Nurses set the pace!

organization.

an ONA committee, a hospital or another nursing
group or community if you will, or if the setting is
healthier Oklahoma. It doesn’t matter the size of the
of nurses working together to set the pace for a

More inside...

Volume 55 • Issue No. 2 June, July, August 2010

Every day I look around, and I see evidence
The ABC’s for Eliminating
Clostridium Difficile

Page 15

Page 21

Executive Director’s Report

Chirs Weigel, RN, BN, MBA, President

“The blog or not to blog” is
the current question facing
the healthcare community.
The world of social media is
a driving force for patients,
physicians, employers and
employers in the healthcare
setting. A demand to create
and disseminate patient
education, health information,
data, and experiences in a
quick and expeditious manner
is upon us. Currently, 540
hospitals in the United States
utilize social media tools:

Hospitals account for 247 YouTube channels, 316
Facebook pages, 419 accounts and 67 blogs reported
in the article, “Risky Business: Tweeting the
Symptoms of Social Media.”

From the patients’ perspective, they are seeking
the connection to investigate on line guidance to
care, consumer details and services as well as
healthcare results. Patients and physicians are even
tweeting about their experiences during surgery.
The patient does so to describe the experience and
relieve nervousness by providing a distraction during
surgery. While physicians use social media as a
way to provide education to consumers, keep family
members informed during surgeries, and encourage
transparency in healthcare.

Social media is now a fact of life, and millions
of employees are actively engaged in networks. So,
the question becomes how do employers guide the
use of social networking during working hours? Do
employers have any right to know what employees
are doing in their private lives regarding social
media?

Employees need to become familiar with their
employer policies regarding networking and guard
themselves from inadvertent HIPPA violations,
possible discrimination, harassment or termination.
at the same time employers need
to be mindful of defining network boundaries by
policy of acceptable and unacceptable behavior,
defining levels of access to social networking sites,
set limits regarding “friendship” among superiors
and subordinates as well as developing practical
guidelines to prevent unthinking, harmful employee
actions.

According to AVG, here are just a few known
facts about social networking: 21 percent of social
networkers accept contact from members they do not
recognize, while 26 percent share files within a social
network and 64 percent said they click on links
sent by other members. As a result of poor security
practices, 20 percent of web users that belong to a
social network have been the victim of identity theft.
In this world of social networking everyone needs
to learn to protect themselves so limit information
on your profile, consider creating false profiles,
monitor your privacy settings and update your Web
browser. Blog safely…. and be sure to Friend ONA on
Facebook and follow ONA on Twitter!

Makandi Mubichi

ONA Executive Director

The ABC’s for Eliminating
Clostridium Difficile

Tribute to Florence
Makandi Mubichi

Page 21

Magnet hospitals. It was
achieved Magnet and the difference it made
what it meant to the
really inspiring to hear
about Magnet Recognition
from the Journey they were
on as well as hear experiences
from the three Oklahoma
hospitals that
had achieved Magnet and the difference it made
not only for the nurses but for patients. It was
evident that Nurses set the Pace!

On Nurses Day, I had the
opportunity to attend
Comanche County Memorial
Hospitals Nurses Day
celebration. It was a great
day. The nurses at Comanche
had the opportunity to learn
about Magnet Recognition
from the Journey they were
on as well as hear experiences
from the three Oklahoma
Magnet hospitals. It was
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not only for the nurses but for patients. It was
evident that Nurses set the Pace!

In March, the ONA Professional Practice
Committee determined that they wanted to
move forward with developing and expanding
opportunities for newly licensed nurses to
transition into the workplace as well as look
at staffing issues. This will be done as a
community with other nursing organizations.
Nurses set the Pace!

ONA works with nurses to Set the Pace

at the Capitol. ONA represents nursing at the
Legislature to ensure nursing’s voice is heard. We
support funding for programs that affect patients,
work to advance nursing practice, provide guidance
on new laws affecting nursing and healthcare, and
educate lawmakers and other policy makers about
nursing priorities.

I know that there are wonderful examples all
across this state. As you are reading this, you are
also thinking about how nurses you know
Set the Pace! I am specifically inviting you to share your
“Strategies for Action” at the 2010 Annual Convention
as a presenter. Details on how to submit a
presentation proposal are in this issue. If are looking
for programs that work, then consider coming to the
2010 ONA Convention.

“Nurses Set the Pace for a Healthier Oklahoma:
Strategies for Action” is our theme and focus of the
2010 Convention. I know that there will be practical
positive presentations. I hope you will join us. Once
you see the initiative and brilliance for which ONA
members are known, then we are confident you
will become a member, too. Convention is just one
of many ways to get involved with the resourceful
nurses of this state. For more ways to become
involved, please visit www.oklahomanurses.org. Hope
to see you in Tulsa this October!
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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 Literacy
- 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 specialties and practice settings.

Oklahoma Nurse Editorial Guidelines and Due Dates

Submission Information

Materials Due
Oklahoma Nurse
Date to Editor: Oklahoma Nurse
Issue Date: July 16, 2010
September 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.
- 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.
- Manuscripts may be reviewed by the Editorial Staff.

2. Photographs should be of clear quality. Black & white photographs are preferred but not required. Please write the correct name(s) on the back of each photo. Photographs will be returned if accompanied by a self-addressed, stamped envelope. Mail photographs to:

Julie Clermont
Editor, The Oklahoma Nurse
6414 N Santa Fe, Ste A
Oklahoma City, Oklahoma 73116

3. E-mail all narrative to ona@oklahomanurses.com

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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.

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Mercy Memorial Leads the Way with Joint “Camp”
ONA Organizational Sponsor

Ardmore—Mercy Memorial Health Center recently hosted a party for some very special patients. What makes this group so special is they walked to the party with no pain in their knees or hips because they were patients at Mercy Memorial’s Joint Replacement Center.

In January 2009, the doors of the joint replacement center opened and since then more than 300 patients have gone through the joint replacement “camp.” Mercy Memorial’s commitment was to create a center where experienced orthopedic physicians, nurses, therapists and social workers carefully plan every step in the process. They guide no more than 10 patients at a time through the procedure of having their knee or hip replaced. Each week a small group of patients goes through surgery, recovery and rehab together.

If you talk to joint replacement nurses, like Debra Wise, they’ll tell you replacing joints today is nothing like even a few years ago. Wise has been an orthopedic nurse for the past 15 years. “The best part of caring for our joint replacement patients is when they come back to visit us only 12 days after surgery and can walk the whole way,” said Wise. Mercy Memorial patients experience surgery on Monday and by Tuesday they are having fun in their rehab group. As Dr. Keith Troop, one of our joint replacement orthopedic surgeons, says, “The camaraderie of group rehab provides patients with motivation and they have a fun time, rather than a difficult, lonely experience.”

The Joint Replacement Center is an important piece of Mercy Memorial’s commitment to providing southern Oklahomans an option for quality health care, close to home. Quality includes how patients are served while at Mercy Memorial. Patients have ranked Mercy Memorial’s joint replacement center in the top two percent of hospitals nationally when it comes to total joint replacements.
Human Capital Theory: Another Way of Valuing RNs Knowledge

Valinda Jones, BSN, RN, Director Clinical Resources, St. John Medical Center-Tulsa

Studies show the nursing shortage negatively impacts patient care and inadequate staffing levels place heavy burdens on nursing staff and leads to burnout and increasing RN vacancy rates. Nursing Administrators struggle to advocate for more RNs in the current financial environment where healthcare facilities are being pushed to decrease or better manage human capital utilization. Nursing leaders must promote the clinical perspective in organizational decisions while remaining cognizant of the financial impact of those decisions. This article suggests that considering staff RNs from the perspective of human capital theory might be another strategy to assist Nursing Administrators.

The defining attributes of nursing human capital are:

- Skills/Competency—an individual’s actual performance in a situation and includes cognitive, affective and psychomotor skills
- Knowledge—acquired through formal education or on the job training
- Experience—comes with practice
- Talent—a personal gift or skill

Nursing human capital is operationally defined as:

- Academic preparation
- Participation in continuing education development
- Specialty certification
- Experience in clinical specialty
- Unit tenure

Covell (2008) describes a relationship between nursing knowledge, skills and experience and patient and organizational outcomes. She proposed that the theory of nursing intellectual capital (NIC) provides a more comprehensive understanding of the conditions that affect patient and organizational outcomes. She conceptualized the relationships among variables as described below:

Nurse staffing and nursing human capital:

- A higher proportion of RN’s has been found to be inversely related to adverse patient events

Employer support for nurse continuous professional development (CPD) and nursing human capital:

- Educational support is necessary to ensure high quality patient care

Nursing human capital and organizational outcomes—investment in CPD leads to:

- Higher retention rates
- Lower vacancy rates
- Greater job satisfaction

Nursing structural capital and patient outcomes:

- Care maps
- Practice guidelines

- Protocols contribute to improved patient outcomes

Nursing human capital and patient outcomes—evidence indicates better patient outcomes are realized when:

- Nursing education is BSN or higher
- Staff experience is >5 years.

According to research funded by the AHRQ, hospitals with low RN staffing levels tend to have higher rates of poor patient outcomes. Specifically, the research found:

- In hospitals with high RN staffing, medical patients had lower rates of UTIs, pneumonia, shock, upper GI bleeding and longer hospital stays
- Major surgery patients in hospitals with high RN staffing had lower rates of UTI and failure to rescue
- Nurses are managing an increased workload due to higher acuity patients and added responsibilities
- Hiring more RNs does not decrease profit margins
- Higher levels of staffing have a positive impact on both quality of care and nurse satisfaction (US Department of Human Services)

Nursing leaders face the daunting task of advocating for the needs of front line nurses, while providing safe patient care and maintaining the financial stability of the organization. Using the principles of human capital should assist them in advocating for improving the RN skill mix.

Valinda is a student in OUHSC CN Nursing Administration Pathway.

References


Nurse Practitioners Can be Eligible for Medicare Funds to Use Electronic Health Records

The government is pumping out billions of dollars to accelerate the use of electronic health records (EHR) and help improve our health care system. Some of this money will go to qualifying nurse practitioners who implement and use EHRs their practice. In fact, nurse practitioners can be eligible for more than $650,000 in incentives from The Centers for Medicare & Medicaid Services.

The Oklahoma Foundation for Medical Quality (OFMQ) is a not-for-profit health care quality improvement organization (QIO) dedicated to improving health care and improving lives. For over 35 years, OFMQ has played an integral role in ensuring quality medical services patients receive. Providers who start early, between now and 2011, can maximize their reimbursement.

"Implementing an EMR is an expensive, time consuming process," said Dr. Dan Goldner, chief information officer for OFMQ. "Often it's the nurse practitioners who are really hands on with the system in a family practice. This is a great opportunity for these providers to get technical expertise to help them make good decisions about EHRs, use the technology to improve care and receive financial reimbursement for this effort," he said.

Nurse practitioners who see at least 30 percent Medicaid patients, primarily in small practice and underserved settings, are eligible for the program. For more information, contact Phillip Smith, Community Development Manager at 405-302-3206. Find more information on the Health Information Technology Regional Extension Centers at www.ofmq.com/hiterec.

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About Oklahoma Foundation for Medical Quality

Oklahoma Foundation for Medical Quality (OFMQ) is a not-for-profit health care quality improvement organization (QIO) dedicated to improving health care and improving lives. For over 35 years, OFMQ has played an integral role in ensuring quality medical services for Oklahomans through national quality initiatives. OFMQ holds contracts with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. www.ofmq.com.

Job, Profession, or Passion: What is Nursing to You?

Shiela Derrevere MS, RN, CHPN
ONA Member, Region 2

Twenty-seven years is a long time, a lifetime to many reading this. I graduated with my ADN in 1983 and worked on a geriatric unit. The transition from school to practice was shocking and unbeatable. I cried driving home each night, wondering why I had gone to nursing school in the first place. Change from big hospital to smaller hospital was helpful but my big "break" (pun intended) came when an ER nurse in our small hospital broke her arm and had to be off for 6-8 weeks. Working full time on the evening shift, I was asked if I would like to cross-train to the ER. Thank goodness, I accepted.

In six weeks, I fell in love with ER, with doing something different, with the rapid comeings and goings of the shifts and especially with learning again. I heard ER staff talking about being Advanced Cardiac Life Support (ACLS) certified and said I'd like to do that. One nurse whose name shall go unmentioned, said she didn't think I had it in me. Like a dare, I was determined to rise above it. I not only became ACLS certified, I became an ACLS instructor. I was then asked to cross-train to the Intensive Care Unit (ICU). I went to a much larger hospital for a hemodynamic monitoring course, and was hired on to their ICU.

The greatest miracle was that, after a few years on weekends in ICU, I began to bloom as a nurse. I got on some committees and started to study for national certification in critical care. About that time, I began to hear from some of my coworkers in ICU that I didn't belong in the unit because I gravitated toward the patients no one else wanted, the ones stuck there on a ventilator, the ones who were dying. I was constantly in trouble because I called doctors at midnight for DNR orders and kept the deceased patients in ICU rooms after exceptional post mortem care for the family to view and grieve...while there was a line in the ED waiting for the bed.

Then, it happened. A former supervisor of mine became the nurse manager of the health system's hospice. She asked me to fill in during some summer weeks for her vacationing staff. I fell in love. I truly found my niche. Three long years later (there was a line in the ED waiting for the bed).

Sixteen years later I am still flourishing there. One nurse, whose name shall go unmentioned, said she didn't think I had it in me. Like a dare, I was determined to rise above it. I not only became ACLS certified, I became an ACLS instructor. I was then asked to cross-train to the Intensive Care Unit (ICU). I went to a much larger hospital for a hemodynamic monitoring course, and was hired on to their ICU.

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Then, it happened. A former supervisor of mine became the nurse manager of the health system's hospice. She asked me to fill in during some summer weeks for her vacationing staff. I fell in love. I truly found my niche. Three long years later (there was a line in the ED waiting for the bed) I became a full time hospice nurse. Sixteen years later I am still flourishing there.

So, how do you get from job to profession to passion? First of all, do not allow yourself to become stagnant. Commit to truly being a lifelong learner! The day you don't learn something new should be the day you don't live anymore. Join and be active in nursing organizations. There is no substitution for this in the invaluable networking and education resources there. With the organizations come professional journals, great websites and conference opportunities as well. If money is an issue, then volunteer to serve on the board of your nursing organization and many times you can get educational scholarships, grants, or even an educational stipend. There is no such thing as a free lunch but I have earned my way by service to several national conferences and have learned so much along the way.

Really listen to your heart. Think about and pay attention to what it is you love. What part of nursing has had a profound impact on your life personally? What made you want to become a nurse in the first place? Think of those things and apply them to the world wide nursing. One of my favorite things about nursing is that there are so many areas and so many options to work in. It is a career in a profession that grows with the individual nurse and with age and experience we rather naturally are navigated to different aspects of nursing. Also, do not be afraid to try new areas of nursing until you find your niche. If you want to avoid "job hopping" ask about shadowing another nurse in the area you are interested. A side job at an agency could get you into some different areas to "try them on."

So, if you believe you are unhappy or unfulfilled as a nurse, I challenge you to reevaluate, participate, and rejuvenate your career. Along the way, you could go from job to profession to passion. I dare you!
Mercy Saves Local Landfills and Big Bucks

ONa Organizational Sponsor

Midwest—In just nine months, Mercy—a group of 30 hospitals in Arkansas, Kansas, Missouri and Oklahoma—has already saved almost $800,000 and diverted more than 20,000 pounds of waste from local landfills. And by all estimates, Mercy stands to save $2 million annually and some 30 tons from landfills once all facilities are at full speed with a new green initiative that involves reprocessing medical devices.

“The health industry is second only to the food industry in contributing to our nation’s landfills,” said Lynn Britton, Mercy president and CEO. “Not only is Mercy impacting our environment by reprocessing medical devices, we are putting the savings back into patient care. This is just one of Mercy’s strategies to reduce healthcare costs while increasing the quality of patient care.”

Following stringent guidelines set by the U.S. Food and Drug Administration, hospitals across the country are beginning to revisit reprocessing devices such as surgical scissors, drills and many opened but unused items. For years, U.S. hospitals have reprocessed devices in-house or through outside vendors but over time, with a more disposable society, landfills are overflowing.

According to a March 2010 study published in the Association of American Medical Colleges journal, devices which are properly reprocessed “do not present an increased health risk when compared with new, non-reprocessed devices.”

“Now, to ensure safety and efficiency, as well as comply with FDA regulations, Mercy is partnering with a leading single outside vendor which disassembles, cleans, inspects, certifies, sterilizes and restores devices to manufacturer specifications and then returns items to Mercy facilities,” said Stacy Howard, RN, MHA, MBA, director of Mercy’s RRO operations and support services. “They meticulously track how many times each device has been processed and recycle them when they need to be retired.”

Along with reprocessing, here are some other ways Mercy is green:

• Mercy Medical Center in Rogers, Arkansas, is one of only 21 hospitals in the country currently Energy Star certified, meaning it uses less energy, is less expensive to operate and causes fewer greenhouse gas emissions than its peers, according to EPA standards.

• Mercy Data Center in Washington, Missouri, opening in summer of 2010, was designed to be compliant with Leadership in Energy and Environmental Design—the standard for green building design. Case in point: of the 255 tons of steel used, 100 percent came from recycled sources.

HCR 1060 “Rebecca’s Resolution”

Eileen E. Kupper-Grubbs RN-BC
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ONA Member, Region 1

Another day to remember: April 19, 2010

It has been 15 years since the bombing of the Alfred P. Murrah Federal Building in Oklahoma City, Oklahoma. On this anniversary, House Concurrent Resolution 1060, which was authored by Representative Scott Martin and Senator Jonathan Nichols, was passed as written by the entire legislature. The process of making this resolution began on January 28, 2010 in the form of an email to the Executive Director of the Oklahoma Nurses Association. The email described how there was only one organ donor from the tragedy that was the bombing of the Alfred P. Murrah Federal Building.

The donor was Rebecca Anderson. She was born in Arkansas, and was a nurse with an Oklahoman’s spirit. William Wilcoxson, a veteran from Duncan, Oklahoma, gratefully received her heart. Rebecca’s kidneys were given to recipients out of state. It is our hope that by remembering the positive moments of humanity like this, we will continue to overcome the adversities presented by the tragedy of April 19, 1995.

Many Oklahomans have no idea that Rebecca was the only nurse who died that day, nor are they aware that she was the only organ donor in the tragedy. This makes Rebecca Anderson’s contribution to the nursing profession of exceptional significance. Three individuals recognized the importance: Oklahoma Nurses Association’s Executive Director, Jane Nelson; the organization’s lobbyist, Victoria White Rankin, and myself as an Oklahoma Nurses Association member. We realized that this was an important message for nurses as well as Oklahomans. Together, we encouraged legislators to create a resolution.

The resolution that passed essentially names April 19th as “Rebecca Anderson Nurse of the Day” in perpetuity. This designation will be awarded to the ONA member selected from a competitive process to serve as the honorary Rebecca Anderson Nurse of the Day through the ONA Nurse of the Day program during legislative season at the State Capitol. An essay contest will be overseen by the Oklahoma Nurses Association and Life Share Oklahoma.

Beyond remembering the moments of grace that arose from that senseless act of violence, ONA hopes to promote the importance of organ and tissue donation. As nurses, let us do our part to increase the understanding of what it means to be an organ and tissue donor while we continue the legacy of ultimate service exemplified by Nurse Rebecca Anderson.
Update on Articulation

The Oklahoma Health Care Workforce Center’s Sub-Committee on Articulation has been meeting quarterly for almost two years to assess progress on allied health and nursing articulation and devise plans to improve the process. The committee is comprised of representatives from allied health and nursing education as well as service representatives. The Institute for Oklahoma Nursing Education (IONE) is represented by the articulation sub-committee chair from that group.

The group has developed a position paper on articulation related to nursing in collaboration with IONE and will soon have developed a position paper for allied health. A survey of articulation practices in allied health and also in nursing will soon be distributed throughout the state and the allied health position paper will be informed by that data. The nursing position paper will no doubt be revised once the data is received. Key points in the nursing position paper relate to current practices, funding, and the nursing shortage. Guiding principles for partnerships, collaboration and articulation in nursing education have also been included. A great deal of discussion has also occurred with respect to accreditation and regulatory challenges for both nursing and allied health. Being a rural state creates difficulties in a program’s ability to meet criteria for faculty qualifications and the lack of flexibility in accreditation standards makes the challenges even more acute.

An exciting component of the work of this group is the development of plans for an articulation summit to be held in Oklahoma City on Monday, November 1, 2010. Stay tuned for more exciting information about this education activity. Dr. Katherine Vestal, FAAN, FACHE will be the keynote speaker but the plans also include working groups to develop transformative strategies about articulation that could provide exciting opportunities in our state as well as the potential for becoming a model for other states to emulate.

Dr. Vestal is the President of Work Innovations, LLC and has an extensive background in allied health and nursing, both in education and health care administration, as well as work redesign and transformation. She will be coming from Michigan to not only challenge us but to spur our work in new directions and jump start our articulation processes. Plan to be in Oklahoma City that day and mark your calendars now.

The articulation sub-committee is anxious for feedback so please contact us at any time. You may send an e-mail to camckenzie@wsgou.edu. Also, please complete the articulation survey when it arrives in your in-box soon. It will assist us in cataloguing articulation efforts within the state as well as give us valuable information to plan priority actions for the group in the future.

Oklahoma consistently has a high number of disasters each year (FEMA, 2010) and a small state population. As a result, Oklahoma usually has the greatest disasters per capita and therefore Oklahoma nurses have the greatest probability of responding to disasters. None of the types of disasters may lead to scarce resource situations; depending on the situation, the lack of resources could last for only a few hours or it may stretch out over many days. ONA supports nurses involvement in the planning for scarce resource situations at the state, county and institutional level. Preplanning is necessary to develop guidelines for adapting standards of care during disasters that result in scarce resource situations.

"As seen in catastrophic health emergencies like Hurricane Katrina, the same level of care may not be available due to limited resources and countless patients. Medical personnel working in these circumstances of care will use every means possible to provide the best level of care possible at the time, but realistically they will not be able to follow everyday standards of care Oklahoma’s 2009 Catastrophic Health Emergency (CHE) Plan, Altered Standards of Care, p. 1)." Several years ago, the CHE Task Force identified the possibility of changes in the standard of care during a disaster and organized a state Adapted Standards of Care (ASC) committee to explore the issues related to planning for changes within our health delivery systems during a disaster. The Oklahoma Nurses Association has been represented on that state committee since the group first came together in 2005. This committee has examined a wealth of literature about health care delivery in a disaster and networked with other state committees to share progress and developments.

Recently the ASC committee proposed to the CHE Task Force adopting guidelines developed in Minnesota entitled Patient Care Strategies for Scarce Resource Situations. In January, the Oklahoma Catastrophic Health Emergency Task Force voted to continue to pursue the functionality of the guidelines offered in Patient Care Strategies for Scarce Resource Situations in Oklahoma. The purpose is to provide clinical guidelines for systems so that they may plan, prepare and respond to a scarce resource environment. The guidelines are intended to be a part of each healthcare facility’s adaptable multi-tiered emergency response plan. A copy of the guidelines can be found on the Oklahoma Nurses Association website: www.oklahomanurses.org.

The guidelines delineate a planning framework for health care facilities to use when faced with scarce resources for the following seven resources: oxygen, medication administration, hemodynamic support and IV fluids, mechanical ventilation, nutrition and staffing. Part of the appeal of the document is the variety of common sense strategies that are suggested for each of the resources. For instance, mechanical ventilation is a resource that many emergency/pandemic planning teams have examined. New York State developed an Allocation of Ventilators in an Influenza Pandemic Planning Document which resulted in a great deal of discussion and controversy. The Patient Care Strategies for Scarce Resource Situations guidelines recommend several strategies for planning for the potential shortage of mechanical ventilators during a catastrophic health emergency:

- **PREPARE** Increase hospital stocks of ventilators and ventilator circuits
- **SUBSTITUTE** Access alternative sources for ventilators
- **ADAPT** Use alternative respiratory support technologies
- **CONSERVE** Decrease demand for ventilators
- **RE-USE** Sterilize ventilator circuits after cleaning
- **RE-ALLOCATE** Assign limited ventilators to patients most likely to benefit if no other options are available. Facilities should not re-allocate ventilators unless this is a state and regionally agreed-upon necessity in an overwhelming situation without potential to receive needed resources or evacuate patients to areas with necessary resources.

A multi-strategy approach allows for adapting standards of care without implementing an all or nothing approach to disaster standards. The ASC committee believes that in order to ensure ethical and equitable decision making, as well as fair and consistent delivery of healthcare, during a catastrophic health emergency, Oklahoma has an obligation to the clinical practitioner, the healthcare community and the public to plan and develop guidelines for adapting standards of care during a disaster. The ASC committee continues to strive for enhanced liability protection for healthcare workers responding in a disaster that result in a scarce resource environment. Nurse leaders will have an important role in educating nurses, other healthcare professionals and the public about strategies to cope with resource constrained environments.

ONA is interested in your opinions and ideas about this the Patient Care Strategies for Scarce Resource Situations guidelines. We would also like to hear your thoughts on how to share this document with health care professionals across the state. www.oklahomanurses.org

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

Submissions must be made online using the submission form and must include:
• Point of Contact, Title, and Abstract, Author(s), credentials, and prior experience
• Note: Authors may submit multiple proposals.
• Deadline: June 30, 2010: This will be a competitive selection process

If your proposal is accepted
• You will be notified no later than August 3, 2010, and
• Asked to present on Thursday, October 28, 2010, at the Convention Center in Tulsa, Oklahoma.
• You will be required to complete and sign CNE credentialing forms, which are available online, before August 31, 2010. Failure to do so may cancel the offer to present.
• Concurrent Session will be approximately 50 minutes in length, with 30-50 attendees.
• Electronics versions of all handouts need to be submitted to the ONA office before October 1, 2010.
• You are required to staff your poster ONLY during the afternoon networking break.
• Suggested maximum size of posters: 36” by 48”

Compensation:
• Keynote Presenters will receive one complimentary registration
• Concurrent Presenters: receive up to a 50% discount on two Convention registrations.
• Poster Presenters receive up to a 25% discount on two Convention registrations.

Exhibitor Invitation to the 2010 ONA Convention
Nurses Set the Pace for a Healthier Oklahoma: Strategies for Action
October 27-28, 2010 at the Convention Center in Tulsa, OK

Full Booth (approximately 8’ wide by 10’ deep)

Booth Prices:
• Prior to August 27, 2010 $845.00
• Prior to September 30, 2010 $950.00
• After September 30, 2010 $950.00

Exhibit Information:
• Tulsa Convention Center, Tulsa, Oklahoma
• Move in times:
  Wednesday, 5:00 p.m.-7:00 p.m.;
  Thursday 7:00 a.m.-9:00 a.m.

Exhibit Hours
• Thursday 9:00 a.m.-4:30 p.m.

Rental Fee Includes:
• Back drape & booth dividers
• 1 Skirted table, electricity available ($15 extra)
• 2 Folding chairs
• 1 Vendor Identification sign with booth number
• Vendor packet
• 1 Lunch Ticket per booth, additional lunches available @ $10
• Other items and amenities available for additional fees

Table Top (no backing, no floor-model pop-ups, no electricity available, lunch not included)

Table Top Prices:
• Prior to August 27, 2010 $825.00
• Prior to September 30, 2010 $880.00
• After September 30, 2010 $880.00

Exhibit Information:
• Tulsa Convention Center, Tulsa, Oklahoma
• Move in times:
  Wednesday, 4:00 p.m.-7:00 p.m.;
  Thursday 7:00 a.m.-9:00 a.m.

Exhibit Hours
• Thursday 9:00 a.m.-4:30 p.m.

Rental Fee Includes:
• 1 Skirted table
• 1 Folding chair
• 1 Vendor Identification sign with booth number
• Vendor packet

$50 coupons for exhibitors that have exhibited with us before

PLEASE NOTE THE FOLLOWING: ONA reserves the right to change these approximate values. Some Convention Sponsorship levels include an exhibit booth and/or discounts to be applied toward the fee. Loyalty Discounts will be given to returning vendors ($50 Off). Reservations may be made online. For more information visit the website, or call (405) 840-3476.

Visit the website
www.oklahomanurses.org
2010 ONA Convention
Nurses Set the Pace for a Healthier Oklahoma: Strategies for Action
October 27-28, 2010 at the Convention Center in Tulsa, Oklahoma

Tentative Convention Schedule

**Wednesday Afternoon**
- Exhibit Hall Set-Up
- House of Delegates
- Convention Registration
- Afternoon Educational Session
  - EVENTS:
    - Oklahoma Nurses Foundation
    - Oklahoma League of Nursing
    - OU Alumni

**Thursday**
- Registration
- Town Hall Breakfast
- Keynote Presentation
- Four Concurrent Sessions
  - Luncheon & Awards
    - Networking Breaks
    - Exhibit Hall
    - Poster Presentations
    - Rush Hour Reception

**Concurrent Session Tracks**
- Administrators/Managers
- Burnout/Life Balance
- Clinical (Practice or Process)
- Educators
- Staff Nurses
- Students

(Hint: To meet the poster presenters visit the poster area during the afternoon break.)

*Luncheon is included with registration fees

For more information visit the website at www.OklahomaNurses.org or call (405) 840-3476.

**Special Events**
House of Delegates, Wednesday, October 27, 2010

Featuring a special welcoming address!
**This is why we call it a Convention:** Using the Momentum of the last 100 years to build the future. ONA’s convention has been the designated annual meeting when regional nursing leaders “convene” in one place to determine the priorities of the organization. Please join us and strengthen the direction of the Oklahoma Nurses Association. Whether you are an observer or Delegate, please plan on attending!

**Rush Hour Reception: Thursday After Session**
Let the traffic tough things out on its own, and join us for a fun reception at the end of the day. In fact, the Convention Committee claims that it is worth staying over Thursday night for all the excitement! Make a night of it!

Local Celebrities
- 50/50 Cash Rally for the ONA-PAC
- Great Give-Aways and Raffles
- And more fun with your fellow nurses than you can imagine!

**It's time you had a night out!**

**Town Hall Breakfast**
Please join us for breakfast and a newly formatted forum on hot topics in the nursing profession!

**Awards Luncheon, Thursday**
This $35 value is included in the price of your registration!
Please Join us as we celebrate some of our most accomplished members.
INTRODUCTION

Outpatient nurses at Jack C. Montgomery VA Medical Center, Muskogee, OK, created a screening tool for Fall Risk in Outpatient Clinics and Home Based Primary Care. The authors created an Evidence-Based Research electronic tool that meets JACHO and VA requirements and includes the provider (Physician, Nurse Practitioner, Physician Assistant) in follow up. The VA population is male and female community-dwelling adults aged 20 to 90+. The VA system is completely computerized, so the main task was to make the tool user-friendly and integrate research and technology into a Research-Based Screen.

The Tool

The tool, the Fall Risk Screen-Outpatient, was developed, tested and implemented at Jack C. Montgomery VA Medical Center. The goal is to improve veteran safety with fall and catastrophic injury prevention. The method comprised teaching nurses to report fall and balance problems electronically with screens and reminders that include the Modified Get Up and Go Test. This Test reports single and recurrent falls; circumstances of the fall; if the patient was injured and needed to seek medical care after the fall; and if the patient would benefit from assistive devices. This electronic tool is efficient, user-friendly, research-based and involves minimal expense. The information obtained goes immediately electronically to the provider for any changes in treatment.

The Fall Risk Screen-Outpatient tool also includes patient/family educational information, a handout from the NCPS (National Center for Patient Safety). The process is based on Evidence-Based Research and can be divided into a three part algorithm:

1) education, (nurse),
2) gait/balance assessment (provider).
3) research-based management (provider).

The education handout chosen, ‘Fall Prevention at Home,’ from the National Center for Patient Safety Falls Toolkit is pleasant, easy-to-read and understandable and is available as a paper copy or computer link.

The gait/balance assessment tool is the 10 Foot Get Up and Go Test! (modified). The clinic nurses observe the patient get up out of their waiting room chair and walk into the clinic. Any abnormal gait, strength or balance or if the patient is in a wheelchair is an Abnormal Get Up and Go Test.

The Get up and Go Test (modified) is defined as follows:

Patients sit in a straight-backed waiting room chair, the nurse observe him/her:
1) Get up (without use of arm rests, if possible)
2) Stand momentarily
3) Walk into clinic
4) Sit down in clinic chair

The nurse inquires about falls, marks the appropriate box in the screen as ‘single’ or ‘recurrent’ falls, comments on recent fall circumstances, patient injury, and treatment for injury in a free text box. The screen also has nursing screen check boxes (per patient report). The nurse checks one or more of the following boxes:
1) assistive devices needed
2) difficulty walking when first gets up
3) medications possibly related to fall
4) recent vision changes
5) shortness of breath on exertion
6) dizziness

The research tool chosen was Preventing Falls in Older Adults by Dr. Laurence Rubenstein (with permission). The provider uses Evidence Based Guideline for Fall Prevention and Assessment and Management of Falls’ based upon Rubenstein research. Management of falls includes history, medication, vision, gait/balance, lower limb joint, neurological and cardiovascular factors. The provider has an electronic plan/action comment box in the screen for medication review/adjustment, environmental modifications/suggestions. They can electronically enter ancillary service consults, gait/balance training, exercise, and/or assistive devices.

RESULTS

The screen has been shared with other Department of Veterans Affairs Medical Facilities. The tool exceeds JCAHO Safety Goal #9, reduce the risk of patient harm resulting from falls. It meets the VA EPRP (External Peer Review Program) ACOVE Measures Basic Fall Evaluation (Assessing Care Of Vulnerable Elders, 75+). The Screen includes health factors that electronically enable data tracking from the VA’s Data Warehouse.

CONCLUSION

The focus of the tool, the Fall Risk Screen-Outpatient, is fall prevention with education, gait training and interventions including available assistive devices. Fall prevention and well-being promotion requires observing patients walk, asking if they have fallen, and taking appropriate action. The people that can be helped the most with use of this Tool are those that have not yet started to fall.

For more information please contact suellen.meador@va.gov or the hyperlink below.

Primary Care Nurses Systematically Assess Fall Risk, Provide Real-Time, Easy-to-Use Alerts to Physicians to Facilitate Appropriate Interventions for Those at Risk.
Saint Francis Hospital, part of the Saint Francis Health System ~ Finding Its NICHE

ONA Convention Platinum Sponsor
Tyleen Smith, BSN, RN, Clinical Manager

We hear it on the news and in the papers that healthcare is not ready for the baby boomers aging needs. Some predict that by 2020, 1 in 6 Oklahomans will be 65 and older with that group doubling by 2030. Only a few hospitals in Oklahoma are prepared for the geriatric tsunami that is about to hit. It is widely known that currently 60% of hospitalized patients are 65 or older with that percentage only increasing in the coming years. We also know that nurses are the ones caring for this large geriatric population. So then the question...how do we prepare the nurses?

At Saint Francis Hospital in Tulsa “NICHE” is the new buzzword. Nursing Improving the Care of Health system Elders is a program of the Hartford Institute for Geriatric Nursing at New York University College of Nursing. The goal of NICHE is to achieve systematic nursing change that will benefit hospitalized older patients. The vision of NICHE is for all patients 65 and over to be given sensitive and exemplary care. The mission of NICHE is to import principles and tools to stimulate a change in the culture of healthcare facilities to achieve patient-centered care for older adults. The focus of NICHE is on programs and protocols that are dominantly under the control of nursing practice; in other words, areas where nursing interventions have a positive impact on patient care.

Saint Francis joined NICHE in 2006 with the first Acute Care Elderly unit (ACE) in the state. This 36 bed unit is dedicated to patients 65 and older with acute medical needs. Saint Francis has improved geriatric outcomes on the ACE unit, largely due to geriatric nursing education, daily patient care rounds, nursing protocols and hourly rounding. Outcomes such as a reduction in falls by 56%, a decrease in restraint rate by 42%, a decrease of 63% for pressure ulcer prevalence and no catheter associated urinary tract infections for a year.

Saint Francis is now infusing NICHE into all adult inpatient nursing units with Geriatric Resource Nurses (another NICHE model), a NICHE page on the Saint Francis nursing website, and taking NICHE based protocols housewide—with the goal of making sure that every nurse has the tools and resources to take care of geriatric patients. The most recent tools are a poster series called the NICHE TOP 10 for dealing with patients with delirium or confusion and a Patient Activity Cart on every adult inpatient unit. These Patient Activity Carts, made from recycled Slinkys and baby dolls to help nurses deal with confused or delirious patients. Saint Francis has been selected twice to present their geriatric best practices at the national NICHE conference, the most recent being for the Patient Activity Carts.

NICHE not only benefits the patients but it also has a large benefit to the hospital. With decreased length of stay and improved nursing satisfaction and a decrease in nursing turnover, NICHE is a win for everyone.

Saint Francis has found its NICHE and is ready for the aging baby boomers. Has your organization found theirs?
Faith Community Nursing Basic Preparation Course Planned

Mary Diane Steltenkamp
ONA Member, Region 1

Faith Community Nursing is recognized as a specialty practice for registered nurses combining professional nursing and health ministry. Faith Community Nursing is often called "parish nurses," "congregational faith nurses," or "church nurses," and emphasizes health and healing within a faith community.

This is an independent nursing practice which does not involve "hands-on" health care. Instead the nurse performs roles of educator, referral agent, advocate, personal health counselor, developer of support groups, coordinator of volunteers, and integrator of faith and health. The nurse performs all duties with a special emphasis on the intentional care of the spirit. The spiritual aspect is key to this nursing. The Faith Community Nurses Association of Oklahoma (FCN/AOK) is an organizational affiliate with ONA.

The Basic Preparation Course for Faith Community Nursing has been offered in the State of Oklahoma since 1999 and has had over 170 nurses completing the program. The next course is scheduled the weekends of September 30, October 1 and 2 and October 14-16, 2010. The weekend course will be held at Our Lady of the Lake Lodge in Guthrie, Oklahoma. Participants must attend both weekends. The course, revised in 2009, includes local faith community nurses and community leaders with expertise in theology, ethics, counseling, community resources and education. This program is approved for 34 contact hours by the Kansas State Board of Nursing.

The course is open to registered nurses of all faith traditions. Registration is limited to 15 persons. Cost is $675 which includes tuition, materials, CEUs, meals, lodging and first-year membership with FCN/AOK. Registration closes September 25, 2010. For more information contact Mary Diane Steltenkamp, Director of Faith Community Nursing at Catholic Charities, 405-523-3000, or e-mail mssteltenkamp@catholiccharitiesok.org.

June, July, August 2010

Is There a Role for ‘Wisdom Workers’ in Professional Nursing?

Patti Muller-Smith, RN, EdD
ONA Member, Region 2

Among the huge cohort of baby boomers nearing retirement age, there are many registered nurses. Many of these retired or soon to be retired nurses are practitioners, educators, and managers who will take with them an enormous reservoir of information, skill and knowledge. They are experts in both the art and science of professional nursing. They have reached a stage in their lives where they recognize that they are no longer able or chosen to not work in the physically demanding or emotionally draining roles that exist in most health care work settings. Many are in search of a greater work-life balance than existing roles can offer. Although the choice to separate from the nursing profession is a viable option for large numbers of nurses, there are still those who find themselves searching for a way to remain active and involved in their chosen vocation.

In the past, mature individuals in their 60s or older were truly unable to continue in the work force. Today, however, with the tremendous advances in our society, there is strong data to support that rather than viewing 60 as the beginning of a declining quality of life, it may really be just the beginning of the most transformative and generative time in our life cycle. Life expectancy is at an all time high and living well and active for 10, 20, or 30 years post retirement is not an unrealistic expectation.

In the Twentieth Century, there was an obsession with all things young. For the first time, adolescence was identified as a distinct developmental period between childhood and adulthood. It was a time of enormous change both physically and emotionally. It was marked by drama and strained relationships between parents and teens. To some extent this has carried over into the twenty first century and has remained in our approach to many life and professional challenges. As the baby boomers age, we are facing the task of identifying those mature individuals who are neither young nor old, who want to embrace new challenges and are still searching for greater meaning in life. They bring with them wealth, resources, social capital and a sense of authority. These are in fact, the ‘wisdom workers’ of this century. Rather than seeing this mature adult over 60 as a state of decline, losing both physical and mental capacity leading to dependency, they see themselves as healthy, vibrant, wise, creative and independent! The boomers are moving into the third phase of their life cycle and still have much to contribute to society and professional nursing.

If we apply this change in thinking to our mature nurse, and look at them as merely moving into the next phase of their professional practice career, the question becomes: How can professional nursing capture this valuable resource pool and use them to address some of the problems that have long plagued our work settings? Nursing literature has constantly addressed the issue of retention and turnover of the young, newly licensed nurse. Proposed solutions have been offered time and time again and yet the statistics continue to range anywhere from 20 to 60% turnover in the first 12 to 14 months in most work settings. Involved in these statistics are issues of competency and creating a positive work setting where there is sufficient support systems to make the transition from student to practitioner and creating a culture that is professionally satisfying and provides for continued growth and personal well-being. Preceptors, mentors and on unit clinical instructors have all been used to reduce the very costly rates of turnover, but the statistics have not changed. Retention continues to be a major issue and nurses leave because of the discord that exists in the workplace. Nurse managers are plagued with the management of relationship problems of the staff that are time consuming and emotionally draining. Managers are charged with creating a positive work culture in addition to their many other tasks. They are responsible for the clinical competency of the staff, the quality of patient care, the financial aspects of managing a unit, and solving both physician and patient/family problems.

Rather then continuing to rename and use proposed solutions that have had limited success in the past, would it not make sense to look at a new and different role that doesn’t draw from the existing pool of practitioners but draws from the pool of mature nurses who are still committed to their profession and have much to offer in the way of experience, skill in maintaining the caring aspects of nursing?

This role would be one where responsibility for the orientation, on going competency, providing support to the staff, and maintaining a collaborative work environment is their primary job. The mature nurse comes equipped to fill this role and would need minimal orientation. They are clinically skilled with development expertise, are committed to advancing the profession; and want to see patients receive the best quality care possible. They are neither practitioner, nor manager. They serve as a resource to both. They may, for lack of a better term, be seen as the ‘unit culture specialist’. They work with newly licensed nurses to develop competence and confidence. They intervene in staff disputes and solving some of the day-to-day physician and patient/ family problems. Their role is to create the positive work environment where positive patient outcomes is the norm and individual practitioners find work rewarding and satisfying. Managers can manage; practitioners can practice; and patients have a caring advocate. In many ways this role, well suited to the mature nurse, provides the link between the science and art of nursing.

This may seem like a simplistic solution to a problem that has long plagued nursing practice and there is always the question of cost. The mature nurse in this role might well be the cost efficient way to solve the problem. Reduce turnover by 10% and you have covered salary costs. If they are of medicare age, they don’t require health benefits. Creating this new role may be a win-win for all concerned. Mature nurses can continue to contribute, staff has a support system to rely on, unit culture built on caring collaboration and competence is maintained and patients have the benefit of caring quality outcomes.

Something to consider!!!!
How is CTE an Investment in Your Future?

A Response by Deanna M. Prufert

“Investing” alludes to images of the continuously rolling stock market ticker or the latest online trading company commercial featuring a random “Law & Order” star. While a successful stock market venture could certainly enhance one’s future, the risk of losing everything is always looming nearby. Broadly defined, to invest is “to expend for future benefits or advantages” (“Invest” def. 2). When making an investment in the future, there is only one option that comes to mind which defies risk, commands respect, and ensures enrichment. This is education. An investment in education requires an expenditure of time, development of organizational skills, and hard work. Investment in an education is guaranteed to enhance knowledge, skills, employability, lifetime earning potential, and quality of life. To actively seek out education is, inherently, an investment in the future.

Career and Technical Education (CTE) is based on preparing students to enter a competitive workforce through education that provides a solid knowledge base, practical skill training, and the adaptability to survive and thrive. At Moore Norman Technology Center, I am preparing for a career in nursing as a student in the Evening Licensed Practical Nursing (LPN) Program. An LPN is a technical nurse, “who is technique-oriented, deals with commonly recurring nursing problems, and knows standardized procedures and medically delegated techniques” (“Nurse” def. 1). This professional definition is an excellent description of what is included in my program of study.

The individualized instruction of my program is organized by learning contracts that detail the blend of textbook reading, interactive software, educational media, and learning activity packets. The hands-on training begins in the school laboratory and extends into the community at local hospitals. Our Health Occupations Students Association (HOSA) also serves to fortify my expertise, with training and preparation for job readiness competitive events. The opportunity to serve as HOSA President has offered a unique perspective into the leadership roles of nursing. Without the personalized study planning of a CTE program, I would not have been able to seek out education as a returning adult student. The self-paced orientation of the program demands responsibility and a sense of accountability that is unrivaled by lecture based educational programs. I have to study, read, perform skills, and write about my progress, or I will fail. The camaraderie of small classes and professional instructors only strengthens my desire to do well, for I want us all to succeed as a team. My success in this program will lead to steadfast employability skills in nursing.

While many college graduates are searching for placement in today’s job market, the majority of nurses are able to find work. Our society is “in the midst of a nursing shortage that is expected to intensify as baby boomers age and the need for health care grows” (Rosseter). The aging population will need care, and I, as a Licensed Practical Nurse, plan to be there to help fill the need. Empowered by an education that forced me to take control of my own learning, I will be a critically thinking, confident, well educated member of the nursing profession. The variety of practical skill application opportunities and individualized instruction provided by a CTE program has provided a well rounded education in nursing. This education has provided me with the confidence that I need to become an active member of the workforce in a job that I love. CTE has defined my future as a nurse.

Works Cited


I would likely never forget the moment I saw the tragic images roll across the television screen. My husband and I were vacationing in Cozumel, Mexico, on the evening of January 12, 2010. As he flipped through the channels in our room, he paused when he came to CNN, and I heard the words “7.0-magnitude quake hit Haiti earlier this afternoon... serious loss of life expected” (Watson, 2010). As we watched news coverage of the damage, I was stunned by the pictures. I had read and heard stories about the poverty and sickness that already afflicted the country of Haiti, the poorest country in the Western Hemisphere. A desire to help Haiti arose from within me. I knew there would be many who gave money or sent supplies to the Haitian people, but I realized then that I was not going to be one who gave from back home. I did not know when, or how, but I knew I would be going to Haiti.

I am a registered nurse by profession. I received my ADN from OSU-Oklahoma City in December 2008, and have spent most of my career working in Intensive Care. There is something about caring for the sickest of the sick that first attracted me to ICU, and this also attracted me to Haiti. On March 17, our group of 25 boarded a flight to Port-au-Prince. We were a mixed bag of mostly male construction workers and pastors. The medical personnel included me and one other RN from Oklahoma with over 20 years nursing experience, my husband who is a first responder, and another EMT. Our small medical team had planned on partnering with a larger medical organization when we arrived in Haiti. We were unsure of the accommodations we would find when we arrived there, but were told there were plenty of medical supplies already in country due to the disaster response from around the world. We brought a first-aid kit for our group with wound care supplies and a few bottles of over-the-counter analgesics and vitamins.

My personal preparations for the trip included brushing up on my first-aid skills, packing Lippincott’s Nursing Drug Guide in my carry-on, and practicing the few words I know in French, hoping they were similar in Haitian Creole. During the two months between the quake and the day we left for Haiti, my imagination had created many ideas of what Haiti would look like, feel like, and smell like. My expectations of Haiti could be best summed up in one word—ugly. I had read about outbreaks of cholera in Haiti. I imagined ugly, desolate landscape, ugly streets filled with rubble, ugly smells of dirt and death, ugly, filthy water to drink, and frail bodies riddled with ugly wounds and diseases.

My first impression of Haiti was true to my expectations. We circled the airport for about 45 minutes before landing. I saw recent cities and piles of rubble from destroyed buildings. After landing, we were re-routed to a warehouse which had been converted to a hospital. When we left the warehouse, because the original one was damaged in the earthquake. It was hot and
dimly lit in this building. After claiming our baggage and going through Haitian customs, we walked through a gauntlet of 300 or more Haitians shouting in Creole, trying to wrestle our bags from us, and pulling at our clothes, begging for money. Once outside, we boarded the bus which would take us to the Nazarene Seminary, Eglise du Nazaréen, in Petionville—our home for part of the week. I smelled a smell on our ride to Petionville which could best be described as burnt plastic. We learned it was the smell of Haitians making charcoal, their cash crop. We nurses found out later that night that we would not be going with the large medical group as we had been told, but would be hosting our own clinic. Since we had so few medical supplies with us, we were able to get some more supplies and medicine from a physician’s assistant on campus. Our clinic was scheduled for Saturday, and we were told to expect the entire community to show up.

Our first full day in Haiti was spent riding in a truck from Port-au-Prince in southwestern Haiti to Desroulins, a rural community in the mountains near the northern coast, where our construction team would build a church and we would have a clinic. We left before sunup to avoid the morning “rush hour” of Port-au-Prince traffic. As we traveled further away from Port-au-Prince, we saw less damage from the earthquake and more of everyday Haitian life. I was taken aback by the beauty I saw there. Strong, sun-tanned bodies labored in fields and rice paddies. Chattering children walked to school, and women balanced goods on their heads to carry to market. Banana and palm trees dotted the countryside, and mountains rose up from the sea in every direction.

We arrived in Desroulins around 2:00 p.m. on Thursday, March 18. Our construction team went to work right away and was joined by Haitian men and women who worked alongside us for the week. I was humbled by how hardworking these people are. Nothing comes easily in Haiti. Most of the people we encountered in the mountains live in thatched-roof huts with dirt floors. They have no electricity, and they walk many miles to the river to get water. Children are taught in one-room schools with no schoolhouses without windows or doors. When the sun sets, the people walk through the hills with no light—no flashlights to light their path. The people of Haiti are quiet and strong, gentle and proud.

We were awakened early on Saturday morning by roosters crowing and donkeys braying. There were 50 or more Haitians waiting outside of our “clinic” at dawn—a thatched-roof hut with a dirt floor. We had hung tarps to create partitions to divide the clinic into rooms—one for our supplies, one for the waiting room, and one for seeing the doctor. We had a large case of medicines and another of supplies. One of the men on our construction team had been an RN in the U.S., while roofing. He was near the nearest town, where there was a Haitian doctor who stitched his lacerations. She had heard that we were going to have a clinic on Saturday, and had come to join us. We were so blessed by this and she was truly a godsend.

All of our patients had walked miles down dusty roads, some as many as seven miles to come to our clinic. As we started to triage by the door, we were greeted by a patient who had been taken into a patient’s room, although unused, would never go to waste in Haiti. The Haitians improvise and make due with what they have.

I hope someday to be able to go back to Haiti and provide nursing care in their communities. My experiences in Haiti have made me want to know more, and to be more prepared and competent the next time that I go. I graduated from Oklahoma Panhandle State University. I am not certain yet of my next step, but I plan on applying to either an ARNP or CRNA program. I want to increase my nursing knowledge and skills and use them to help those in need, both in the U.S. and in disaster-stricken lands such as Haiti.

References
The ABC’s for Eliminating Clostridium Difficile

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Background: Clostridium difficile is a pervasive bacteria with new virulence that has ravaged our patients and our healthcare institutions. Clostridium difficile is a gram-positive, spore-forming bacillus. It can cause a host of Clostridium difficile associated diseases (CDAD) such as diarrhea, colitis, pseudomembranous colitis, and toxic mega colon which can lead to sepsis and potentially death. This infection is unique in that it is not an impact health care with an additional 3.2 billion dollars annually (Health Facilities Management, 2008). CDI usually stays for patient an average by 2.6-4.5 days in the hospital and increase each individual episode of care 82500-83500 dollars. More alarming is the mortality rate increase after a CDI incident. At thirty days the patient has a known mortality rate increase of 2.6-4.5 days in the hospital and increase annually (Health Facilities Management, 2008). Pseudomembranous colitis, and toxic megacolon associated diseases (CDAD) such as diarrhea, colitis, pseudomembranous colitis, and toxic mega colon which can lead to sepsis and potentially death. Fecal management systems (FMS) contain infectious diarrhea and provide relief to patients from constantly needing stool. C–Clean Hands and Clean Environment. The use of soap and water is critical to prevent CDI transmission. Alcohol based hand washing with soap and water will remove the bacterial surface from the hands. A sodium hypochlorite (bleach) solution of 10% is recommended for any surface in which the patient may come in contact. Clean the surface well, noting that disinfectants require 10 minutes kill time. Then let the surfaces air dry. Surfaces that are wiped dry generally have not the disinfectant in place long enough kill bacteria. As noted with hand hygiene, alcohol based products for cleaning in patients with CDI rooms are not appropriate. Testing for Clostridium Difficile: Loose or watery stools should be submitted in a clean, leak proof container. Specimens should be transported to the laboratory as soon as possible and be refrigerated until testing. Stage at room temperature could possibly lead to toxin deactivation which could lead to a false negative result (APIC, 2008). Most laboratories only accept one specimen per day because studies have shown that more than one stool per day will yield the same result. Likewise, most pathogens in the stool are shed intermittently, and therefore, a negative result should be verified by retesting.

Testing for Clostridium Difficile

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Conclusion: While community-acquired CDI is possible, we must concentrate our efforts to prevent the spread of Clostridium difficile in healthcare facilities. Utilizing the ABC’s, nurses should advocate for antibiotic stewardship, early barrier protection, and clean hands/clean environment. Antibiotic stewardship is important to prevent the elimination of the patient’s intestinal flora, reducing the likelihood of a Clostridium difficile infection (APIC, 2008). Hand washing, with soap and water, with each contact with a Clostridium difficile patient before leaving the room prevents the bacteria and the spores from leaving the patient’s room. Concentration on the proper antibiotic, proper treatment, proper dose, and the proper duration will lead to a more harmonious healthcare environment with increased patient satisfaction and decreased healthcare cost.

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Bobulsky, GS, Al-Nassir, W, Rigs, MM; Sethi, AK. Donkey CJ (February 2008). Clostridium difficile skin contamination in patients with C. difficile-associated disease. Research Service, Louis Stokes Cleveland Veterans Affairs Medical Center, 10701 East Blvd, Cleveland, OH 44106, USA. Clin Infect Dis. 2008 Feb 14;46(3):447-50. Since CDI is a toxin mediated disease, most of the diagnostic tests involve detection of the toxin. Enzyme immunoassays (EIA) for toxin A and/or B are the most widely used. These tests are more cost-effective. They have a quick turnaround time, yielding results the same day if the specimen arrives to the lab in time, and with test results the next day in most cases. However EIA assay are not recommended for testing the stools of patients less than one year of age, because the testing lacks specificity for that age group. Cell cytotoxicity assays are more sensitive than EIA test, and the results are ready in a shorter time frame. However, the test requires the maintenance of live cells for testing, is more costly, and tests require more skill and expertise (APIC, 2008). It is also possible to culture the stool specimen for Clostridium difficile, but a culture requires 72 hours, with absolutely no chance for a faster result. However, the bacterial culture may be the most accurate method for the detection of the B1/NAP1/027 strain (APIC, 2008). Hand washing, with soap and water, with each contact with a Clostridium difficile patient before leaving the room prevents the bacteria and the spores from leaving the patient’s room. Concentration on the proper antibiotic, proper treatment, proper dose, and the proper duration will lead to a more harmonious healthcare environment with increased patient satisfaction and decreased healthcare cost.


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It is difficult to pick up a health-care or nursing journal today without seeing an article chastising healthcare teams for their lack of teamwork. There are many teambuilding models available addressing teambuilding principles and competencies. This article concisely presents an overview of two prominent models, the PUCK model (Blanchard, 2001) and Lencioni’s Functional Team model (Lencioni, 2002). Both of these models are presented as fables in short, informative and enjoyable books. The PUCK model is summarized first followed by Lencioni’s model.

Ken Blanchard and colleagues (2001) write about a man who, after being fired from his job for not being a team player, learns the skills of team building and team participation by coaching his son’s hockey team. The acronym PUCK is used to illustrate how repeated reward and recognition focused on aligned behavior is the key to forming successful teams. The PUCK model, discussed below, stands for providing, unleashing, creating and keeping.

P = Providing: Clear Purpose and Values—A Compelling Reason for Being
- Create a challenge, a reason for being, and a “holy grail” that commits and motivates people to work together.
- Set clear and compelling goals and strategies, both for the individual and the team.
- Be clear about your values.
- Create a team charter that formalizes commitments to each other and clearly states what the team wants to accomplish, why it is important, and how the team will work together to achieve results.

U = Unleashing: Developing Skills—Developing Your Bench Strength
- Start with the basics: Build individual skills that will bolster team skills.
- Provide feedback to build skills, confidence, and accountability.
- Learn each other’s roles.
- Build a sense of personal and collective power by using self- and collective skills to achieve extraordinary results.

C = Creating: Team Power—None of us is as smart as all of us
- Build a game plan for the team and stick to it.
- Share leadership.
- Reward team work.
- Rotate positions to build flexibility, introduce change, and build mental and physical skills.
- Turn individual skills into team skills.

K = Keeping: The account on the Positive—Repeated Reward and Recognition
- Look for behaviors that reflect the team’s purpose and values and reward, reward, reward!
- Catch people doing things right or approximately right.
- Redirect toward the goal: do not punish.
- Link all recognition and reward back to the purpose and goals (Blanchard, 2001, p. 189-190).

This model can be used by the nurse leader in staff interactions. The “P” clear purpose and value, means that nurse leaders must set clear and achievable goals for self and staff. The “U” represents the skill sets nurse leaders must utilize to create healthy teams. Strong skills will create confidence and strengthen the patient care team. Team power, “C” is acquired by creating a clear, purpose-driven patient-care team. The “K” keeping a positive account represents the responsibility to reward behaviors that reflect the team’s purpose and value. Such rewards aim at achieving positive patient outcomes and effective team work. As this example shows, the PUCK model can be easily applied in nursing. As a Nurse Leader utilizes this model, the results will be effective teambuilding and better patient care.

Lencioni (2002)’s Five Dysfunctions of a Team is a leadership fable about a technology company struggling to attract and keep customers. The new CEO recognized the company’s innovative products and great talent was negated because the executives were not a team: They were struggling but unable to agree on an appropriate solution to their problems. The team eroded into naming, blaming and shaming. No one was accepting responsibility nor making important decisions. Deadlines were being missed, morale was declining, and the company was losing the battle for market share.

Lencioni (2002) illustrates team dynamics and team work by showing what teamwork is not, termed the five dysfunctions of a team. Then he provides a clear picture of how a healthy team interacts and what it feels like to be part of a successful team. To achieve this goal requires that leaders address the team’s dysfunctions head on: Ambiguity is the enemy of results. The five dysfunctions are discussed below accompanied by strategies to move dysfunctional teams to healthy teams (Lencioni, 2002).

1) Absence of Trust—Team members must:
- Open up to each other.
- Openly share their apprehension.
- Overcome the need for invulnerability.

2) Fear of Conflict—Failure to productively address disagreements.
- Leads to preservation of a sense of artificial harmony.
- Results in the ability to accept some conflict, acknowledging that one no gets use to conflict.

3) Lack of Commitment—Arises from failure to fear all the teams concerns before making a decision:
- Is evidenced by ambiguity.
- Thus, if people don’t feel like they’ve been listened to, they won’t really get on board (committed).

4) Availance of Accountability—All team members are not on the same page results in:
- Organizational leaders won’t hold each other accountable because they want to avoid interpersonal discomfort.
- Lowered standards.

Lencioni (2002) points out that some employees are hard to hold accountable. They may appear to be helpful or become very defensive and intimidating. These team members must be pushed respectfully for the team to become a functional team. When team members are not held accountable to the team’s interests and goals, the tendency is to look out for their own interests. This is the ultimate dysfunction: The tendency of team members is to seek out individual recognition and attention at expense of team results.

5) Inattention to Results—To focus team members on building a functional team, it is essential that:
- Leaders and team members make the collective ego greater than individual egos.
- Leaders don’t leave any room for interpretation when it comes to defining results.
- Expected results must be stated simply and specific enough to be actionable.
- Team performance must be measured regularly so the team can react more quickly on needed changes.
- The focus must be on creating the best team possible, not shepherding careers of individual athletes.
- Goals are reviewed regularly and addressed quickly when needed.
- Resources are re-directed as indicated to achieve results.

Lencioni (2002) asserts that addressing these five dysfunctions results in cohesive teams that trust one another; address conflict; commit to decisions and plans; hold one another accountable; and focus on the achievement of collective goals.

In nursing, the dysfunctions identified by Lencioni can adversely affect a nursing team. The absence of trust occurs when nurses do not address concerns with physician or co-workers. Lack of commitment may occur when a lack of direction and commitment to patient care results in nurses’ lack joy in their work. The fourth dysfunction, avoidance of accountability, is seen when the nurse leader does not give staff clear sets of expectations. In these cases, staff may choose silence rather than confront behaviors not conducive to teambuilding. The fifth dysfunction, inattention to results, is known in nursing as “eating their young.” They put their own personal needs and egos ahead of their colleagues; ultimately the team and patient care suffers. Nurse leaders must quickly address these dysfunctions and redirect team member behaviors to achieve positive actions and outcomes.

Research has shown that positive teamwork results in collaboration, improved problem-solving and communication, increased morale, and, ultimately, improved patient care outcomes. The key to teambuilding is creating a framework with clear expectations and open communication. As nurse leaders, we must develop and encourage others to apply team-building strategies that can improve teamwork and patient care.

**References**


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Cultures of candor have acquired new implications in today’s health care environment; thus, candor is a central, urgent issue for Nurse Leaders. This article presents selected thoughts from Bennis and colleagues’ book Transparency (2008).

Essential Elements of cultures of candor:

Candor is an interpersonal process that promotes the authentic expression of different points of view in search of actionable wisdom. A culture of candor exists when there is a free flow of information and critical information gets to the right person at the right time for the right reason. This free flow of information happens in environments where there is sufficient trust for people to be authentically open and candid. Cultures of candor are comprised of integrity, trust, speaking the truth to power, and virtuous truth that allow leaders and employees to deal fairly with each other.

Integrity: Nurse Leaders acting with integrity practice what they preach. When a mistake is made, leaders call for an intensive postmortem as a learning opportunity. When leaders are consistent in their approach to errors, employees know the rules of the game won’t change and they are more willing to tell the truth.

Trust: Cultures of candor and trust are always linked. Trust is an outcome of the Nurse Leaders’ accumulated actions and behaviors. Trust is hard to earn, easy to lose, and once lost, nearly impossible to regain. Trust is a hard-edged economic driver, and a learnable and measurable skill.

There are 4 practical actions Nurse Leaders can take to foster trust: 1. provide equal access to employees; 2. refrain from punishing staff that constructively call attention to flawed information; 3. refrain from rerewarding staff who echo only what they think the Nurse Leader wants to hear; and 4. empower and reward staff who speak virtuous truth.

Candor-Based Fear: Candor-based fear is fear of job retribution (risk losing influence and support); social retribution (risk damaging social network); hurting others’ feelings (risk being perceived as disagreeable); losing face (risk looking bad); and fear of change.

Vital Lies: Employees learn how to keep secrets (vital lies) at home and bring this learned behavior to work with them. They learn the things to notice, what to say about what they notice, and the things not to notice and they learn to never say anything to outsiders about the things they don’t notice.

Virtuous Truth: The act must meet the criteria listed in Box 1. When these criteria are satisfied, employees have a moral obligation to speak the truth to power if the actions of leaders might be harmful to any of the stakeholders. An organization in which employees are empowered to know (verify) and speak the truth is an integral part of a culture of candor.

Communications must have at least a chance of bringing about positive changes.

Vital Lies

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<tr>
<th>Essential Elements</th>
<th>Requirements</th>
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<tr>
<td>Verifiable</td>
<td>1. Communication must be truthful: do no harm to innocents; and not out of spite or anger.</td>
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<td>Rights-Based</td>
<td>2. Communication must not be self-interested: the benefits must go to others, or to the organization.</td>
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<td>Benefits-Based</td>
<td>3. Communication must be the product of moral reflection on right versus wrong and a messenger who is willing to pay the price.</td>
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<tr>
<td>Feedback-Based</td>
<td>4. Communication must have at least a chance of bringing about positive changes.</td>
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References:


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Cultures of Candor

Betty Kupperschmidt

June, July, August 2010
Nursing is a service oriented profession full of caring, compassionate individuals who are able to earn a livelihood caring for clients in need of their nursing expertise. Many nurses donate their time and skill set in the community for both personal and professional reasons. Nurses often report that these activities provide a level of personal satisfaction and well-being beyond what they receive in their workplace. Community service, also called service learning, is identified as a key competency for programs educating health professionals. Many healthcare institutions promote service learning in their framework and use these activities as part of a career ladder. Whether driven by a personal desire to help others or a professional expectation, working in a volunteer capacity is a natural extension of fundamental nursing principles of assisting ourselves and others to achieve the highest possible level of wellness.

Nursing education is the primary means for the instillation of service learning concepts. Nurse educators across the world have recognized that inclusion of service learning into nursing curriculum promotes this behavior post-graduation. Literature supports the inclusion of a service learning component into educational programs to promote civic engagement and expand the learning environment for students and faculty. Potential benefits to nursing students include personal and professional development, increased self-directed learning and an increased connection between theory and practice. The institution has the potential to benefit from increased institutional visibility, student and faculty engagement in college life and student retention. Nursing student service learning activities of a health promotion nature have the potential to benefit the health and wellness of the community at large.

Although research is present to support the benefits of service learning in higher education, there are little formal guidelines for its incorporation into nursing programs, especially at the associate degree level. The majority of institutions are directed to incorporate these elements in ways that are appropriate, convenient and reasonable for the organization to achieve. At the associate degree level, this inclusion of additional program requirements has the potential to further strain a crowded curriculum. The immersion of service learning as part of the curriculum rather than additive is essential to gain maximum benefit from all the parties involved.

Incorporation of service learning into the associate degree program in nursing at Rogers State University (RSU) began with identification of those core competencies that service learning and the program as a whole shared. Participation in service learning reflects course objectives of caring interventions, collaboration and communication. Reflection of these course objectives in the service learning activities provided an additional opportunity for the students to incorporate these ideals into their personal nursing identity. Students were self-directed in the choice of their service learning and as recommended by the literature were required to complete a journal reflection exercise by the conclusion of the semester. Reflection was defined as an active, persistent, thoughtful consideration of the experience. Faculty team members facilitated the reflection process by asking questions for the students to reflect on such as “Why am I doing it?” “What am I learning?” Faculty team members then engaged students in discussion using a computer based discussion board format.

After the incorporation of the service learning component into the associate degree in nursing program RSU faculty, institution and the local community voiced overwhelmingly positive comments. A student participant voiced that “prior to volunteering I experienced reservations about whether this is what I am supposed to be doing but after volunteering...I am confident that I am headed to the career that is right for me and I do have enough compassion’ volunteer at local free clinic.”
The Tomato Garden
An old Italian lived alone in New Jersey. He wanted to plant his annual tomato garden, but it was very difficult work, as the ground was hard. His only son, Vincent, who used to help him, was in prison. The old man wrote a letter to his son and described his predicament. Dear Vincent: I am feeling pretty sad, because it looks like I won’t be able to plant my tomato garden this year. I’m just getting too old to be digging up a garden plot. I know if you were here my troubles would be over. I know you would be happy to dig the plot for me, like in the old days, Love, Papa.

A few days later he received a postcard from his son. Dear Pop: Don’t dig up that garden. That’s where the bodies are buried. Love, Vinnie.

At 4 AM the next morning, FBI agents and local police arrived and dug up the entire area without finding any bodies. They apologized to the old man and left.

That same day the old man received another letter from his son. Dear Pop: Go ahead and plant the tomatoes now. That’s the best I could do under the circumstances.

The top three hobbies of nurses I’ve known have been reading, cooking and gardening. Maybe our innate gardening interests arise from the healing pharmaceuticals found in so many plants. I’m one of those nurses who loves to garden with flowers, vegetables, landscaping, people. I even gardened at work. My office feels naked without something green and growing in it. I had a huge airplane plant with a profusion of babies that provided many smiles and conversations through passalong plants given to a patient, their family member, visitor or co-worker.

Corny Passalongs
Why do potatoes make good detectives? Because they keep their eyes peeled.

My wife’s a water sign. I’m a earth sign. Together we make mud. (Rodney Dangerfield)

God made rainy days, so gardeners could get the housework done.

Gardening is a sport. Hoe for it.

What did the bananas do when it saw the monkeys? Split.

What do you get if you divide the circumference of a pumpkin by its diameter? Pumpkin pi.

What do you call a stolen yam? A hot potato.

Knee: a device for finding rocks in your garden.

Bulb: potential flower buried in Autumn, never to be seen again. (Henry Beard)

When did my wild oats turn to prunes and all barren? (Lucy Parker)

Just wanted you to know I have entered the snapdragon part of my life. Part of me has snapped... and the rest of me is draggin. (e-mail 2008)

Old Farmer’s Advice
Your fences need to be horse-high, pig-tight and bull-strong. Keep skunks and bankers at a distance.

Life is simpler when you plow around the stump. A bumble bee is considerably faster than a John Deere tractor. Forgive your enemies; it messes up their heads. Do not corner something that you know is meaner than you. When you wallow with pigs, expect to get dirty. The best sermons are lived, not preached. Most of the stuff people worry about ain’t never gonna happen anyway. Don’t judge folks by their relatives. Don’t interfere with somethin’ that ain’t bothering you none. Good judgment comes from experience, and a lotta that comes from bad judgment. If you get to thinkin’ you’re a person of some influence, try orderin’ somebody else’s dog around. Don’t pick a fight with an old man. If he is too old to fight, he’ll just kill you. (e-mail 2002)

Mother Nature's Gardening Humor
Finding a coiled two foot snake under a trashcan, while sweeping the patio

Bing dive bombed by martins, while hoeing corn

Getting stuck in mud up to your knees

Walking into a sticky spider’s nest strategically built the night before, not knowing where the spider is

Oklahoma sheer force winds leveling your plants, flat

“Will Sing for Worms” robins

Praying mantis impersonating a flower bud

Cat Gardeners
You might be a Redneck Gardener if:

You think a chain saw is a musical instrument. A half moon reminds you of your spouse pulling weeds.

Kudzu covers your arbor. You’ve ever cleaned your house with a leaf blower. You empty the trash when you have enough to fill the pickup. You can amuse yourself for more than an hour with a hose. You’ve been cited for reckless driving on a lawnmower. (Mike Garofalo)

I have no plants in my house. They won’t live for me. Some of them don’t even wait to die, they commit suicide. (Jerry Seinfeld). For nurses with this level of green thumb talent, I have two words for you, “silk plants.”

For Oklahoma summers, try at least one patio cherry tomato plant and some zinnias. They’re guaranteed to improve your humor. Remember that each year gardening is an experiment and “Bloom where you are planted.” (Mary Engelbreit)
When I hear the name “Florence Nightingale” the words that pop into my mind are: seeker, rebel, founder, servant, and visionary. Other immediate responses are: war hero. Lady with the Lamp, evidence based practice, and first wound care nurse. Ms. Nightingale is our founder who set forth a chain of events that have brought us to where we are now.

The philosopher Nietzsche once said, “He who has a why to live can bear almost any how.” I identify Florence as a seeker because she knew she had a calling in life and she dedicated her life to seeking and fulfilling that purpose. She was initially a student of God’s word and later a teacher of the nursing profession and theory. She was born in a time when nursing was not a noble profession and to her parents dismay chose to fulfill a path and so also identify her as a rebel. She chose her path based on her own belief and broke the “mold” of that era.

Florence Nightingale was also a great founder in our history. During the Crimean War she cared for the wounded and the sick. And during that time she also was the first to bring forth evidence based practice. Ms. Nightingale’s research determined that prior to nurses providing care in the war the mortality rate of those sick and wounded was an astounding 60% and six months after nursing care was incorporated the mortality dropped to 2%! In my eyes this was a HUGE step for nursing! This was the first evidence to prove that nursing care definitively changed the outcomes of our patients. She had a vision for nursing and took that vision to the next level in setting precedence for nursing in the future.

I believe we have to look at our past to truly see our future and what an outstanding past we have. Florence Nightingale was also a great founder in our history. During the Crimean War she cared for the wounded and the sick. And during that time she also was the first to bring forth evidence based practice. Ms. Nightingale’s research determined that prior to nurses providing care in the war the mortality rate of those sick and wounded was an astounding 60% and six months after nursing care was incorporated the mortality dropped to 2%! In my eyes this was a HUGE step for nursing! This was the first evidence to prove that nursing care definitively changed the outcomes of our patients. She had a vision for nursing and took that vision to the next level in setting precedence for nursing in the future.

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Florence Mubichi was a student, then a peer and most of all a friend. On the long journey to return to her home in Meru, Kenya in February when she realized the end was near, we had opportunity to reflect on her life and career that spanned 27 years. I share the following tribute:

She began her nursing career as an Enrolled Nurse (equivalent to LPN in the US) in 1973 in a Methodist mission hospital and school of nursing in Maua, which at that time was one of the few opportunities for her to continue her education. She married her high school sweetheart, Stephen Mukichi Paul after completing the EN program. She excelled in that program as she had done in secondary school (high school) before that. As a result of her outstanding abilities she received a scholarship at Aga Khan Hospital Nursing School in Nairobi to pursue a diploma in Registered Community Health Nursing, completing that program in 1976.

Between 1979 and 1987 she completed Midwifery training, served as acting Matron (Director of Nursing), clinical instructor in the mission nursing school in Maua, and ISN in the US at Oklahoma City University. After completing the ISN she returned to Kenya serving as Principal Tutor (Dean or Director) of the mission nursing program where she had studied in Maua. Under her leadership, the school and their graduates were top performers in all of Kenya.

As a life-long learner, she continued her education again in the US, at Benedictine University in Chicago earning a Masters' in Public Health degree, and later a second masters' in Nursing Education at the University of Oklahoma. When she enrolled in my course at OU, she made an appointment before the class started to see what she could begin working on. When I told her I had worked in Africa for several years, she said, “Oh, I am so lucky to have you as a teacher.” I don’t believe I have ever had a student say that before or since. She had recently completed all requirements and was ready for her dissertation at Walden University at the time of her death.

Florence and I discussed her contribution to nursing in both the US and Kenya and she estimated that she had taught well over 3,000 nurses in her career. At a time when Kenya had few nursing programs, 3,000 nurses constitutes a tremendous impact on both nursing and health care in this East African country. She would probably not have been a nurse at all if it weren’t for the notice of her exceptional personality, capabilities, persistence and intellect by the Methodist Missionaries who then assisted her to earn nursing capabilities, persistence and intellect by the Methodist Missionaries who then assisted her to earn nursing capabilities, persistence and intellect by the Methodist Missionaries who then assisted her to earn nursing capabilities, persistence and intellect by the Methodist Missionaries who then assisted her to earn nursing credentials, first as an Enrolled Nurse (LPN), then to a diploma program, and later ISN. Florence then continued her academic career to earn two masters’ degrees and was all but dissertation (ABD) for her doctorate in Community Health Education when she died.

The world is a better place because of Florence Mubichi, and I am a better person for having known her.
Specialty Nurses Association can be an Organizational Affiliate of ONA

The Oklahoma Nurses Association encourages nursing and health-related organizations to become organizational affiliates of ONA. They must first meet the basic requirements set by the ONA Board of Directors. These requirements include that the organization has a governing body comprised of a majority of registered nurses. In addition, the organizational affiliate must pay an annual fee of $5000 and be approved by the ONA Board of Directors. Organizational Affiliates are also responsible for maintaining a mission and purpose harmonious with the purpose and functions of ONA.

Benefits to these organizations include: voting seat in the ONA House of Delegates and the opportunity to make informational reports or presentations to the ONA House of Delegates within the organization's area of expertise; a column in the Oklahoma Nurse; a seat on ONA's Governmental Activities Committee, which works closely with ONA lobbyists to support nursing issues in the State Legislature; a reduced Exhibitor rate at ONA/ONSA Convention for the organization; and many more.

When a specialty nurse organization joins ONA as an organization affiliate the individual members also have individual benefits that include participation in the Nurse of Day program at the Capitol during Legislative Session and reduced registration for convention and conferences which is less than the non-member fee.

ONA currently has three organizational affiliates: Clinical Nurse Specialists (CNS), Oklahoma Section of the Association of Women's Health Obstetrical and Neonatal Nurses (AWHONN) and the School Nurses Organization of Oklahoma (SNOO). We look forward to their participation in our events. ONA's website is www.oknurses.com and is a great resource for information that pertains to ONA and ANA.

What is CMSA-OK and What Can It Do For You?

by Micki Johnson
ONA Organizational Affiliate

The Case Management Society of America-Oklahoma Chapter is a professional organization dedicated to the support and development of Case/Care Management. CMSA-OK was formed in 1992. We serve local Case Managers and those who support Case Management in all practice settings and areas of care coordination, including Workers Compensation, Hospital, Social Services, and Home Care. Our Chapter is part of a national organization 11,000 members strong with approximately 70 Chapters. Some of the upcoming activities CMSA-OK will be sponsoring include:

- Educational Meetings providing CE and networking opportunities. Our next meeting is May 20th, on the topic of Social Security Disability. Check in is 5:30pm. Go to www.cmsa-ok.org for details.
- Local yearly Educational Conference in the fall with more CE credits, networking, and FUN. This year's theme is "Going the Distance with Case Management" the Triple Crown: Educate-Advocate-Collaborate. It will take place on October 6th and 7th at UCO Campus.
- Case Management Week festivities Oct 10-16th including a reception honoring our Case Manager of the Year and Award of Service Excellence winners as well as our profession.
- Golf Tournament at River Oaks Country Club, July 26th
- Political presence representing our members' interests on issues affecting Case Management Professionals and client/patient well-being such as Multi-State Nurse Licensure and the Case Management Model Act.

If you are interested in finding out more information about CMSA-OK, visit our website at www.cmsa-ok.org. Or contact Micki Johnson at 1-800-398-2059 or mrijmeet@aol.com.

What Nurses Do

By Peggy S. Hart Miller, PhD., RN
Political Activities Director, ONA
ONA Member, Region 6

Legislative Day has come and gone but the legislators are still in their appointed places busy about their appointed tasks. Nurses know the importance of sharing with their elected officials those issues that impact nurses and the public that is served. In fact, legislators most who are not nurses, depend on nurses to share and direct decisions of public health concern. Nurses are a valuable resource.

Health Care Reform has passed at the federal level and now the states must decide how to implement the reform. Nurses can and should be major players in the delivery of quality cost effective health care. Nurses must be present at each level of planning and implementation of the reform. The nurses that are involved include each one of you. Every nurse in Oklahoma has a story to tell with numerous examples that validate what does and does not work. Nurses must tell these stories. Nurses must step up to the plate and be actively involved in determining solutions that really make a difference and that work.

Nurses must be involved in innovative and creative efforts that develop new and diverse positions. Think tanks where nurses can brainstorm to solve problems that meet health care needs will be exciting and challenging events. Imagine being in attendance at one of these meetings! My own imagine runs wild.

I shared a vision with the legislative day attendees that nurses can and should be the first line care providers in the provision of health care. Imagine that an advanced practice nurse is employed by a large industry and has professional registered nurses working under her. The registered nurse performs routine assessments on each employee and each member of their family. This nurse provides all teaching, health prevention and health maintenance to the appropriate medical care giver.

The salaries of the nurses would be provided by the industry. Insurance would be provided for situations requiring hospitalization and/or surgery needs. Expected outcomes of this system would be fewer hospitalizations, fewer clinic visits, healthier employees and their families, less expense for health care for the industry. This is just one example of how nurses might help resolve the health care crisis.

What solutions can you think of that apply to your particular situation? Nurses should not be at the table to receive but to give by providing solutions. We are the experts for prevention and health maintenance. That is what nurses do.