President’s Message

Is Nursing a Profession?

The acquisition of professional status has allowed certain individuals and groups to attain power, prestige, and economic influence. Does nursing have professional status? This topic has been debated for decades. The questions I want to pose in this president’s address are, is nursing a profession, and are you a professional? Each spring during the final semester of the senior year I co-teach a course “Professional Seminar.” The content for this course includes attributes of a profession. Students are asked the question “Is nursing a profession?” Students sign up into self-selected groups. Each group is responsible for exploring one attribute of a profession and determines how nursing meets the attribute for being a profession. Scholars have analyzed the concept of professionalism and the following attributes were identified decades ago, and are still in use today.

- Specialized body of knowledge. Does nursing have its own specific body of knowledge and do nurses make significant contributions to health care. Does society value the services and accept nursing’s claim of specialized knowledge and expertise in health care?
- Motivation/Service. Is nursing’s motivation to serve the client rather than self-interest? Does nursing share their knowledge with others by participating in part-time job?
- Code of Ethics. Does nursing have a developed Code of Ethics that guides practice?
- Training Period. Does nursing have a standardized and systematic educational program for entry into the profession?
- Relevance to Social Values. Is nursing responsible to society. Does nursing view their work autonomy; self regulation? Does nursing have the ability to control the work of nursing? Can nursing influence state and federal policy makers?
- A sense of community. Does nursing have collective strength of its members in a professional organization?

Based on these attributes of professionalism, professionals have been distinguished from other workers. Professionalism in nursing has been intensified along with role expansion of the nursing profession in the rapidly changing healthcare environment. Nursing professionalism reflects the manner in which nurses view their work and is a guide to nurses’ behaviors in practice to assure patient safety and quality care.

Do the discussion to answer the question “Is nursing a profession?” The students identified several barriers that keep nursing from achieving professional status. Scores for a sense of community was rated low. The students expressed most nurses felt positive about being a nurse, however less than 3% of the registered nurses in North Dakota belong to NDNA/ANA. How can nursing influence or strengthen the profession without having a strong membership in the professional organization that develops the professional standards. Professional standard formulation and dissemination are functions of ANA. Consequently, these standards must be translated into policies and procedures in health care agencies. Nurses need to participate in forming the standards and demonstrate knowledge of their practice. Recently, ANA sent out a draft of Nursing Scope and Standards of Practice for public input. Did you take time to review this draft document? The new draft requires entry level nurses to have and understanding of evidence based practice. How many nurses understand evidence-based practice? The emergence of personalized health care will require nurses to continuously develop, revise, implement, monitor and evaluate nursing research is well-established source of evidence. In addition, staff nurses and advanced practice nurses are potential builders of evidence. In addition, staff nurses and advanced practice nurses are potential builders of evidence where it is lacking.

Another area with low scores is the area of education. Nursing continues to have multiple entry levels into the profession. The nursing profession is losing its status because of the fragmentation of education and knowledge. Are we ready to address this issue? Some states are looking at BSN in 10. Is North Dakota ready to look to the future once again and address this divisive issue?

As you review the attributes of a profession ask yourself these questions:

President’s Message continued on page 4
You are cordially invited to join the North Dakota Nurses Association

See the NDNA Website at www.ndna.org
Click on Membership

Under how to join
Click on Membership Application (ANA website)
Click on Full Membership
(To be ready to provide your email address)

Full membership is just $20.50/month! Less than 70¢ a day!

The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.

The Pump Handle is a monthly newsletter distributed by the Division of Disease Control at the North Dakota Department of Health. This monthly newsletter contains topics from all programs in Disease Control including Influenza, West Nile Virus, immunizations, food borne outbreaks, HIV/AIDS, TB, STDs, viral hepatitis and disease control sponsored events.

The Epi Report is a quarterly publication that provides a more detailed description of the various Disease Control programs. You can be added to the mailing list for each issue by contacting Sarah Weninger at sweninger@nd.gov. This link will direct you to both the Pump Handle and the Epi Report. http://www.ndhealth.gov/Disease/NewsLetters/NewsMain.htm

Nurses
Caring Today for a Healthier Tomorrow

National Nurses Week begins on May 6, marked as RN Recognition Day, and ends on May 12, the birthday of Florence Nightingale, founder of nursing as a modern profession. The theme this year is “Caring Today for a Healthier Tomorrow”

From bedside nursing in hospitals and long-term care facilities to the halls of research institutions, state legislatures, and Congress, the depth and breadth of the nursing profession is meeting the expanding health care needs of America.

Writing for Publication in the Prairie Rose

The Prairie Rose accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and in APA format. The article should be submitted electronically in MS Word to beckyv@ndna.org.

Please write Prairie Rose article in the address line. Articles submitted for continuing education need a purpose, objectives, and a post-test. You may request the necessary contact hour forms from Becky at beckyv@ndna.org.

Articles are peer reviewed and edited by the staff and RN volunteers at NDNA. Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don’t know how or where to start, contact the office at NDNA: 701-223-1385.

The Prairie Rose is one communication vehicle for nurses in North Dakota.
Raise your voice.

The Vision and Mission of the North Dakota Nurses Association

Vision: North Dakota Nurses Association, a professional organization for Nurses, is the voice of Nursing in North Dakota.

Mission: The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.
I recently had the opportunity to represent NDNA as the President Designee at ANA’s Constituent Assembly. I found it to be very interesting and thought-provoking as I look at the future of the nursing profession and our own state organization.

The various sessions were focused toward preparations for this June’s House of Delegates. A condensed version of “Crucial Conversations” looked at how new nurses and their state associations that have different priorities and philosophies (i.e. collective bargaining vs. workplace advocacy) could dialogue constructively to reach a win-win solution. I learned a lot about the history and evolution of ANA and its positions about both collective bargaining and workplace advocacy. I am hopeful ANA can be a unified organization for nurses regarding health care related issues and leave the union issues separate.

Edward O’Neill, Director of the Center for the Health Professions, talked about the changing paradigm in health care, and what nursing will need to do to help direct health care reform. He identified 5 key areas:

1. Organizations and people need to be flexible and able to adapt to fast-paced changes
2. Stronger than ever emphasis on quality, using evidence-based practice to guide practice changes
3. Using information technology to master handoffs for seamless care across the continuum
4. Changing our expectations; that health care delivery needs to be different and that nursing can lead the change
5. Honing our leadership skills, nursing partnering with new collaborators, including communities and government

The last session focused on attracting new members and increasing the participation and involvement of existing members. People belong to and are active in organizations for one of three reasons: to make a difference, for personal and professional development, or for social opportunities. Our challenge is to develop specific strategies that will address each of those areas. I look forward to working with Jane and all of you as we strive to strengthen our local organization.

I would like to thank NDNA for the opportunity to attend Constituent Assembly, and look forward to the House of Delegates this June.

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This article is part of a series, looking back at the history of NDNA and looking forward to what the next decades will bring, as we ready for our 100 year anniversary in 2012.

As I prepared to write the next in a series of articles, I was lost as to where I should begin, so I closed my eyes and just picked up a bound volume of the Prairie Rose. I had chosen the time frame from Oct. 1979 through Dec. 1984. How appropriate, since I graduated from nursing school in 1980 and amid the haze of being a new graduate, landing that first job and being a newlywed, I can vow I missed much of what was happening in the professional association then known as the North Dakota State Nurses Association (NDSNA). I thought what a great opportunity to reminisce and catch up on what I had missed.

As I read, it did not take long to have a profound sense of déjà vu. In the April, May, June 1980 edition of the Prairie Rose, Betty Maher (Past Executive Director), wrote of her travels across the state and penned these questions: “Why do we have so few active members? How can meetings stimulate new members as well as cover business? Is our group representative of all nurses and nursing concerns? Do we become top heavy with management and education? Do staff nurses bring out the concerns of the day to day professional nursing problems?”

Betty expressed the belief that most problems could be dealt with at the grass roots level. She spoke of issues of distance, travel, time as barriers to participation and that nurses could and should get together and discuss issues of importance to them. She spoke of the ability to start a district with just a few interested nurses. About a year ago NDNA restructured the organization with just that thought in mind. The confines of a more formal structure have been replaced with the ability for “grass roots” nurses to gather as informally as a lunch or coffee, without the need for specific bylaws or rules of meetings; fast forward thirty years to check in with Betty’s questions and you will find NDNA still struggles to entice nurses to gather to discuss issues.

I echo Betty’s words; “nurses need to talk about nursing with nurses. Other disciplines make our decisions because we don’t make them ourselves”, and I will add, and when we leave the practice and policy decisions to so few, your voice is silenced.

The spring 1982 edition carried an article written by Carolyn Gatschel that reviewed the history of the “nursing diagnosis’. Hard to believe that before 1960 most nurses were firmly reminded diagnosis was the purview of physicians only. In actuality the term nursing diagnosis was used as early as the 1950s and was hotly defended by nursing by the mid 1950s. By the time the 1982 article was written a proliferation of literature spoke of the nursing diagnosis and from a legal point of view the terminology became part of the nurse practice act. The struggle of this time was to facilitate use of the accepted terminology by the practicing nurse. The lag from inception of the nursing diagnosis to its wide spread use spanned several decades.

In nearly every edition Barb Pierce wrote a membership/creative finance report. The amount of energy that went into recruitment, retention of members and fund raising was nothing short of gargantuan. During the early 80s NDNA's membership was at 12% of all RNs in ND. Today, if you round up, it is at 3% of the 10,000 RNs in ND. It was during this time the Refresher Course was born. Today the use of the Refresher Course has slowed to a trickle. A variety of issues have surfaced that would indicate the days of refreshing in this manner may be near concluded. The need for nurses...
Am I familiar with the ANA Code of Ethics and do I have a personal code of nursing ethics and behavior?

Am I familiar with the ANA Nursing Scope and Standards of Practice?

Do I positively defend nursing and speak of being a nurse proudly?

Do I share professional knowledge by serving on committees and being a mentor?

Am I a contributing member of my staff, profession, community and society as a whole?

Do I belong to and participate in my professional nursing organization?

Do I defend social justice?

Do I subscribe and read nursing journals?

Do I participate in nursing research?

Am I certified in my nursing specialty area?

Are you a professional? It falls on the shoulders of every RN to reflect the professional aspects of nursing. Everyday duties often overwhelm us, fatigue and frustration may arise. In spite of these factors, I hope each of you declares today a “professional acts” day and becomes the exceptional spokesperson for nursing.

CONSENT TO SERVE FORM

Name: ______________________________________

Credentials: ______________________________________

Address: ______________________________________

City: ______________________________________

State, Zip: ______________________________________

Area of Practice: _______________________________

Employer: ______________________________________

Past NDNA positions (if any): _______________________

I wish to have my name placed on the ballot for the NDNA office or position of: _______________________

I wish to submit my name to volunteer to participate on the following committee: _______________________

A copy of the current NDNA Bylaws can be obtained at www.ndna.org under the membership section.

Position descriptions are found in the bylaws. Or contact info@ndna.org.

IF ELECTED, I CONSENT TO SERVE AND AGREE TO fulfill to the best of my ability, the duties and responsibilities for the office for which I am submitting my name: _______________________

Signature: ______________________ Date: ______________

Phone: ______________________

Email: ______________________

Please return to:
NDNA
c/o Becky Graner
5265 Hwy 1806
Mandan, ND 58554
to be proficient in using information technology and possessing knowledge not included in their first preparation background, leave many needing a richer learning experience. A major obstacle is the inability for participants to secure a clinical site. Facilities are reluctant to provide a “free” experience to those seeking to refresh. Rules and regulations across the country are disincentive to awaken any type to become their own rules that apply to nurses when refreshing. In the past two full time staff persons managed the program, today just one part time person. The course is now available as a download from a secure website; however NDNA no longer offers the course to out of state refreshers, instead focusing on providing the service to ND nurses only.

The January, February, March 1981 Prairie Rose headline read “What is Entry into Practice?” In 1980 I received a book titled “American Nursing and the Failed Dream: A critical assessment of nursing education in North Dakota” by June Harrington. The history of nursing education is reviewed through a lens of few of us have ever considered; especially as we so fervently embrace that we are indeed a profession.

The book describes the days when nursing was most often performed by the least desirable women in a society. The author then walks the reader through the influences of Florence Nightingale; the history is carefully dissected and viewed through the lens of a society trying to elevate the image from one of street walker to cultured lady. An added benefit of being a nurse at that time was nursing provided a means for women to earn a living independent of finding a husband. The push for university degrees grew out of the belief this “education” would further elevate the status of women. Conflict regarding the length of time and how nurses were trained increased with the need to quickly produce nurses to serve in WWI and WWII. The push to move nursing education from apprenticeship training to one of university education is a fundamental conflict that continues today. In 1913 Lavinia Dock, considered well educated and accomplished said nurses are “workers, toilers, no matter how high she may build her career or how noble she may make it... she is still from the world of workers”. Her words while disturbing, have a ring of truth.

Harrington grants several paragraphs of space in her book to the legislation that was passed here in ND in the mid-80s that established a baccalaureate degree as the entry to practice requirement. She quickly adds by 2003 the legislature was reversed. She also points out the long ago establishment of the associate degree program as the real culprit that confused the issue of a “standard body of knowledge”. And she soundly blames Mildred Montag and associates as the group that put the fork in the road, taking us along a path we have been finding ourselves today. Nurses educated anywhere from 2 to 4 years, a creation in the past of a “technical nurse” which has evolved to the “practical nurse”, which has opened a door to creating medication aides, nurse aides, medical technicians, and unlicensed assistive personal are all part of the “failed dream”. And these early education program innovators by failing to consult with the end consumer (hospital) of these workers (nurses) created a mismatch of epic proportions between what is needed versus what is produced. The apprenticeship training so disdained by those who sought to change nursing education, merely became the responsibility of the employer. As Harrington points out this pattern of creating different ways to become licensed is also repeated in the proliferation of nursing organizations. Every time a new organization is created that represents nursing we splinter our collective power. By having separate and often competing organizations that represent nursing, we risk confusing others and potentially diluting our voice. Back to the 1984 question, “Is Nursing a Profession?” Challenging nurses to answer this question typically elicits an emotional response of “of course it is!” However asking the same nurse to define what it means to be a profession, often elicits thoughts of what is involved and how we should fast forward to the future, however indicates it is time to poke the dragon and deal with the fire once and for all. The original article did not identify an author, but the premise was media's depiction of nursing contributed to the inability to be considered a profession.

Back to the perks of my job is I am occasionally asked to read and write reviews of either about to be published or newly published books. Several months ago I received a book titled “American Nursing and the Failed Dream: A critical assessment of nursing education in America” by June Harrington. The history of nursing education is reviewed through a lens of few of us have ever considered; especially as we so fervently embrace that we are indeed a profession.

The book describes the days when nursing was most often performed by the least desirable women in a society. The author then walks the reader through the influences of Florence Nightingale; the history is carefully dissected and viewed through the lens of a society trying to elevate the image from one of street walker to cultured lady. An added benefit of being a nurse at that time was nursing provided a means for women to earn a living independent of finding a husband. The push for university degrees grew out of the belief this “education” would further elevate the status of women. Conflict regarding the length of time and how nurses were trained increased with the need to quickly produce nurses to serve in WWI and WWII. The push to move nursing education from apprenticeship training to one of university education is a fundamental conflict that continues today. In 1913 Lavinia Dock, considered well educated and accomplished said nurses are “workers, toilers, no matter how high she may build her career or how noble she may make it... she is still from the world of workers”. Her words while disturbing, have a ring of truth.

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Original Nightingale Pledge
“I solemnly pledge myself before God and in the presence of this assembly; To pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug; I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping; and all family affairs coming to my knowledge in the practice of my calling; With loyalty will I endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care.”
2011 Graduate Nurse Educator Scholarship

The North Dakota Nurses Association announces applications are being accepted for the 2011 Graduate Nurse Educator Scholarship.

Qualifications:
- Must be enrolled in an approved graduate or doctorate level nurse educator program and have completed at least one semester of study with at least a 3.5 GPA.
- Must present a NDNA member and show proof of membership for the past 2 consecutive years.
- Must show proof of an active, unencumbered RN license.
- Must provide two (2) letters of recommendation from colleagues.
- Provide publishable, article for the Prairie Rose based on one of the following topics:
  - The community of nursing
  - Professional issues in nursing education
  - Creating the nurse of the future
- Pursuing graduate or doctorate degree that specifically prepares the applicant for the role of a nurse educator.
- NDNA membership as described and unwavering dedication.
- Must show proof of an active, unencumbered RN license.
- Must provide two (2) letters of recommendation from colleagues.
- Provide publishable, article for the Prairie Rose based on one of the following topics:
  - The community of nursing
  - Professional issues in nursing education
  - Creating the nurse of the future
- (APA format)

Scholarship awarded based on the following criteria:
- Pursuing graduate or doctorate degree that specifically prepares the applicant for the role of a nurse educator.
- NDNA membership as described and unwavering dedication.
- Must show proof of an active, unencumbered RN license.
- Must provide two (2) letters of recommendation from colleagues.
- Professional, articulate, and intellectually challenging article that requires little editing for inclusion in the spring 2011 issue of the Prairie Rose.
- Preference will be given to the applicant who provides evidence of present or anticipatory employment in a school/college of nursing.

Scholarship award: $1,000.00

You may also email all materials to info@ndna.org

Deadline for application November 11, 2010

Name ___________________________________________________________
Address _________________________________________________________
City, State, Zip ___________________________________________________
Email (must provide) ____________________________
Phone __________________________________________________________
Name, location of College _________________________

Anticipate graduating in which year? __________________________
Present semester of study ____________________________
Official description of course of study ____________________________

(Please provide a copy of official grade transcript)
RN license number ____________________________
(Do not send a copy of your license)
NDNA membership number ____________________________
(provide proof of membership x 2 years)
Are you presently employed by a school or college of nursing?
Name of employer? ____________________________

Checklist for documents to be included in this application
☐ 2 letters of recommendation
☐ Membership proof
☐ Journal article in APA format

(Applications without all indicated items will not be accepted)

Recommended Reading May 2010

Nursing in the Storm: Voices from Hurricane Katrina

Voices from Hurricane Katrina takes you inside six New Orleans hospitals—cut off from help for days by flooding—where nurses cared for patients around the clock.

In this book, nurses from Hurricane Katrina share what they did, how they coped, what they lost, and what they are doing now in a city and health care infrastructure still rebuilding, still in jeopardy.

In their own words, the nurses tell what happened in each hospital just before, during, and after the storm. Danna and Cordray provide an intimate portrait of the experience of Katrina, which they and their colleagues endured.

Just a few of the heroic nurses you’ll meet:
- Rae Ann and twenty others, including her husband and children, who wait on a hospital roof for help to come.
- Lisa, in the midst of caring for patients, who has not heard from her husband in 5 days.
- Roslyn, who has 800 people in her hospital when the power generators shut down.
- Linda, who uses bed sheets to write out help messages on a hospital roof, hoping someone will see them.

And just when you think they are rescued, for some, the nightmare becomes worse when they are dropped into the swirl of human desperation in their nursing uniforms without protection, tired, hungry themselves to face the victims of disaster who demand their food and water and that they care for the injured and ill.

Reading their story will make you cry, and then make you mad; this should never happen to anyone in this country again!

The book also discusses how to plan and prepare for future disasters, with a closing chapter documenting the “lessons learned” from Katrina, including day-to-day health care delivery in a city of crisis. This groundbreaking work serves as a testament to nurses’ professionalism, perseverance, and unwavering dedication.
How Do I Find the “Virtual NDNA”?

The NDNA website remains the same at www.ndna.org. HOWEVER, to provide up to date information and to link all the websites and resources now developed and used by NDNA we have added a link to a new comprehensive resource called the “Prairie Rose Petal”.

http://sites.google.com/site/ndnaprairierosepetal/home

The event calendar on the original NDNA website will still list activities and new members can join by clicking on the membership tab. All online contact hour offerings and CNE-Net application for contact hour(s) can be accessed through the new Prairie Rose Petal as the CNE-Net information has its own website at http://sites.google.com/site/ndnacenet/home.

The Prairie Rose Petal will provide the most up to date news, forms, and activities. Links to the ND Nurses Journal Club, ND Nurses Voice Blog, the online Prairie Rose newspaper, and the Members Only link.

If you have questions or problems accessing these sites please contact us at info@ndna.org.

Proclamation
National Nurses Week
May 6-12, 2010

Whereas, The nearly 10,000 registered nurses in North Dakota comprise our state’s largest health care profession, and

Whereas, The depth and breadth of the registered nursing profession meets the different and emerging health care needs of North Dakota population in a wide range of settings, and

Whereas, The North Dakota Nurses Association, as the voice for the registered nurses of this state, is working to chart a new course for a healthy nation that relies on increasing delivery of primary and preventive health care, and

Whereas, A renewed emphasis on primary and preventive health care will require the better utilization of all of our state’s registered nursing resources, and

Whereas, Professional nursing has been demonstrated to be an indispensable component in the safety and quality of care of hospitalized patients, and

Whereas, The demand for registered nursing services will be greater than ever because of the aging of the American population, the continuing expansion of life-sustaining technology, and the explosive growth of home health care services, and

Resolution, That all nurses in this state join me in honoring the registered nurses who care for all of us, and be it further

Resolved, That the residents of North Dakota celebrate registered nursing’s accomplishments and efforts to improve our health care system and show our appreciation for the nation’s registered nurses not just during this week, but at every opportunity throughout the year.

ANA Appointed to National Committee Providing Immunization Guidance

ANA Strengthens Nursing Voice on Nation’s Premier Panel on Vaccine-Preventable Diseases

SILVER SPRING, MD–The American Nurses Association (ANA) has been selected as one of only two nursing organizations on the only U.S. government committee that makes recommendations for the administration of vaccines to children and adults to control vaccine-preventable diseases.

ANA begins its participation on the Advisory Committee on Immunization Practices (ACIP) this June as a non-voting liaison organization that provides immunization expertise. The committee’s 15 voting members, named by the secretary of the U.S. Department of Health and Human Services, provide recommendations to HHS and the Centers for Disease Control and Prevention (CDC) on preventable disease-reduction and vaccine safety strategies.

“We’re working hard to make registered nurses the champions of immunization,” said ANA President Rebecca M. Patton, MSN, RN, CNOR. “We’re pleased and excited that the CDC recognizes nurses’ immunization expertise and the integral role for nurses in setting immunization policy, educating the public and promoting vaccinations through direct contact with patients.”

In partnership with the CDC, ANA is running a two-year initiative aimed at increasing vaccination rates within the community called “Bringing Immunity to Every Community.” The program is intended to increase nurses’ knowledge and competency in immunization issues and position them as leaders in increasing vaccination rates among the public and health care professionals.

The program includes a Web site, http://www.ANAImmunize.org, a comprehensive resource for nurses to become competent, educated advocates for immunizations.

ANA will showcase http://www.ANAImmunize.org at the American Nurses Association’s National Convention April 19-22 in Atlanta.

The ANA is the only full-service professional organization representing the interests of the nation’s 3.1 million registered nurses through its constituent member nurses associations, its organizational affiliates, and its workforce advocacy affiliate, the Center for American Nurses. The ANA advances the nursing profession by fostering high standards of nursing practice, protecting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

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SILVER SPRING, MD–The American Nurses Association (ANA), the largest nursing organization in the U.S., today launched a comprehensive new online tool available exclusively to ANA members. The customized ANA Edition of Mosby's Nursing Consult, developed jointly with Elsevier—the world leader in nursing information—delivers robust clinical information to ANA members like never before, in an organized, easy-to-use format.

"ANA is thrilled to offer this valuable new benefit to our members," stated Marla J. Weston, PhD, RN, and ANA chief executive officer. "We have worked diligently with Elsevier to create a customized, single-source tool that ANA nurses can utilize to enhance and improve patient care in countless aspects of their day-to-day practice. As our member community knows, evidence-based nursing continues to grow in both scope and application. The ANA Edition of Mosby's Nursing Consult puts a tremendous clinical resource in nurses' hands—keeping our nurses at the forefront of this essential aspect of practice. We encourage every ANA member to utilize this member benefit to its fullest."

The ANA Edition of Mosby's Nursing Consult delivers—all in one integrated, user-friendly online application—a compendium of monographs, practice guidelines, and peer-reviewed clinical updates representing the best, most current work of nursing experts and thought leaders throughout the profession. The compilation includes the following:

- 50 evidence-based nursing monographs containing a concise review of the current evidence available on common clinical problems (including current practice and synopses of current literature), and presenting specific recommendations for nursing care.
- Practice guidelines to help locate best-practice recommendations for more than 400 common health care diagnoses, conditions, and procedures—including both current safety alerts (if any) and any official organizational position statements relating to the topic.
- Nearly 80 clinical updates—original, peer-reviewed, best-practice clinical articles, written by nurse experts, focusing on specific areas of patient care.

"As evidence-based practice evolves as a core value of nursing practice, ANA members will now have access to an unparalleled set of evidence-based nursing content," said Eileen S. Robinson, MSN, RN, director of Nursing Continuing Education for Elsevier. "Whether at the bedside, in staff development and education, setting policies and procedures, or leading their organizations, ANA members will have access to Mosby’s Nursing Consult, which will provide them with the clinical content they need to make the best practice decisions."

For more information concerning the ANA Edition of Mosby’s Nursing Consult, visit the members-only section of Nursing World at www.nursingworld.org/membersonly.

The ND Nurses Journal Club has a new face and web address. We have removed the need to be invited to participate and added several different ways to communicate. The EBP Overview tab provides many excellent sources of information, the topics and questions list the active topics and the questions are individually listed in the ND Nurses Blog found under the “Talk Café” tab. The Talk Café also has a chat room where you can meet others to discuss issues, topics or devise a question. There is a guest book where you can sign in and share your email address with others.

Under the CAT! Articles/ Forms tab there is a link to a variety of tools and a link to the document library where participants can share articles that pertain to any of the PICO questions. We invite any other ideas or suggestions, send to becky@ndna.org

CNE-Net, the education division of the North Dakota Nurses Association (NDNA), is accredited as an provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

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Why healthcare directives? According to the ND Century Code (2009), “any competent adult has the right and responsibility to make the decisions regarding his/her own health care, including the decision to have health care provided, withheld or withdrawn.” How advance care planning is presented, how an individual is asked questions, the setting, and timing are all major contributors into the decision making process (Vachon, 2010). Predicting what treatments someone will want is complicated by the person’s level of understanding the nature of the illness, and the ability of medical treatment to cure or sustain life, as well as the emotions families experience. Some people may be asked when they are poor when their health is deteriorating. Studies indicate that many patients have not participated in effective advance care planning. Other studies demonstrate how preferences change over time (AHQK, 2003; The Pew Research Report, 2006). Individuals cannot possibly comprehend all the possible future options and choices they may have to address every possible situation. Communication is the underlying key to removing most barriers (American Bar Association, 2002).

Palliative Care continued on page 10

Palliative Care Issues

Nancy Joyner, RN, MS, APRN-CNS, ACHPN
Clinical Nurse Specialist-Palliative Care
Altru Health System-Altru Hospital

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that provides specific treatment orders for CPR, medical interventions for comfort cares, limited or full treatments, antibiotics, and artificial hydration and nutrition. It is completed based on conversations among healthcare professionals with the individual and/or his/her agent and in conjunction with any existing healthcare directive surrogated individuals (Dunn, Moss, & Tolle, 2007).

The form may be used either to clarify a request for all medically indicated treatments, including resuscitation, or to limit medical interventions. The goal is to ensure that seriously ill person's wishes regarding life-sustaining treatments are known, communicated, and honored across all health care settings. More specific objectives of the national paradigm are:

- To facilitate the development, implementation and evaluation of POLST Paradigm Programs in the U.S.,
- To educate the public and health care professionals regarding the POLST Paradigm,
- To support, perform and fund research related to end-of-life care, and
- To improve the quality of end-of-life care. (POLST, 2010)

The POLST is invaluable as it separates code level from other treatment options. It stresses that CPR is attempted and that the choice of not having it attempted is Allowing Natural Death (AND). Often by the concept of DNR, the “do not” dredges up the negative concepts of ‘no care,’ abandonment, and may suggest that the individual is giving up, suicidal or not even trying. POLST makes it clear that DNR does not mean ‘do not treat’.

Healthcare directives and POLST are beneficial tools to assist with advance care planning. They assist in preparing for sudden, unexpected illness, from which an individual may recover as well as the dying process and death itself. Starting the healthcare conversation and completing documents should begin when individuals are healthy and continue along the health/illness continuum as goals and preferences may change. As individuals develop chronic conditions and functional decline, advance care planning becomes a gift for those who may help make future healthcare decisions, both for the agent and healthcare professionals, alike (Bomba, 2005, NHDD, 2010).

A day has now been set aside nationally to recognize the value and the gift of advance care planning using healthcare directives as the first step (Hammes, 2010). As caregivers, it is our responsibility to encourage all adults to start the discussion with their healthcare providers, family members, and friends to choose an agent and to start making decisions about their future healthcare (Dunn, 2001). Healthcare professionals must gain knowledge and education about the processes and choices individuals may make, educate the individuals, their family members, other healthcare professionals, and the community about choices, as well as the survival and quality of life with the life-sustaining treatments that are considered (Hammes & Briggs, 2010).

It is every healthcare professional’s obligation to honor and respect an individual’s healthcare directives, and to act on those directives, on an ongoing basis, as situations and choices change within the legal and ethical components of the document and discussions (Jaffe & Knight, 2008). The basic focus should change from viewing the patient as a disease or illness and focus on him/her as an individual, giving him/her dignity and respect. These topics are of life and death, of emotion, concern, and may go against the usual grain of health improvement, wellness, and anti-aging when all forms of care are available. All healthcare providers should be able to “do not treat” when necessary. POLST makes it clear that CPR is not indicated (Sabatino, 2007). Treatment options which may prolong life can and should be provided when CPR is not indicated (Sabatino, 2007). Treatment that keeps the person alive but does not offer a chance of recovery should always be given. Medical technology has increased to the point that the human body can be “kept alive” almost indefinitely. The risks, benefits, and expected outcomes of what are of best interest for the individual as well as the individual’s preference need to be considered with any of these discussions. Often healthcare directives are completed with an agent while executing a financial will that has little or no input with the person’s healthcare professional. Generic advance directives fail to account for the different needs of people who may die in the next year, or anyone wishing to address and changes are occurring. Previously, states are adopting legislation reflecting the wishes of individuals at home, avoiding the added benefit of reducing medical costs (Compassion and Support, n.d.).

The added benefit of reducing medical costs and preferences of the patient. Improvements will realign the level of care based on the best interest of the patient, care of not futile interventions at end-of-life. In many cases, life-sustaining treatments only prolong the dying process. Reducing unwanted, unwanted, and often futile interventions at end-of-life will realign the level of care based on best interest and preferences of the patient. Improvements in patient and family satisfaction are seen with the added benefit of reducing medical costs (Compassion and Support, n.d.).

Since the early 1990s, the needs of the seriously ill and dying in the community have been addressed and changes are occurring. Previously, EMS and first responders were automatically responding to in-home CPR, but it is unknown if CPR is attempted, and the patient may make it clear that DNR does not mean ‘do not treat’.

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## Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Agent</td>
<td>An adult who has the authority to make healthcare decisions under a healthcare directive for the individual granting the power.</td>
</tr>
<tr>
<td>Advance Care Planning (ACP)</td>
<td>The process whereby an individual makes decisions about his/her future healthcare.</td>
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<tr>
<td>Advance Directive (AD)</td>
<td>See Healthcare Directive</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
</tr>
<tr>
<td>Code Status/Code Level</td>
<td>The status of an individual with respect to desire for resuscitative efforts (i.e., CPR), should the need arise; unless the individual specifically requests not to be resuscitated (i.e., DNR status), CPR is performed.</td>
</tr>
<tr>
<td>DNR</td>
<td>Do Not Resuscitate</td>
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<tr>
<td>Durable Power of Attorney</td>
<td>An individual executes legal documents which provide the power of attorney to others in the case of an incapacitating condition that can be financial and/or medical.</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>Healthcare Agent</td>
<td>See agent</td>
</tr>
<tr>
<td>Healthcare Power of Attorney</td>
<td>A written instrument that includes one or more health care instructions, a power of attorney or healthcare or both.</td>
</tr>
<tr>
<td>Instructive Directives</td>
<td>A written document that specifies what life-sustaining treatments an individual would or would not wish in various health situations.</td>
</tr>
<tr>
<td>Living Will</td>
<td>A collaborative effort of national, state and community organizations committed to ensuring that all adults with decision-making capacity in the United States have the information and opportunity to communicate and document their healthcare decisions.</td>
</tr>
<tr>
<td>National Healthcare Decisions Day (NHDD)</td>
<td>A written document in which one person (the principal) appoints another person to act as an agent on his or her behalf, thus conferring authority on the agent to perform certain acts or functions on behalf of the principal.</td>
</tr>
<tr>
<td>Power of Attorney (POA)</td>
<td>A written instrument that specifies what life-sustaining treatments an individual would or would not wish in various health situations.</td>
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<tr>
<td>Power of Attorney for Healthcare</td>
<td>A written document which in which one person (the principal) appoints another person to act as an agent on his or her behalf, thus conferring authority on the agent to perform certain acts or functions on behalf of the principal.</td>
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<td>Principal</td>
<td>An adult individual who has executed a healthcare directive.</td>
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**POLST** Physician's Orders for Life Sustaining Treatment - a form that constitutes medical orders to ensure that a seriously ill person's wishes regarding life-sustaining treatments are known, communicated, and honored across all health care settings.

**Principal** An adult individual who has executed a healthcare directive.
The article below is a reprint from the Utah Nurses Association (UNA) Newsletter and is dedicated to educating nurses about the risks they and their co-workers face in performing routine patient care. It will also give you information about what you can do to help you and your co-workers. Please see “Safe Patient Handling” (ANA) http://www.anasafepatienthandling.org/ for the most up to date legislative activity.

Nearly all of us are aware of nurses with back pain—or we may suffer from it ourselves. What we may not realize is how enormous the problem is.

“My name is Elizabeth White. I am an RN who graduated in 1976 from the BYU College of Nursing. In December, 2003, I was working in the Surgical ICU at Arrowhead Regional Medical Center, the San Bernardino, California county hospital. My assignment that night was a 374 lb patient who was on a ventilator and also on spinal precautions. I was able to get help to turn and bathe him only once that shift. However, because he was on spinal precautions his mattress was flat, but had to be in reverse Trendelenburg because of the vent. He slid down to the foot of the bed, of course. Only one other staff member was available to help pull him away from the foot of the bed. By the end of the shift, I was in so much pain I could hardly walk. I ended up leaving clinical nursing: nearly six (6) years later I still have pain on a daily basis.”

Last year, over 71,000 nurses suffered a back injury—but these are only the injuries that can be directly traced to work. 48% of nurses complain of chronic back pain, but only 35% have reported a work related injury.i

Many of the injuries will simply be endured by nurses and health care givers, with no recourse to any compensation. The cumulative weight lifted by a health caregiver in one typical eight hour shift is 1.8 TONS.ii

Back injuries are incremental and pain often presents in unrelated circumstances.

Cost of the problem
Nurses back injuries cost an estimated $16 billion annually in workers compensation benefits. Medical treatment, lost workdays, “light duty” and employee turnover cost the industry an additional $10 billion.iii

The Bureau of Labor Statistics show an inexcusable situation. Fig. 1 is a 2007 Bureau of Labor Statistics chart of the industries with the highest numbers of worker injuries.iv The top category: hospitals. In addition, the fourth and fifth categories are also of health care workers. In total, over 505,000 health care workers were injured. We know that a large percentage of these injuries are due to patient handling.


Fig. 1

It is interesting that the Bureau of Labor Statistics divided health care into three categories, when they are really of one industry. A more accurate chart would look like Fig. 2:

Fig. 2

The Bureau of Labor Statistics have even acknowledged that back injuries caused by patient handling are largely preventable.iii

The causes of nursing back injury, or, YOU MUST NOT BE USING GOOD BODY MECHANICS

Hospitals and nursing homes are well aware of the risks of back injury resulting from patient care. Virtually all of us have had numerous “back injury prevention” classes over our work life. Why then, are the injuries so high? Is it because we just don’t listen? Or, is it because there is no safe way to manually lift and care for patients? Just look at the diagram below for a comparison between the NIOSH lifting standards and everyday patient care reality.

There are physiological reasons for this. William Marras, PhD, CPE, Honda Professor and Director of the Biodynamics Laboratory, Institute for Ergonomics at Ohio State University has made extensive studies on what happens to the human back under stress.vi

Basic anatomy lesson: the intervertebral disc is fibrous, dense tissue with a resilient gel filled center. The outer fibrous ring is called the annulus fibrosis, and the center the nucleus pulposus. It has no blood supply, and no nerve endings. It receives its fluid and nutrients by osmosis from the adjacent vertebrate bone through the end plate, which also attaches the disc to the vertebrae.

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Pathophysiology, or, We all have our limits

When lifting tolerances are exceeded, the end plate of the intervertebral disc is damaged with tiny tears called microfractures. No pain is felt, since nerve endings are not present in the disc or the end plate. These microfractures then heal with protein aggregatins and scar tissue which is thicker and less permeable than the normal tissue. Over time, with many microfractures occurring, most of the end plate of the vertebra converts to scar tissue. The disc can no longer absorb fluid and nutrients. It becomes weakened, porous, soft and dry, which is the condition we know as degenerated disc. The softer tissue then bulges into the spinal column causing pain and muscle spasm, or the gel in the center of the disc can even herniate through the end plate of the vertebra causing pain and muscle spasm, or the gel can even herniate through the soft porous outer tissue, causing much greater pain. With severe degeneration, the disc can collapse, which narrows the space available for the nerves, causing pain and muscle spasm.

downward pressure will cause damage to the disc end plate at pressures from 700 to 1300 lbs. Since many caregivers are physically small, the limits should be at the low end of this. However, most manual patient handling includes pushing and pulling elements. With pushing and pulling, damage occurs at about 1/3 the force. Nurses understand shearing: shearing damage to the disc occurs at lower forces than pressure.

What are safe lifting pressures for the disc, or, Should you lift a “little 100 lb grandma?”

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Linen changes and bathing of bedridden patients
Celing lifts can use repositioning slings to move the patient around for linen changes and bathing.

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Linen changes and bathing of bedridden patients
Celing lifts can use repositioning slings to move the patient around for linen changes and bathing.
Nursing Workforce Diversity Grants
Section 4804 (p. 875) expands the workforce diversity grant program by permitting such grants to be used for programs that offer training for medical, nursing, or other health professions; or for programs that assist students or individuals in obtaining required licensing, certification, or credentialing; or for programs that support the development of research on diversity in the health professions.

Graduate Nurse Transportation Assistance Grants
Section 4809 (p. 879) authorizes $500 million for FY 2012 through FY 2015 to establish a grant program to provide transportation assistance to graduate nurses. This section authorizes grants for the purpose of enabling graduate nurses to complete clinical training experiences that are necessary for the completion of their educational programs.

Quality
Many recent studies have demonstrated that what next care costs consumers already using nursing and quality patient care are consistently linked at one and setting purposes. Because nursing care is a vital component of today’s patients, a plan that achieves, improves, reduces or minimizes this disparity, would be critical to the success of health care reform. The Medicare Hospital Compare Website would be vital to helping consumers make informed decisions, and full data would be processed and incorporated into the site.

Accountable Care Organizations (ACOs)
• Patient-centered medical home.
• Care management.
• Care coordination.
• Chronic disease management.

Additional Nursing Provisions
Section 5010 (p. 878) requires the Secretary to provide technical assistance and support to states and other entities to develop a standard payment system for long-term care services. The statute includes provisions that would allow states to use such funds to develop a standard payment system for long-term care services, including the independent living centers.

Nursing Home Quality Improvement
Section 5006 (p. 876) establishes a program to improve the quality of nursing homes, including the development of quality improvement plans, the establishment of a quality improvement team, and the provision of training and technical assistance.

Nurse-Midwives
Nurse-Midwives, are proven providers of high-quality, cost effective primary care. ANA has been advocating for the inclusion of nurse-midwives in the core of primary care, and the statute specifically authorizes the inclusion of nurse-midwives in the Medicare payment system.

Health Clinics
Section 3501 (p. 589) requires the Secretary to develop a program to develop best practices related to “culture change” and information technology in nursing facilities.

Nursing Home Transitions
Section 5007 (p. 875) directs the Secretary to create a standardized complaint form and requires states to establish a complaint resolution process. It also provides whistleblower protections for employees who report potential violations of law, fraud, waste, or abuse.

Primary Care those services furnished by physicians in 2013 and 2014. The federal government will pay 100% of the incremental costs

Expenditures and Improving Health Outcomes
Section 1202 (p. 216) authorizes states, with federal grant support and after conducting a mandatory assessment of need, to establish evidence-based nursing home visitation programs for married, infant, and early childhood programs. These programs would be designed to support nursing home visits, including the provision of informational materials to visitors, and the implementation of quality improvement plans.

Medicare  community-based interdisciplinary, interprofessional teams to support primary care practices within a certain area. Such teams (ACOs)—based on the share of savings they achieve for the Medicare program.

Accountable Care Organizations (ACOs)
Section 3612 (p. 277) establishes a shared savings program under which a group of providers and suppliers may form a legally structured arrangement to manage care for Medicare fee-for-service beneficiaries. An ACO that achieves savings may retain a percentage of these savings, which will be used to offset Medicare payments to participating providers.

Primary Care Teams
Section 3303 (p. 209) creates a program to develop and support primary care teams aimed at reducing expenditures and improving health outcomes. Independence at Home is a demonstration program that will provide home-based primary care services to certain Medicare beneficiaries who are diagnosed with a complex set of chronic conditions.

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Home Care and Education Reconciliation Act of 2010. Section 1202 (p. 207) authorizes a demonstration project for pediatric ACOs that serve State Medicaid programs. In addition, the Department will provide incentive payments to other health care professionals or organizations that provide care to children, including nurse practitioners, physician assistants, and clinical nurse specialists.

Additional Provisions
Section 4003 (p. 888) establishes a new grant program for school-based health centers. The final program will be authorized to provide grants for construction and equipment for new school-based health centers. The statute authorizes $5 million for each of fiscal years 2010 through 2013 to carry out this grant program. School-based health centers that serve large populations of Medicare-eligible children will have priority for grant consideration.

American Nurses Association (ANA)
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Diversity
Tribal colleges or universities.

Nursing Home Violence Services
Section 2301 (p. 209) authorizes states, with federal grant support and after conducting a mandatory assessment of need, to establish evidence-based nursing home visitation programs for married, infant, and early childhood programs. These programs would be designed to support nursing home visits, including the provision of informational materials to visitors, and the implementation of quality improvement plans.

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