 Terry Gonsoulin, RN, Executive Director, the hospice board of directors and the hospice leadership team investigated a growing trend across the county, which was to provide hospice care in an inpatient setting. The dream was born to build a hospice house in the Oklahoma City metropolitan area.

After much lobbying, research and work by Terry Gonsoulin, President of the board of directors of the former Oklahoma Hospice Association a law and regulations were written and passed in 2004 by the Oklahoma state legislature that would allow hospice inpatient facilities to be built and regulated in the State of Oklahoma.

Through a generous donation by the INTEGRIS Baptist Medial Center Volunteer Auxiliary they made this dream a reality for the staff of Hospice of Oklahoma County, Inc. In July of 2009 INTEGRIS Health announced that Odyssey Healthcare of Oklahoma, Inc. was being acquired by Hospice of Oklahoma County, an affiliate of INTEGRIS Health. This acquisition provided a unique opportunity to expand the hospice capabilities in a dedicated twelve bed inpatient hospice house.

The INTEGRIS Hospice House is an additional option in end-of-life care when families cannot take care of their loved ones in their own home. When the INTEGRIS Hospice House was first purchased the average daily census was 4 patients and currently the average daily census is 8 patients a day. Depending on the acuity the current staffing ratio is 1 RN to 4 or 5 patients.

Monica Moller, RN, Hospice of Oklahoma County case manager and INTEGRIS Baptist Medical burn center nurse became the clinical manager of the inpatient unit. Ms. Moller brings strong clinical skills in pain and symptom management as well as a compassionate attitude towards her patients and families.

The INTEGRIS Hospice House is located in northwest Oklahoma City at 13920 Quailbrook Drive on the north side of Memorial Road. The 8,500 square foot facility has spacious private suites with cable TV, VCR/DVD players, Wi-Fi connection, bedside reading lights, and private bathrooms along with comfortable seating that converts into a sleeper. A family room is available for our guests with a kitchen and laundry facility. There is also a library, which provides a quiet retreat for families and others who need privacy or simply a place to pray or meditate. Meals are prepared for the patient and one family member.

At Hospice of Oklahoma County, Inc. we recognize the family is an important factor in patient care and the INTEGRIS Hospice House is open twenty-four hours a day for visitors, family and friends. Pets are also recognized as important members of the family and are welcome as scheduled visitors. Pet therapy is also available.

INTEGRIS
Hospice House
AN AFFILIATE OF
HOSPICE OF OKLAHOMA COUNTY INC.

There are primarily two levels of care provided in this facility: inpatient and respite care. Inpatient care is available at the INTEGRIS Hospice House when pain or other distressing symptoms cannot be managed at home, when family situations escalate and the care giving demands of the patient cannot be met or when the terminally ill hospitalized patient needs to transition into end-of-life care. Respite care is short-term inpatient hospice care that provides relief for the caregiver.

Hospice care is covered under Medicare, most private insurance plans, HMO's and other managed care organizations. Hospice of Oklahoma County is a 501 c (3) and also relies on the generosity of others through donations made to the United Way and the Combined Federal Campaign. Funding is also obtained through memorials and grants.

Referrals to the INTEGRIS Hospice House may be initiated by a medical professional, community agent, friend and family member by calling (405) 848-8884. Other hospice agencies may also contract with the INTEGRIS Hospice House to place their patients in the facility for inpatient care.

Closing the Door to Conflict

V. Lynn Waters
Faculty, University of Phoenix
Chief Nursing Officer

According to Rotella, Gold, Andriana & Scharf (2002), families, partnerships, and friendships can break up over what appear to be surmountable conflicts. I would add that in the workplace staff is included in this concept and the efforts to control the damages from conflicts can be very unproductive. Without an indepth discussion of the issues, conflicts, and differences, the concepts of reconciliation and forgiveness are likely to be confused with power, empowerment and revenge. It is important for leadership to understand conflict, how to work to resolution and the processes considered significant as part of the resolution including forgiveness and reconciliation. The following is quoted from an article in the *Times News* on July, 2006, forgiveness is the beginning and follows with reconciliation:

The Bible says, "If your enemy is hungry, feed him; if he is thirsty, give him something to drink. In doing this, you will heap burning coals on his head" (Romans 12:20). In other words, by refusing to seek revenge, and treating someone in a way that is opposite to the way they treated us, the cycle can be broken, and peace can begin.

Forgiveness is a process or the result of a process that involves changes in our emotions and attitudes. It is actually what I believe to be the first step in breaking the cycle and precludes reconciliation. According to Abigail & Cahn (2007), forgiveness is an actual letting go of the feelings of retaliation and revenge (p. 232). Forgiveness is characterized by a reduction in the focus and moving from negative to positive feelings. Moore (2003) discusses that forgiveness is actually a change in feelings but certainly does not infer that there will be no consequences as a result of the deed. Moore (2003) believes that forgiveness should likely only occur when there it is merited with good reasons noted.

Reconciliation as noted by Abigail & Cahn (2007) is a behavioral process where a specific action is taken that follows forgiveness and affords us the opportunity to repair a relationship or potentially even create a new one (p. 232). Forgiveness is seen as a mental process that follows conflict where reconciliation is more of the external process or actions associated with our choice to forgive and in my mind to forget. Reconciliation lends us to move forward in our lives and relationships and supports us in regaining the trust and foundation of our relationships with others.

In resolving conflict forgiveness is the emotional and mental components and reconciliation is the actions as a result of our forgiveness. I believe reconciliation to be all inclusive of the action(s) relating to forgiveness. I think Moore (2003) puts a twist to the idea of reconciliation moving us to see that forgiveness and reconciliation can be contradictory. For example, if you simply come to terms with what happened, you may have to ask yourself are you able to completely forgive and reconcile or are you simply going through the motions. As a result of thinking through the conflict, one may understand what happened and one may not like it but in order to move forward one must take it internally and decide if they are ready and able to move forward with possible consequences. I believe this is a crucial step that must occur in order to move forward in any relationship, including working relationships. At work some staff simply maneuvers through the motions of forgiving and are not really on board with full forgiveness and reconciliation. My experience with this reaction to conflict tells me that the staff is either not ready or not willing to come to terms with the conflict and what surrounds the conflict. They may choose to go through the motions in lieu of turning internally to evaluate, decipher, forgive and forget. For example, I have seen staff nurses upset with the numbers of nurses working on a given shift that are not the number that the matrix for their unit and that number of patients calls for. Staff become upset, disgruntled and vocalize to each other about their feelings and occasionally do this in inappropriate places and at inappropriate times. They sometimes refuse to help each other, not respond to the another staff member's needs, and in essence cause more chaos and conflict than if they had just teamed together and got the work done. The following day they may be better able to discuss the situation rationally with their supervisor and peers and come to terms that staffing situations are sometimes unavoidable. In their minds I think they believe that the conflict is over and done but I do not think there is real forgiveness. I find that many times nurses internally feel that the staffing shortage is an effort by management to make their lives harder and that no one actually is concerned for their working conditions. Nursing staff can be very good at portraying feelings of forgiveness to those around them and may even appear to have reconciled with their peers and the management for the shift's issues. However when something similar occurs again they at times repeat the same process over. There is not any true forgiveness, no reconciliation and in the end dissatisfied staff and a dysfunctional team. When they do not forgive and reconcile with each other, the conflict returns and can become intensified. Conflict must be discussed and analyzed all the way down to the heart of issue(s).

Wilmot & Hocker (2007) discuss how all of the ways that people mistreat each other can cumulate to become the foundation for the discussion of forgiveness. When staff lack trust or believe that no one cares about them they may not be able to move to forgiveness and reconciliation. The issues need to be explored including why was there a shortage of staff, who was notified and what happened in the background by management to prevent. The conflict, forgiveness and the resolution needs to be communicated to the staff and a solid trusting relationship established. Once established, staff likely can not only move to forgiveness but reconcile with their management team, their peers and the organization.

Reconciliation may lead to changes in relationships in the workplace with some being good and others not so good. Communication is discussed and is recognized as key to being able to move forward. Moore (2003) discusses reconciliation in terms of truth about what happened in the past, mercy and the ability to accept forgiveness, justice by making things right and peace by harmony. Moore (2003) talks about "closing the door" (p. 344) and that this is not always easy to do. I can attest to that however at the same time I can clearly see that closing the door to conflict is critical. It is a final step to resolving conflict and bringing about forgiveness and reconciliation. This ultimately leads conflict to rest and in some way allows for recuperation to transpire and change to begin and survive.

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