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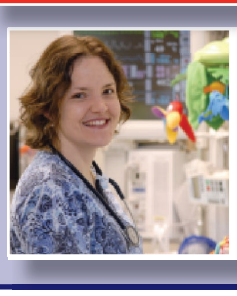
DNA Reporter

The Official Publication of the Delaware Nurses Association

Constituent member of ANA, Charter member of CAN

The Mission of the Delaware Nurses Association is to represent the interest of professional nurses in the state of Delaware. The Delaware Nurses Association also advocates for health care issues through legislative channels and regulatory activity, resulting in positive outcomes for all Delawareans.

Inside DNA REPORTER



In the PICU, it is Never "Just Another Day at the Office"
Page 10

Upcoming Events
Page 14

Guest Editors

Maureen A. Seckel, RN, APN, MSN, APRN-BC, CCNS, CCRN

Maureen Seckel

Maureen A. Seckel earned her BSN from Boston University and her MSN for the University of Delaware. She is a board certified Medical Critical Care Pulmonary Clinical Nurse and has worked in critical care as both a direct care nurse and clinical nurse specialist for over 28 years. She is currently a Clinical Nurse Specialist at Christiana Care Health System working with patients in both the Medical Intensive Care Unit and the Pulmonary Step-down, including acute and chronic ventilator patients. Maureen is a member of the Evidence Based Nursing Practice Council and Co-Chair elect of the Advanced Practice Council at Christiana Care Heath System. She is also chair of the American Association of Critical Care Nurses Workgroup for Evidenced Based Practice. Maureen can be reached by email at mseckel@christianacare.org or at her office at (302) 733-6023.

continued on page 2

Norine Watson, MSN, RN, CNAA-BC

Norine Watson

Norine Watson, MSN, RN, CNAA-BC is the Director of Nursing Excellence at duPont Hospital for Children of the Nemours Foundation and currently the President-Elect of the Delaware Nurses Association. Nowatson@Nemours.org office (302) 651-6470.

Nurses' Week always causes me to pause and reflect on both my personal and professional nursing practice; what I have accomplished and what I hope to do next year. First of all I must mention what a pleasure it has been to be the co-Managing Editor of the DNA Reporter. This experience broadened my perspective of nursing not only throughout the state of Delaware and also in the multitude of practice environments and opportunities for nurses that exist. Additionally it has given me the opportunity to work closely with and learn from my co-Managing Editor, Maureen Seckel, who not only understands but also continually strives for excellence in nursing practice. Every time I talk about my work with the *DNA Reporter* I speak with enthusiasm for learning and experience that I have gained and also for

continued on page 2

Executive Director's COLUMN

Sarah J. Carmody
Executive Director

Sarah Carmody

Happy Spring! This past year at the Delaware Nurses Association has been one of growth and change. We have moved forward with offering state-only membership and our organizational affiliate program. Both programs will provide for a strong voice on legislative issues, community outreach and education and for providing a solid foundation for networking and nurses working together. I hope that you and/or your specialty organization will join us. The benefits and information on both programs can be found on our website. Please do not hesitate to call the office with any questions regarding either program.

Additionally, the DNA is moving forward with the formation of its nursing foundation. The foundation is being developed so that scholarships can be offered for both the experienced nurse and those entering the profession and to support educational activities of nurses in our state. This is very exciting for the DNA and I look forward to reporting on the foundation updates.

During Nurses Week, the Delaware Nurses Association will be celebrating nurses at the Blue Rocks games May 10th and 11th. I hope you and your family will come out to the ballpark while we cheer on our local team and celebrate

continued on page 3

Index

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Guest Editor, Norine Watson...

continued from page 1

my professional relationships that have been strengthened through this role. This issue is one that Maureen and I are particularly proud of because it is comprised of clinical nurse exemplars that are derived from nurses' experiences and written directly from these nurses' hearts. Many of our authors for this issue are first time writers; we hope that you will enjoy their stories.

Now we are delighted to pass the managing editor roles on to Bonnie Osgood from Christiana Care and Daryl Miller from A.I. duPont Hospital for Children because we know that this experience will bring them the same level of professional satisfaction. We are also confident that they will bring new insight and perspective to their managing editor roles and the Reporter will become an even better vehicle to support the mission of the Delaware Nurses Association, which is representing the interest of professional nurses in the state of Delaware and advocating for health care issues through legislative channels and regulatory activity, resulting in positive outcomes for all Delawareans.

Next I look forward to continuing as the President-Elect of the Delaware Nurses Association. I can think of no other professional leadership development experience that would be more valuable than having the privilege of working closely with my friend and mentor Penny Seiple. Penny has moved the Delaware Nurses Association in a very positive direction by expanding membership and the board, thereby enabling our professional organization to reach out to more nurses than ever before. My goal is to learn and follow her inclusive nursing leadership style. I wish you all a happy nurses week and look forward to reflecting on our shared accomplishments next year.

Guest Editor, Maureen Seckel...

continued from page 1

This issue of the DNA Reporter is dedicated to all Delaware nurses and I am honored to have published a few of their exemplars in this issue. I have enjoyed reaching out to Delaware nurses as the Co-managing editor of the DNA Reporter since 2004 with my colleague Norine Watson, and would like to share my personal history of 30 years in nursing. There are really 3 main parts to my story.

Patient Advocacy

I became a bright and shiny new nurse when I graduated from Boston University in 1978. I worked on a surgical unit before finding my niche in nursing, critical care nursing. One of the driving forces for me to work in an ICU was the ability to follow and care for my patients when they became sicker. I had been frustrated by transferring patients off of my surgical unit for a higher level of care despite my best efforts and willingness to learn. I remember going to the ICU to visit a patient I had cared for and had no idea of what all those tubes and wires were, why he was tied up and looked so sad. I became a critical care nurse in 1980 after taking a hospital sponsored critical care course and have never looked back. I remember so many patients and so many stories. I loved the advocate role and providing family centered care. I spoke nursing and was able to translate to my patients and families what was happening. I was young and enthusiastic and knew that I could make a difference in a life.

Personal Advocacy

My nursing career supported my husband while he was in school and we moved across the country several times for school and job opportunities to further his career. We started our family and moved to Delaware in 1988 and I started work as a staff nurse in the Surgical Trauma ICU at Christiana Hospital. I still loved critical care nursing but was beginning to wonder what my role in nursing was. I knew I could make a difference in a patient's life but wanted to change systems to make it better for many patients. I enrolled in 1991 in the clinical nurse specialist track at the University of Delaware.

Nursing Advocacy

I love the role of the clinical nurse specialist and it allows me to expand on my earlier nursing career. I continue to want to make that impact into a patient's or family's life but I can also influence many areas in our healthcare system that impact patient care. I am a nursing advocate by helping to change practice to bring evidence into what we do everyday in healthcare and helping to make it doable for the direct care nurse at the bedside. My goal is to support nursing to provide best patient care. I can impact nursing in so many ways by teaching, publishing, speaking, doing research, joining national organizations, volunteering, being part of the shared decision making structure, mentoring, etc. I am a nurse.

DNA Reporter

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Delaware Nurses Association
2644 Capitol Trail, Suite 330
Newark, DE 19711
Phone: 302-368-2333 or 800-381-0939 FAX 302-366-1775
Email: information@denurses.org
Web: http://www.denurses.org

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Managing Editors
Daryl Miller, RN, BSN
Bonnie Osgood

Photographer
William Campbell, EdD, RN

The *DNA Reporter* welcomes unsolicited manuscripts by DNA members. Articles are submitted for the exclusive use of T*he DNA Reporter*. All submitted articles must be original, not having been published before, and not under consideration for publication elsewhere. Submissions will be acknowledged by e-mail or a self-addressed stamped envelope provided by the author. All articles require a cover letter requesting consideration for publication. Articles can be submitted electronically by e-mail to Daryl Miller, RN, BSN, @ dwmiller@Nemours.org or Bonnie S. Osgood, RN, MSN, CNA,BC, @ bosgood@christianacare.org.

Each article should be prefaced with the title, author(s) names, educational degrees, certification or other licenses, current position, and how the position or personal experiences relate to the topic of the article. Include affiliations. Manuscripts should not exceed five (5) typewritten pages and include APA format. Also include the author's mailing address, telephone number where messages may be left, and fax number. Authors are responsible for obtaining permission to use any copyrighted material; in the case of an institution, permission must be obtained from the administrator in writing before publication. All articles will be peer-reviewed and edited as necessary for content, style, clarity, grammar and spelling. While student submissions are greatly sought and appreciated, no articles will be accepted for the sole purpose of fulfilling any course requirements. It is the policy of DNA Reporter not to provide monetary compensation for articles.

Exemplar

Barbara Schilling, RN, BSN, RNII

Barbara Schilling earned her Diploma degree from the Helene Fuld School of Nursing at West Jersey Hospital. She has been a staff nurse in Labor and Delivery at Christiana Care Health System since 1979. Barbara is certified in Outpatient Obstetrics, she is an RNII and a member of the Professional Nurse Council and the OB/GYN Triage council. She is also completing her BSN with Immaculata University.

Barbara Schilling

I have been a nurse for more years than I'd like to say. I was a graduate nurse when I started in the Labor and Delivery unit at the General Division and I have never left. I have outlasted the move from the General Division in 1985, where we put fetal monitors in the trunk of our cars, because we knew how important they were and did not trust them to the moving company. Our new Labor and Delivery department was great, but at the same time it was scary. It took me weeks to find my locker and the cafeteria. It also took a long time to get used to the name, Christiana Hospital.

It is amazing, as nurses, how we adjust to change. Within weeks of being in our new department, we made ourselves at home. We adapted to being on the second floor and although we feared it, delivering babies in the elevator never happened. The changes within our department helped us to focus on how to make the birthing experience better for our patients. We had gone from having patients rushed to the delivery room, giving them a saddle block, and delivering the baby, to gradually letting the patient deliver in her room, but we still had to leave the room with the baby to do the initial assessment in the delivery room. The concept of birthing rooms were created in the late 1980s, but there were only a few physicians who agreed to deliver their patients in this new room.

The move to the new Women's and Children's Health Service building was equally scary. It again took me a few weeks to find my way around our new building. The day the building opened, I was the triage nurse sitting at the front desk with the admitting staff. I was not quite sure what my job was, but I knew I was going to be great at it. As the years have progressed, I am still an OB/GYN nurse and my position has changed to a dedicated OB/GYN Triage nurse. From the first day that I stepped foot in the Labor and Delivery unit those many years ago I felt that I was home. Nurses can get frustrated and post to different positions in nursing and in their facilities, but my love and passion has always been with my patients and co-workers. There really was nowhere else for me to go. I have always been home.

Executive Director's Column...

continued from page 1

the profession of nursing and all that nurses do. The flyer and the order form can be found on our website-www.denurses.org. Thank you for being a nurse!

Speaking of celebrating nursing, it is time once again for the Nurse Excellence Awards. Please take the time to nominate your favorite nurse, colleague, mentor or even yourself. We had a wonderful celebration last year, and this year will be even better. The application is easily accessed via the DNA website so don't wait, send it in today! The awards ceremony is scheduled for July 17, 2008 at the Modern Maturity Center in Dover, Delaware.

I welcome your comments and ideas, please do not hesitate to call or drop me an email. Happy Nurses Week!

Congratulations New Grads!

As you move on to starting your nursing career, don't forget about the value of your state nurses' association. The Delaware Nurses Association's events, dinners, and committees are an ideal way to network with seasoned nurses, find a job you may not have considered and save money on liability insurance, accreditation and conference registration fees.

And to start out your saving, as a new nurse graduate, membership in the DNA/ANA is only $114.50 for the first year! Join online at www.denurses.org. Again, congratulations and we hope to see you at some of our upcoming events

Exemplar

Lisa Mack

Lisa Y. Mack, RN, C, RNII

Lisa Mack earned her degree in Nursing from Gwynedd Mercy College. She is an ANCC board certified Psychiatric-Mental Health Nurse and has been an RN for 28 years. She is currently employed as a psychiatric crisis nurse and RNII at Christiana Care Health System. Lisa is a member and chairperson of her unit's Shared Decision Making committee and designs and maintains the unit's website. She is also the commodore of her yacht club on the Chesapeake Bay.

I have been a psychiatric nurse for nearly 27 years and have spent most of that time working with the both the chronically mentally ill and indigent populations with co-morbid addictions. Frequently, I don't feel that the care that I render to this patient population makes much of an impact on their lives. Their prognosis at times can be grim and their recidivism high. These patients are often underserved and overlooked in our society and their voices unheard.

For the past 5 years since I have worked at Christiana Care Health System in the psychiatric crisis department in both the city and suburban emergency departments. I see and treat patients who are "in crisis" who may be suicidal, chemically impaired, and/ or psychotic. I field phone calls on the crisis hot line and often spend an hour or more in the wee hours of the morning talking with distressed and anxious patients who have awakened in a panic, riddled with anxiety, cannot reach their therapist, and have no one else to turn to.

I also see patients who are taken to our emergency department by the police or by their families, and who are not willing to talk to us or cooperate with the assessment and treatment process. Patients in crisis can be violent or verbally abusive. I have been spat at, cussed at, kicked, and swung at over the many years that I have chosen to work in this field. My patients rarely thank me for the care that I give and even less acknowledge me for a job well done at the end of the day. I am often in survival mode, just trying to finish out my stretch of 12 hour shifts with my own psyche intact.

I have held the hand of an elderly man as his wife of 60 years lay unresponsive in the emergency department, while he says his last goodbyes. I have cried with parents who have lost a teenage child to suicide and have grieved with many others who have lost loved ones to the tragedy of gang related violence, motor vehicle collisions and "natural causes." In their grief, they are grateful for my presence, assistance, and comfort throughout the process but are so overwhelmed and consumed in their pain, that it is difficult for them to express their gratitude directly. Yet, my coworkers and I continue to face the hurdles and heartache day after day, often in the face of crisis and continue to try to advocate for our patients and do the best job we can.

There is one client though who stands out in my mind that I treated in the Crisis Assessment and Psychiatric Emergency Services (CAPES) unit a few months ago. In order to protect his privacy, I will call him Kevin. Kevin was in his mid twenties and had been diagnosed a few years earlier with Bipolar Disorder. He was the youngest in his family and had been born and raised in Wilmington. He was employed full time at a job he liked which was physically demanding, and had his own car and apartment. Kevin was not typical of the patients we frequently see. He was educated in a private high school, attended college, graduated with his BA degree, and moved back to Delaware after graduation. He has a good relationship with his parents, brothers and extended family and was grateful for the opportunities he had been given in his life and had no complaints to offer. He was not entitled, was not self pitying and was trying to live his life productively and independently. Kevin was not suicidal, homicidal or using illicit substances to self medicate and attended his counseling sessions and took his medication as prescribed. He presented to the emergency department one evening and requested to see psychiatry because he was scared that this "bipolar disorder was going to ruin" his life. He was intelligent and well read enough to know how incapacitating this illness could be and was terrified that he would not be able to have a wife, raise a family, and find the happiness he had enjoyed throughout his young life.

We talked at length that evening in the CAPES unit. I offered him reassurance and acknowledged his fears and forebodings. I could not make him any promises to allay his fears that despite all the best intentions and treatment, that he would live "happily ever after" but I listened to Kevin. I offered options for outpatient treatment and gave him our crisis hot line number. Kevin was discharged after a few hours in the ED and went home. I felt unsettled and sad for him. Here was a young man who was doing everything "right" by way of actively participating in his treatment but I still didn't feel that I had "done" anything for him.

Two nights later, I was working in the CAPES unit at our other facility, when the crisis line rang and the caller requested to talk to me. It was Kevin, and he had called to ask if "we" see people as outpatients. I knew Kevin was already in treatment but why would he want to switch locations and therapists if he had already had time invested with another service within the health system? Kevin was quick to correct my misperception of his inquiry. He said to me, "no, I don't think you understood my question, I was not asking if I could start treatment at Pathways, I wanted to know if you personally could see me as an outpatient?" He then added that, "you really listened to me and I felt very comfortable and at ease talking to you and hoped that you could be my therapist." I was moved when he said this, and told him that, although I appreciated his wanting to continue in treatment with me, I was employed as a nurse in the psychiatric crisis department and was not licensed to see private patients. I thanked him for the compliment and we left it with him agreeing to continue his current therapy.

It was after this conversation, that I started to reconsider furthering my education. I had started on the path of continuing on with my degree on several occasions over the last 27 years. I have amassed numerous credit hours but have never had the discipline to complete my degree and move forward with obtaining an advanced practice degree in psychiatric nursing or clinical counseling. In recent years, I have repeatedly stated that I am doing exactly what I want to be doing in nursing and had no interest in advancing my career and doing anything else, as I liked my hours and was content with my salary. I am a practical person and felt that if I invested the time and effort to returning to school while still working full time then the "payoff had to be worth it." Lately, I have started to reconsider this mindset. I have become much more involved in the policies and operations of our department and have taken on several projects within the crisis unit. I now co-chair the Shared Decision Making Committee, and will take over as chairperson in January 2009. I do the schedule for our unit, keep the statistics for the CAPES unit, and am designing and implementing our unit web site. Additionally, I have ongoing performance improvement projects that I am tracking to streamline patient flow and also to insure compliance with hospital wide policies and JCHAO mandates. The more active I become here within my own department, the more I think of other areas where I believe I can have an impact, and the more I realize that getting an advanced degree is necessary.

So in closing I acknowledge that although, I frequently do not see "success stories" in the population I serve, there are moments when even though I may not be cognizant of the impact I am playing in someone' s life, my being here at this moment in time does make a difference.

Exemplar

My Story: A Profession and a Passion

Faith Broadwater Seltzer, RN, BSN

Faith Broadwater Seltzer

Faith Broadwater Seltzer earned her BSN from the University of the State of New York, her Arts and Sciences degree from Penn State University, and her nursing degree from Frankford Hospital School of Nursing in Philadelphia. Faith has been a nurse for 15 years and is currently employed as a cardiac nurse at Christiana Care Health System in the Clinical Decision Unit. Faith is a member of her unit's Shared Decision committee, has been a safety mentor, and a member of the Professional Nurse Counsel.

My story begins on a snowy Christmas night in 1970. I was 20 years old, pregnant and two weeks overdue with my first child. My whole day had been one long nightmare as my family and my husband's family fought over where we should have eaten first and where we should have stayed the longest. By the time my husband and I finally got home I had consumed two huge Christmas meals, had everyone in both families mad at me and was feeling stuffed, unloved and very, very fat. It took some time for me to realize that the discomfort I was feeling was labor pains. I was putting them down to nerves and eating two meals to make both families happy. Once I did realize that I was on the road to a whole new life, the excitement, and yes, the fear took over.

Back in 1970, the only stories that were ever told to young women were the "horror" stories of terrible, long labors. Even the physician had not gone over what I might expect to happen. I was scared, young and in pain. My husband went home, sent by the hospital staff because "it would be a long time before the baby would be born and you might as well get a good night sleep." Bowing to their superior knowledge, my husband went home. As I lay there in a small darkly lit room, all by myself after a long, stressful day, I can remember saying a little prayer, asking God for help. Before I had opened my eyes a nurse appeared. She took my hand and went over everything that would happen. She made me feel safe. I believed her when she said that everything was fine and my baby would be beautiful and healthy. She checked on my progress and then told me I was much farther along than she had been told. She rushed to bring the physician in and then stayed with me until my daughter was born. In her presence I felt safe. She knew what she was doing, she made a difference. I can remember looking at all the equipment in the room and watching her as went about her duties and thinking, "I wish I could make a difference like that."

A year and a half later I had a new son. He was six weeks old and he had been fretful all day. I had walked him back and forth all day and he finally fell asleep about 11:00PM. He didn't have a temperature and when I called the physician he diagnosed it as colic. Around 1:00AM I awoke to a grunting sound coming from my son's crib. When I got up and went to him I was horrified to see him jerking in a terrible state. My husband and I rushed him to the nearest Hospital as there was no 911 system back then. On that terrible ride I made a lot of promises to God if only he would save my baby. As we ran into the emergency room the nurse at the desk took one look at my son, took him from me, and rushed him to the back room. She then came back for us and talked to us the whole time we were there. Once again I felt that safe feeling. My son was in her hands, she knew what she was doing, and he was safe. I watched as she moved through the room doing the things that she had to do. I can still see that emergency room in my mind to this day. I clearly remember thinking "I could never to do this, how smart she must be to be able to save lives like she does." I don't remember the physician saying more than a few words to us, but the nurse kept us continually informed. She went with us to the room where our son was admitted and came back the next day to check on him.

After that experience I took a first aide course at the Red Cross. The instructor told me I did better than the two emergency medical technicians who were in the course. He encouraged me to pursue additional training in health care. For the first time I felt like maybe I could do it.

It wasn't until many years later that I decided to go back to school. I graduated from nursing school in 1993 and two of my daughter's friends were in my class. After I started working, I tried to remember the reason I went into nursing whenever I felt stressed and overworked. But it wasn't until one of my patients after returning from a few days off, said to me "Oh I'm so glad you're back, I feel so safe when YOU'RE here." that I knew that I had finally paid back the debt that I owed to nursing. I finally did and do make a difference, I made my patients feel, and did in fact keep them safe. I was in the most special and wonderful career ever, I was a NURSE!

Exemplar

Jeanne R. Collins, RN, BSN

Jeanne Collins

Jeanne R. Collins has been employed as a registered nurse at the VA Medical Center in Wilmington for the last 31 years. She received her BSN from the University of Delaware. Jeanne's experience has included assignments on a surgical floor, Post Anesthesia Care Unit, Primary Care and, presently, Gastroenterology Procedure Clinic.

I have had the pleasure of being a registered nurse for the past 31 years. My experience includes floor nursing, critical care, outpatient clinic, and specialty clinic nursing. If I had it to do over again, I'd do it in a heartbeat. I have cared for many patients in those years, many touching my heart and my soul. Of all the patients I have been fortunate enough to encounter, one patient has left a mark that will last forever.

I was working in a primary care setting when this particular patient came into my life. He was accompanied by his stepfather who was very attentive and concerned about his son's condition. The patient was a gentle man in his mid-fifties, who had been diagnosed with colon cancer by a private physician several weeks prior and had undergone surgery for that cancer. Unfortunately, during the four week period between his original diagnosis with subsequent resection, and his appearance into my clinic, he had lost his medical coverage. He was as lost as his insurance coverage and was truly in need of help. He stated that he and his stepfather were "having trouble" managing his colostomy. Upon examination, the skin over half of his abdomen was excoriated. His colostomy bag was ill-fitted and he was soiled. I had to wonder how long he had been managing like this. My heart ached for him and the lack of knowledge that he had about caring for himself. I was humbled as I watched the loving interchange between my patient and his stepfather yet angry that a situation such as this existed within the healthcare system. I was honored to assist this family with learning the care that was needed. Their desire to learn was evident.

My interaction with this patient ended on that day. All told, I probably spent only one hour or so with him yet his memory will live on within me forever. He established care within my facility and required admission many times over the next several months. Unfortunately, this patient had been diagnosed with a Stage IV rectal cancer with metastasis to his liver and lungs and required chemotherapy. He also developed a urethral obstruction and abdominal abscess from his original surgery, requiring additional surgery, a nephrostomy tube, and port placement. He was subsequently unable to tolerate chemotherapy. Shortly thereafter, he was placed under the care of hospice. My patient, who I had met just six months prior, passed away at home.

Probably no one patient has evoked such strong, long-lasting emotion in me. I often think of my time caring for him, short as it was. I realize that no matter how many scientific advances are made, no matter how aggressively we can treat a disease, or how hard we try, we, as healthcare professionals will sometimes lose the battle to illness. In these cases especially, the value of human kindness and compassion comes to the forefront. I am forever grateful that I took the time to truly care for my patient that day. For that short time, I was his advocate. I can choose to dwell on the sadness of the man's condition or I can remember the tremendous empathy I felt for him. I hope that I was able to touch his life just as he had touched mine. Sometimes the best medicine we can offer our patients is ourselves as human beings. I wasn't able to cure my patient but maybe I was able to comfort him. Maybe I was able to show compassion and help him feel safe and feel that he was not alone. After all, isn't that what quality of life is all about? Isn't that what nursing is about?

Exemplar

Lisa Luneau-Nepon

Lisa Luneau-Nepon earned her BSN from City College of New York. Lisa is an AIDS certified registered nurse and has been an RN for more then 30 years. She is currently employed as the HIV Coordinator at the VA Medical Center. Lisa is a member of the Association of Nurses in AIDS Care and the American Nurses Association.

Lisa Luneau-Nepon

I first met my patient in May of 2005. He had just learned that an old girlfriend had recently died of AIDS and was very worried about the possibility that he might have become HIV-infected from her. His HIV counseling and testing were done by me and we spoke at length regarding his fears and if he would be suicidal if he learned he was HIV-infected. The patient paused to pray for strength. He assured me that his faith would not allow him to harm himself or others. I offer to be available for additional questions and the patient agrees to call me. We planned an appointment for him to return for results in one week.

When the patient returned to me for his HIV results, he asked if I had good news for him. Unfortunately despite his hope, I had to tell him that he tested positive for HIV infection. The patient started to cry immediately after learning his test results and we sat together while he cried. When the patient was done crying and could make eye contact with me, I asked if we could make plans for his care. He wanted to know what the next steps would be. We planned for additional labs to evaluate his immune function, an appointment with the infectious disease specialist and had a conversation about his social circumstances. The patient shared with me that he would not share this news with his family just yet. He did not have friends and was socially isolated living alone. He did have plans to move in the near future and was hoping to be accepted into a senior citizens apartment building. We spent some time talking about his plans and he identified ways I could help with the application. He agreed to come back the next week. I had no way to reach him easily by phone and I told him I was glad we would have the chance to speak again before his next medical appointment.

The patient continued to see me in clinic for several months. He did move and was satisfied with his new apartment. In January 2006, the patient came for a routine clinic appointment and when I asked how he was, he asked if he could close the door. The patient began to share with me an extensive delusion that he had had for many months. He believed he was being poisoned by the dumpster outside his building, his fire alarm was spying on him, and that there were groups of men from his stay at the YMCA that followed him and kept tabs on him and knew when he had appointments. Despite paying his lease in advance, he was not planning to return to his apartment and was thinking about living in the street. He would not consent to a referral to a psychiatrist in our mental health clinic however, he did agree to keep me posted and that I would be in touch with him between his clinic visits. He agreed if he began to feel worse he would let me know. This situation continued for six months. I continued to see my patient monthly and to have phone conversations between appointments. In July 2006, the patient presented to the emergency department feeling suicidal and consented to an inpatient psychiatric admission. He has been receiving ongoing psychiatric care since that admission.

In November 2007, he was diagnosed with throat cancer. Rapidly within a 3 week period, he followed up with ENT tumor board and radiation oncology, had a port placed, and a peg tube inserted. He could not express his fears to me except to say "things are closing in on me." I expressed my concern and asked if he would let me know if he was feeling suicidal. For this patient of few words, he acknowledged it was a worry. The patient agreed I could speak to his brother and allowed me to be present when he met with the VA oncologist who would be caring for him. The patient identified questions he had and gave me permission to ask if he were not able to do so himself. I introduced him to the staff who would be providing his chemotherapy and we were also able to make short term plans in the event he had difficulty with his peg tube feedings or medications at home. Eventually, he did have difficulty keeping up with the hydration needed for chemotherapy and at his request was placed in a nursing home until his chemotherapy and radiation treatments were completed. He will reevaluate his living arrangement at that time.

I have been so touched by this patient's isolation, fear, and silence and that he has allowed me to get to know him and to care for him. I am touched by many of the patients that I care for who struggle with their illness and the stigmas related to HIV, mental illness, and substance abuse. Patients trust me and I care. I am a nurse.

Exemplar

Laura Brown, RN

Laura Brown graduated in 1994 with an Associate Degree in Nursing from Philadelphia Community College. Laura has worked at the VA Medical Center in Wilmington, Delaware for 13 years and has worked in critical care for the past eight years. Currently, Laura is pursuing her BSN at Wilmington University and will graduate in the spring of 2009.

Laura Brown

I laugh

I laugh, not to cry.
If I cry, I cannot do my job.
This is who I am.

To cry at home is not the thing to do.
I have to live my life.
To cope is to laugh.
This is who I am.

Every patient is my Father.
I love each patient.
I help because I can.
This is who I am.

Do you understand?
I care more than anyone can
understand.
I watch people die...and feel
helpless...
But...I tried.
This is who I am.

I worked so hard to keep this person
alive.
They died, anyway.
I laugh when driving home—
to keep myself from crying.
This is who I am.

Tears of joy for the recovered patient
seen in normal clothes.
I am an unknown.
He doesn't know me.
Doesn't know he was too sick to
remember me.
This is who I am.

Emotion owns me, for I was useful in
his recovery.
He will live to see other days.
I am happy.
This is who I am.

I am a nurse.

Data Bits

Dot Baker, RN, MS(N), CNS-BC, EdD
Associate Professor, Nursing, Wilmington University


Dot Baker

In celebration of Nursing Excellence, this column will present language that nurses and others can use to depict our optimal (excellent) qualities. As you review the findings, think about how many of the descriptors describe your nurse colleagues and yourself. Remember that we are captive by the words alone. We must also capture our auras, spirits, actions, and personalities in order to most fully describe our nurse colleagues and ourselves.

First of all, thesaurus results for the term "excellence" revealed these terms: fineness, brilliance, superiority, distinction, quality, and merit.

Then, a search for "excellence" via Bartleby's produced a number of synonyms and terms that name, describe, characterize, & qualify "excellence." See how many describe your colleagues and you —Better yet, use these "excellence" descriptors frequently!

acknowledged accuracy	noteworthy
blue ribbon	objet d'art
classic	paragon
conspicuous	quality
desirable	stand out
dignified	star
distinguished	superior quality or worth
essence	superlative
exceptional	tiptop
exquisite	touchstone
first degree in rank	ultimate object of endeavor
first rate	vintage
flourish	brightest
foremost	captivate
magnificent	deserve praise
merit	eminent
most profound	essential character
only	established model
par excellence	favorable
perfecting	gold standard
privilege	hallmark
promise	harmony
splendid	highly reliable
surpass brilliance	ideal
tireless	outshine
virtue	phoenix
alone	prime
beauty	quintessential
best or truest	refined
better	remarkable
choice	significant
distinction	skilled
exclusiveness	stupendous
extraordinary	suitable
first class	superior
goodness	surpass all others
great worth	value
highest classification	world class
inspired	
more useful	

LASTING SIGNIFICANCE

Ponte et al. (2007) investigated nursing power to determine characteristics that frame compelling nursing practice and influence work settings. Their findings in *The Online Journal of Issues in Nursing* seem related to excellence in nursing practice. They state that "Nurses who have developed a powerful nursing practice…

> **Acknowledge** their unique role in the provision of patient and family centered care
> **Commit** to continuous learning through education, skill development, and evidence-based practice
> **Demonstrate** professional comportment and recognize the critical nature of presence
> **Value** collaboration and partner effectively with colleagues in nursing and other disciplines
> **Actively position** themselves to influence decisions and resource allocation
> **Strive** to develop an impeccable character; to be inspirational, compassionate, and have a credible, sought-after perspective (the antithesis of power as a coercive strategy)
> **Recognize** that the role of the nurse leader is to pave the way for nurses' voices to be heard and to help novice nurses develop into powerful professionals
> **Evaluate** the power of nursing and the nursing department in organizations they enter by assessing the organization's mission and values and its commitment to enhancing the power of diverse perspectives" (pp. 5-6).

—Let's use this "What is Excellence" poem to capture and depict NURSING EXCELLENCE among us—

What is Excellence?

- **Is** attitude. It is more than competence. It is a spirit. It is setting the mind on the best that can possibly be.
- **Has** presence, sustained by every person's achievement.
- **Abhors** the static. It demands movement.
- **Can** be experienced everywhere and we must expect it everywhere.
- **Will** never be possible to the seekers of "second best."
- **Needs** to be viewed as a consistent and universal goal.
- **Is** spurred by the belief that few things that have been done before would be good enough again.
- **Is** an idea alien to the word impossible.
- **Embraces** a morality of aspiration more demanding than just morality of duty.
- **Demands** standards, follow-through, and rewards.
- **Flourishes** on energetic desire, not repose.
- **Has** a deep relationship to an ideal of perfection.

–Author Unknown

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Exemplar

Michele McHugh

Michele McHugh

Michele McHugh has been an RN with St. Francis Hospital for over 17 years. She earned her Associate Degree in nursing from Wesley College and is currently enrolled in the RN to BSN program at Immaculata University. Michele is presently employed as a staff educator for the Emergency Department as well as an ACLS and PALS instructor. She is currently working on implementing Shared Governance through our Evidence Based Practice Council.

This is a story that has impacted the way that I practice nursing. I had been a wound care nurse for about 5 years and was called to a 35 year old female's home. Her insurance company had been refusing to cover any more home care visits for this patient. She has had a wound on her left hip that over a course of two years would continue to heal and then reopen. The patient had been a patient of our agency before so we all knew her. The patient had a 2cm x 1cm wound that would heal over on the surface. When she would transfer to her wheelchair she would bump the hip and then the wound would reopen. She would have constant drainage from the wound. This prevented her from doing all of her normal activities. She stated that "she would have embarrassing drainage." The insurance company thought that the patient was not compliant with her care. This was a classic sign of osteomyelitis I told the patient and the insurance company. I had to explain what osetomyelitis is and how it occurs to both the patient and the insurance company and her primary physician. I explained to the patient that her wound would look and appear like it was healed but in reality it was only superficial and that is why it would always reoccur. I explained to her that through my experience that the only true way to heal osteomyelitis was through the following. First, we needed to get an x-ray of the wound to rule out osteomyelitis. I once learned from an infectious disease physician that any wound that is over a bony prominence and opened to the air for more than 6 weeks is considered osteomyelitis. I called her insurance company and her physician and asked them for an x ray.

There was hesitation from the doctor to order it as well as the insurance company to pay for it. The x-ray was inconclusive and suggested that a bone scan be done. I had to do a lot of convincing to the insurance company to pay for the bone scan. The x-ray will not show new osteomyelitis if existing bone degeneration is present. The patient had the bone done and it was positive for osteomyelitis. I went back to my patient and began to teach her about the next steps that she was going to take. A consult to a surgeon will be made and then to an infectious disease doctor. I explained that it would take some time to heal this wound, but if we followed the plan she would be healed and not have to worry any more. I explained that the surgeon would go in and debride the wound, this would make it bigger. In order for the osteomyelitis to be gone he had to debride and scrape the bone. This would result in having a major surgery. Then she would be expected to be on intravenous antibiotics for at least three to four weeks. There was a lot of teaching that I was doing. We sat for sometime and discussed the Pro's and Con's and she decided to go with the surgery. Two weeks later she had the surgery and was completely healed. She had asked me why all of the other nurses and doctors did not know all the steps or suggest this sooner. I stated to her "they were not wrong; I had many years of wound care training and classes." I learned that I made a difference to this patient and her quality of life by being her advocate. I feel as though being an expert in the field gave me a better chance to plead my case to the insurance company. The patient was happier and I gave her back a better quality of life. I have since changed fields and will still always remember what a difference I made in her life.

Exemplar

I Am the Power of Nursing

Patricia Boucher

Patricia Boucher has been a nurse with St. Francis Hospital for over 11 years. She earned her degree from Community College of Philadelphia, and is currently enrolled in the RN to BSN program at West Chester University. Patricia is currently employed as a critical care nurse for the Intensive Care Units. She was also the recipient of our 2005 Nursing Excellence Award.

Responsibility as a critical nurse is not just a career, it is a choice. Being blessed with the gift of healing allows me to stimulate the feelings of a patient to become internally relaxed in order for the healing process to take place. My hands multitask with care and gentleness to ensure comfort. My eyes view the patient as a competition to defeat the illness or pain associated with the diagnosis. My ears listen with attentiveness awaiting approval of tasks at hand. A patients' body language speaks loudly and can be heard by a conscientious nurse. The future of the healing process can be envisioned through a nurses' ability to be prepared for the recuperation period.

Being a patient's advocate grants me the power to be a mediator between the patient and the doctor. A nurse is responsible for emotional support, physical assistance and the ability to be a sounding board for the patient and their families. This is all part of being a good patient advocate.

The power of nursing comes from the heart. There are daily choices made to use my power and decisions are individualized, depending on the staffing policy at the establishment. A nurses' power comes from the heart and it is displayed through the care one must give to the patients. Nurses are educators. They teach their patients on a daily basis while enhancing the patients' lives so they can improve themselves. Nurses have the power to be resourceful. Nurses can direct their patient's concerns that are not related to their illnesses to a social worker or case assistant. The assistant can direct the patient to optional transportation opportunities to doctor appointments and other resources that can lesson the frustration of the patients' rehabilitation when needed.

Nurses' power is endless. The end of a shift comes and the nurses' responsibilities end, but the work does not stop. A nurse carries the patients concerns with them after hours. Worry and hope is fathomed in the mind of the nurse wondering if all protocols were followed. The nurse can choose to use her power by contacting the nurses' station after shift change and following up immediately with concerns.

Nurses that further their education will only enhance the care that the patients will receive. Medical information gained from education that is obtained over time allows a caretaker to utilize experience and expertise. Knowledge is power and I am the power of nursing!

Pattie Boucher RN

Exemplar

Nancy Lizzi
St. Francis Hospital

Nancy Lizzi

Nancy Lizzi has been an RN with St. Francis Hospital for nearly 8 years. She earned her degree from Cooper Medical School of Nursing and is currently enrolled in the RN to BSN program at Immaculata University. Nancy is presently employed as the Nurse Manager of Same Day Surgery and PACU for the Surgical Services Department. Nancy has also achieved her CNOR certification, and is currently working on implementing Shared Governance through our Recruitment & Retention Council.

Several years ago I worked at a large teaching hospital with a physician who specialized in treating patients with Reflex Sympathetic Dystrophy. This is a complex disease of continuous and intense chronic pain. We had a very large population of these patient come to the operating room. One day as I was doing a pre-operative visit I met M.B. She was a twenty one year old woman with reflex sympathetic dystrophy of her right shoulder, neck, and face. The patient began to share the despair she felt regarding how she looked. She could not carry out the minor activities of daily living. She explained that she had not had her hair washed in quite some time due to the excruciating pain. The more she shared with me; I realized that to make her feel better we needed to do more then surgery. I identified a need to improve M.B.'s self image. I promised that I would try to wash her hair while she was anesthetized. I had the experience behind me to understand the risks involved with this endeavor. It was important to instill a sense of total well being for this patient. This seemed to cheer her up. I knew this could be carried out safely and set out to inform the surgeon and anesthesiologist.

I arranged to meet with the surgeon. I needed to convince him that washing her hair to improve her self image was an integral part of M.B.'s care. I knew from my experience he would be concerned about adding time and extended anesthesia to the procedure. The Anesthesiologist would be concerned about the patients' airway as we were washing her hair. Once I had them convinced that this could be carried out safely, I needed to educate the operating room team. It would be very important to be prepared and efficient to minimize the amount of time the patient stayed under anesthesia. We needed to have all our supplies ready and know the role of each team member so we could act quickly yet safely. The plan was to shampoo and dry her hair after her surgical procedure was completed. The day of surgery everything went smoothly. The team all knew what we were going to do and everyone worked well together.

During M.B.'s postoperative period she was very cheerful and optimistic. She recovered quickly and was discharged within a few days. Approximately six weeks after her surgery, during her postoperative visit M.B. boasted to her surgeon about her "wash and dry." The entire team considered this such a big success that a policy was written for shampooing hair in the operating room. M.B. visited us on several other occasions for repeat surgery, each time she delighted in having her hair washed and dried.

Exemplar

The Power of Nursing

Dorothy Hyatt

Dorothy Hyatt has been an RN with St. Francis Hospital for almost 18 years. She earned her BSN degree from Widener University in 1990 and her MSN from Wilmington University in 2002. She is currently employed as a staff educator for the Medical Surgical Departments and a BLS instructor. Dorothy achieved her CMS certification in 2003 and became a Certified Diabetic Educator (CDE) in 2006.

Many nurses will answer the question "Why did you choose nursing?" with a heartfelt statement about wanting to help people. The answer can sound trite, but is truly profound. I believe it comes from a deep place within us where there is a wellspring of goodness that can powerfully affect those around us. Call it what you will. I believe it is God-given.

What does this look like in action? Here is a small example, not of the power of one nurse, but of the power of the nursing profession.

One morning I arrived to work on a busy medical unit. As a fairly new nurse, I found it helpful to get to work early and take a quick look in my patient's rooms before report. In one room I found a family in despair. The early morning sun on their faces revealed lines of concern and anxiety as they hovered around their mother and wife who was clearly distressed, short of breath and in pain. I said a quick hello and said I would be back as soon as report was over.

Time has blurred the memory of the medical details of this dying person, but not what I was able to do for this family, because of my role as a nurse. They were simple things, things that nurses do every day. And they helped people.

The first steps were to get orders for morphine and a foley catheter. The patient had been given lasix to help her congestive heart failure and was exhausted by her frequent trips to the commode. While her family understood this, they did not know that a simple catheter could help her rest, and that morphine could help her respiratory distress as well as her pain. Once she could conserve her energy and breathe better, she could be present with her family.

The next thing was to call Spiritual Care and gently start a conversation with the family about what they would like us to do in case their loved one stopped breathing or her heart stopped. To nurses, code status is part of our daily world, but for each family it is a venture into the unknown. Nurses can be sure-footed guides for families into this territory. A DNR order was also written.

By the end of the day, the family still hovered over their loved one, and was still concerned about her. However, now they were able to continue their important end-of-life work together, unhampered by physical suffering. When their loved one died that night, it was a peaceful passing, the way she wanted it.

The interventions that day were simple: a catheter, a medication, a phone call and a conversation. All learned in Nursing 101. Putting them together that day, for that family: that's the power of nursing.

Exemplar

In the PICU, it is Never "Just Another Day at the Office"

by Rebecca Schorn, RN, BSN, CCRN

Rebecca Schorn—RN, BSN, CCRN, Nurse Clinician Level 3, is currently a PICU nurse at Nemours/AI duPont Hospital for Children. She is active member of the Magnet Drivers for Nursing Excellence and is involved in international health care community.

Rebecca Schorn

When I come to work each day, I never know what to expect. On one particular morning, I arrived to join two other PICU nurses preparing to care for a patient returning from the OR. The patient had been experiencing complications in the OR during a complex and very long organ transplant. The PICU night shift nursing staff had been in constant communication with the OR team. As we prepared the room, anticipated medications, and stocked extra supplies I remember thinking how quiet and empty the room seemed; the calm before the storm. That stillness was shattered by the sound of a ventilator being rushed down the hallway followed by a hospital bed surrounded by ten people doing their best to safely and quickly arrive at their destination: PICU room 19.

The PICU's critical care team worked feverishly to stabilize the patient. Several residents were pushing syringes of fluid to bring up the child's blood pressure. At one time, six nurses were administering medications and blood products while at the same time stabilizing IV access. Respiratory therapists were managing the ventilator and securing the endotrachael tube. The PICU Nurse Educator and Clinical Pharmacist were on hand to safely prepare clotting factors, emergency medications and infusions. The social worker and chaplain were liaisons of information and support to the family as they watched us help their child fight for his life.

I soon found my role in caring for this patient to be coordinating care and making sure someone was completing all of the tasks each physician wanted. I was honored to have been chosen to be one of this patient's caretakers, but found myself very much relying on the other team members. I needed the senior nurses who were teaching me to administer medications with which I was less familiar but I was also teaching a nurse on orientation who was observing and helping in any way she could.

When one of my nursing colleagues came to relieve me for lunch I was frustrated because the patient's IV that monitors blood pressure had malfunctioned. As I joined the others in the lunchroom a physician asked how things were going? As soon as I told her about the failed IV, she immediately got up from her lunch, joined her four other physician colleagues to successfully reestablish the IV.

At one point it became necessary to move the patient. All hands were on deck: respiratory, nursing, residents, fellows, and physicians were gloved and in charge of a certain areas. "OK, ready, on three, 1, 2, 3." More than once, the PICU Attending and PICU Fellow called for a time out. During these time-outs, we, as a team, systematically reviewed the assessments and interventions. The physicians looked to the nurses and team members and asked for input. Did we cover everything? Did we miss anything? What is the next step? We all knew and understood the goal. There were multiple collaboration meetings with the surgical team to determine how to proceed.

Fast forward three months…after multiple repeat trips to the operating room and several months in the PICU, I had the privilege of caring for this patient the day he was transferred out of the unit. It was that day he took his first steps since surgery. I remember barely able to keep up as he triumphantly walked a lap around the unit. As I thought back to the first day I met him, I had tears in my eyes thinking how this precious life had been saved after coming so close to being lost.

It wasn't enough to just stabilize the patient the first day but we delivered consistent and compassionate to care in all the days that followed which lead to such a positive outcome. At the American Association of Critical Nurse's National Teaching Institute conference, motivational speaker Michael Stahl, and himself a trauma victim at age 9 said, "What you [nurses] do goes beyond checking numbers and hanging medications, you change lives and you save lives." That is the power of nursing.

Exemplar

A Shared Purpose

by Diane Fitzgerald, RN

Diane Fitzgerald

Diane Fitzgerald, RN, graduated from The Bryn Mawr Hospital School of Nursing in 1981 with a nursing diploma, from Rosemont College in 1988 with a BA, and from West Chester University in 2006 with an MEd. She is currently enrolled at West Chester University in their RN to BSN program, and will begin coursework in the summer of 2008. She has 18 years of NICU experience at The Children's Hospital of Philadelphia and The Chester County Hospital in West Chester, PA, and two years experience in the PICU at The AI du Pont Hospital for Children in Wilmington, DE. She is enduringly committed to holistic, family-centered care. She can be contacted by email at Dfitzger@Nemour.org

While I may have a penchant for babies, and, on a good day, I might even confess to wish to be memorialized posthumously as "The Baby Whisperer," I am not so certain that my "neonatal enthusiasm" is consistently met with equal enthusiasm by my colleagues in the PICU. Although my passion may not always be clearly comprehended or well received, I maintain the conviction that being a *lover of babies* in the PICU sometimes reaps unexpected rewards and benefits for those who deserve them the most: the babies and their families.

After years of infertility work-ups, medications, hormones, temperature charts, and mood-swings (a symptom whose origins were both psychologically and biochemically well founded), Les and Lena Tyler finally succeeded in conceiving a son: his name was to be John. Although the beginning of Lena's pregnancy was met exclusively with joyfulness and bliss, such emotions were short-lived; after a failed attempt by obstetricians to halt Lena's 24-week labor, John was born.

While it is challenging enough to be born four months early when you are a white male, John's challenges were far more substantial than anticipated. John was born with a critical airway, rocker-bottom-feet, and a host of other congenital anomalies. John was transferred hours after birth from the safety and security of the local suburban hospital to the NICU at AI du Pont Hospital for Children for emergency airway management. John's arrival to the safety of a major pediatric medical facility did not bring a sense of comfort. Just minutes shy of a surgical procedure to secure his airway through the creation of a tracheostomy, John suffered a pulmonary hemorrhage and a subsequent cardiac arrest. While John received his tracheostomy as planned, the periventricular leukomalacia that resulted from the injury rapidly transformed John's short-term medical issues into a life-long uphill climb for John and his parents. The Tyler's dreams for "the perfect family" were irrevocably obliterated in that single moment in time.

Despite the tragic events of his birth and the subsequent medical crises, just two weeks into John's stay in the NICU, John was deemed, nonetheless, the most stable patient in the unit. As physical and budgetary constraints often have it in hospitals bustling with far too many sick patients and far too few resources, John was transferred from the womb of the NICU to the frenzy of the PICU.

I met John's parents on their arrival to the PICU. Their hour commute to du Pont to accompany John on the second leg of his medical journey (equating to a distance of about 100 yards) spoke volumes of their devotion to him. In an effort to assuage Les and Lena's fears and anxieties—and perhaps even their anger or resentment—I met them at the threshold of Room #9 (a room the size of the entire NICU to which they were accustomed). I introduced myself, and, purposefully settled John in-with their assistance. It was evident from John's labeled laundry bag, his neatly folded "outfits," his pile of *Chunky Books*, and his home trach equipment, that this was a family accustomed to being actively engaged in their son's daily care; I capitalized on that knowledge.

While I knew hours later, as the Tyler's were packing up to return home, that no miracles had been accomplished during the brief time that we all spent together, I hoped that a small inroad was created that would allow them to sleep well that night. I made sure that Les and Lena had our unit's direct phone number, and that they knew that their phone calls were welcomed. I assured them that, in the event of an emergency, our first call made after contacting John's physician, would be made to them. Prior to leaving the PICU that evening, I walked the unit with the Tylers and gave them a tour of their son's new "home," and I touched base with Lena in a phone call before she went to bed that night.

Weeks passed, and I watched the Tyler's gradually settle into their new environment. They appeared far less reserved and called regularly. While Les was a bit more reserved by nature, Lena began to enter John's room daily, greeting me with a smile. Slowly the Tylers came to terms with the reality that their dream to return to the comfort and security of the NICU was not going to materialize; slowly, too. they came to view the PICU staff as their new family.

When caring for John, I made certain to attend daily rounds with the NICU staff (all in all an effortless task as I was well acquainted with most of them from my previous work experiences in urban and suburban NICUs). I felt honored to be a "go-to" person for John. Nonetheless, having just emerged from my keyboard on my previous discharge paperwork for another long-term PICU patient, when our unit social worker, Andi Bowen, shared that the NICU social worker was eager to find a primary nurse for John to prepare his Discharge Summary and to facilitate his discharge process, I admit to feeling less than eager to rise to the calling. Despite my trepidation at *re-entering the world of the endless paper trail* that nurses all cherish, I was asked by our Assistant Nurse Manager, Mari Welch, to step up to the plate. The decision, in truth, was an effortless one; the result—John had a new primary and I was afforded the opportunity to work extensively with a family that I had come to wholeheartedly honor and respect.

As time progressed, I felt honored to have become a member of the Tyler's temporary "PICU family" and, as "families" are renowned for their ability to rise to challenges, I became part of the team who would be responsible for the collective effort to launch the Tyler family home.

While it was I who facilitated the final weeks of the requisite teaching and who assured that the essential elements of the discharge process were completed, and while it was I who actually composed the requisite Discharge Summary and who facilitated the inter-disciplinary communications, John's discharge was, nonetheless, far from an individual effort carried out by a single nurse.

A willing team of consummate professionals assisted in navigating the process of John's final days-including the tasks of fulfilling the daily teaching schedule and supervising the SFC, seeing to it that my "love notes" regarding certain discharge details that needed addressing by the NICU staff were sent on their merry way, and assuring that John's immunizations were up-to-date prior to discharge. Supported by my colleagues, several nights prior to John's discharge, our Charge Nurse, Dana Mannino, afforded me a light patient assignment and, hence, the spare time at work (there is nothing like that eleventh hour!) to compose John's Discharge Summary. Without such a collective effort, the Tyler's would not have had the experience that they were afforded in the PICU.

Patient care in the PICU is always a group effort: there are no islands where we work. Team-spiritedness is essential for the high-level maximal functioning of any well-oiled professional machine. It is a rare blessing to be afforded the opportunity to be a cog in the wheel of that machine in a realm in which we have experience and expertise, as assuming such a vital role with true passion reaps limitless rewards. While it may appear that the nurse is the exclusive recipient of such rewards, it is clear from my experience with the Tylers that the patients and their families are the true beneficiaries when we are working "in our realm," as…

When we do what we love, it is evident to patients and families that we love what we do.

Exemplar

The Installation of Hope
Its Place in Our Daily Practice

Diane Fitzgerald, RN, graduated from The Bryn Mawr Hospital School of Nursing in 1981 with a nursing diploma, from Rosemont College in 1988 with a BA, and from West Chester University in 2006 with an MEd. She is currently enrolled at West Chester University in their RN to BSN program, and will begin coursework in the summer of 2008. She has 18 years of NICU experience at The Children's Hospital of Philadelphia and The Chester County Hospital in West Chester, PA, and two years experience in the PICU at The AI du Pont Hospital for Children in Wilmington, DE. She is enduringly committed to holistic, family-centered care. She can be contacted by email at Dfitzger@Nemour.org

People often inquire as to how I manage to spend my professional career "in such a depressing environment." When they do, I tell them the story of the chicken and the frog.

Jacob Light was the vertically challenged, petite, blue-eyed little Jewish boy in a suburban neighborhood who always seemed to be left out of the crowd. An eternal optimist-at-heart, one day, eager to be included (despite knowing that he was not welcomed), good-natured Jacob decided to do the next best thing: he engaged in the skateboarding activity on the other side of the street in his own driveway. As fate would have it, Jacob's adventures came to a catastrophic ending when his skateboard careened into the street just as a car was passing by; hence, the beginning of Jacob and Jacob's family's newfound familiarity with a previously unknown universe: The PICU at AI du Pont Hospital for Children.

I met Jacob on his third day in the PICU. His injuries were so extreme that the neurosurgeons placed an intra-cranial bolt to prevent any further damage. CAT scans left little doubt in the minds of *The Team* that Jacob had sustained significant brain damage, and that his outcome would be grim.

Fortunately, there was a bright side to Jacob's tragedy: his mother, Renee'. Jacob's mother would have nothing to do with buying into the doom-and-gloom picture that was painted for her daily on morning rounds, as the attending physicians and residents, pharmacists and therapists, discussed Jacob's long-term prognosis. Daily, following morning rounds, as the funeral dirge slowly ventured on to the room adjacent to Jacob's, I would enter the room to evaluate Jacob's status: his CCP, his ICP, his vital signs, his Glasgow Coma Scale rating. Each time I entered Jacob's room after rounds, I was met by Jacob's mom, shaking her head side-to-side as she visibly demonstrated her disgust regarding the discussions that took place outside of her son's room.

"I'm not buying it, "she'd proclaim each day. "They don't have a clue what they are talking about. I know my son. He's walking out of this joint on two feet." Several follow-up CAT scans, his intra-cranial bolt removal, an MRI or two, and 4,000 neuro-checks later, Jacob started to prove the medical team wrong and his mother right. He demonstrated spontaneous movement of one hand; shortly thereafter, Jacob was responding to commands. On the day that will live in my mind-and heart-forever... Jacob smiled.

Throughout it all, I was honored to bear witness to Jake's (as by now we were on a pet-name basis) recovery. While I had to remain consistently conscientious of providing medically accurate information and to maintain that ever-present delicate balance of being part of a team, I refused to join the groupthink and abandon hope: I made the conscious decision to join Jake and Renee's Team. While I had consistent conversations with Renee' regarding test results and specialists' consult results regarding Jake's potential outcomes, I walked that fine line that nurses often find themselves walking. To support Renee' and to provide support for her hopefulness, I made vague references to other families who also refused to abandon hope despite what they were told was their child's "reality," and I joined the B+ Team in Room #6 in the PICU at AI du Pont Hospital for Children.

"So, one day a chicken walks into the library and he asks for a book, so the librarian gives him a book.
The next day, the chicken walks into the library and he asks the librarian for two books, so the librarian gives him two books.
The next day, the chicken walks into the library and he asks the librarian for three books, so the librarian gives him three books.
By now, the librarian is curious about what the chicken is doing with the library books, so she follows the chicken out of the library and down the road to a pond.
The chicken carries the three library books to the edge of the pond and places them in front of a frog.
'Read-it. Read-it. Read-it." says the frog."
~As told by Jake Light

Weeks after his admission, Jake turned the corner medically and was transferred to the Rehabilitation Unit. Although the news of his transfer was met with jubilation, Jake was soon to return to the PICU when his overzealous efforts to recover landed him out of his wheelchair and on his head-once again-this time on the floor. Fortunately for Jake, his second PICU stay was short-lived. Jake returned to Rehab once again where he resumed his road to recovery.

I visited Jake in Rehab as he tried—and tried again-and again-and again-to have a bowling ball make contact with the pins. I visited him at 6 o'clock at night sometimes, when he could barely keep his eyes open as the daily challenges of rehabilitation used every available resource at his disposal-physical and emotional. Nonetheless, weeks after re-entering Rehab, Jake left the hospital....just shy of his mom's prediction-well and recovering-but in a wheelchair.

A month ago, Jake came to visit us in the PICU. He made his grand entrance doing wheelies in his wheelchair; he asked to visit his old rooms. His speech was markedly improved.

Last week, Jake came to the PICU and it was evident that his mom's dream had been realized: Jake walked the length of the PICU halls! Stopping by the lounge to visit me at lunchtime, I stood-in awe—as Jake shared his chicken joke. His speech was almost perfectly clear and he stood for the duration of the joke's recitation, leaning only slightly on his walker.

Jake's journey remains with me every day I spend in the PICU. His courage and his mom's conviction to "stand by her man" guide my daily practice. I've learned over time, and in particular through experiences such as Jake's, that science isn't always so exact, and that sometimes hope springs eternal in the most unexpected places. Moreover, I've learned that, sometimes, when we are really fortunate, that place is the PICU at AI du Pont Hospital for Children.

We Know You Have Leadership Qualities.

Why not share them with the Delaware Nurses Association?

It is time to start thinking about which position on the DNA Board or committees would be best suited for your individual strengths and interests.

Visit the DNA website at www.denurses.org to review the board position descriptions and information on committees. Questions? Call the DNA office at (302) 368-2333.

International Conferences: A Personal Experience In Globalization

Marge Bailey, RN, C, BSPA

Marge Bailey

Marge Bailey is the Nurse Manager of an adult inpatient psychiatric unit, psychiatric nurses in two emergency departments, and consult liaison nurses at Christiana Care Health System. She is certified in Psychiatric Mental Health Nursing. Her past work experiences include staff nurse medical/surgical unit, charge nurse adult/adolescent psychiatric/drug and alcohol inpatient/partial programs, infection control/ employee health nurse, nursing preceptor, nursing coordinator, staff development specialist, utilization review nurse, marketing nurse, director of nursing, and senior manager education/operations of collections.

The conference opportunities for nurses to attend are endless. Particularly exciting is the opportunity to present a poster at a conference geared toward an interest of practice. Perhaps even more exciting is the opportunity to do both at an international conference.

Imagine my surprise when the poster, which I co-authored with three of my Christiana Care Health System colleagues, was chosen to be presented at the 2007 conference of the International Council of Nurses (ICN) in Yokohama, Japan. Judith Brown Sanders APRN, MSN, BC; Rose Brownstein RN, C; Michelle Lauer RN, BSN, BC; and I submitted a poster abstract to the ICN months before the acceptance email was received in November, 2006.

Submitting the poster had initially required homework on our part to determine who would be our audience. The International Council of Nurses is a federation of 129 national nurses associations. The ICN works with these nurses associations on issues of importance to nursing. Any nurse who is a member of their national nursing association is a member of the ICN. The 2007 conference's overall subject was, "Nurses at the Forefront: Dealing with the unexpected." That sounded like a normal occurrence during the day of any nurse.

The ICN works internationally, not only to represent nursing, but to globally influence health policy. The three specific areas, which the ICN addresses, are Professional Practice, Regulation, and Social-Economic Welfare. The ICN has nursing networks, a series of reference fact sheets, position statements, and scholarships. The ICN could easily be described as a prime example of the globalization of nursing.

Our poster, "The Crisis Assessment and Psychiatric Emergency Services Unit: Locking the Revolving Door." described an innovative, collaborative effort between Christiana Care Health System, and the State of Delaware. The CAPES Unit, located in the Wilmington Hospital Emergency Department, was planned in collaboration with the State to address the issue of improving psychiatric care for patients seeking mental health treatment in the Emergency Department. The State assists Christiana Care Health System in funding and staffing the unit. Outcome data has demonstrated an improvement in communication and coordination, internally and externally, as evidenced by the decline in involuntary admissions from the Wilmington Emergency Department.

Although I was the only author traveling to the conference, my co-authors and I worked hard to follow very specific guidelines for the poster. We focused on presenting our topic to appeal to nurses worldwide. In addition, the poster dimensions were very different from the typical size poster that we normally see at conferences in the United States. The ICN discouraged the use of color, the posters were higher and narrower than our norm, and even certain wording was required to be a specific font. It took a number of attempts to get it right.

Then the challenge of travel with a poster became apparent. Traveling independently in Japan for a more than a week prior to the conference meant that the poster had to travel as well. The hotel was unable to accept items sent in advance. Fortunately, the outer hard cardboard poster tube fit perfectly in my lawn chair canvas bag! Later, in Tokyo, I found an additional short strap that I was able to put around my shoulder to aide me during on and off train travel, while pulling a suitcase. Japanese train travel is highly efficient. The trains only stop for a few minutes, not long enough to give the traveler time to retrieve a poster left behind on a seat.

As this particular conference was international in subject, so was the venue. Yokohama is a large city located across the bay from Tokyo. The location of the conference was in the Minatomirai area of Yokohama, a reclaimed area re-built to target the conference trade. Tall glass enclosed skyscraper hotels, malls, restaurants, designer stores, beautiful bay views, and even an amusement park, were located within the conference area to capture the convention goer's yen during those evening hours.

The conference center itself was well equipped for a conference of visitors speaking multiple languages. Before each presentation, an attendee had the opportunity to obtain a small transmitter, which had a cup-like attachment that was placed over the listener's ear. Each presentation began with directions as to which specific station to tune to for translation in English, Spanish, or French. The majority of presentations were in English; however, at times it still required the listener to use the transmitter, as the presenter might occasionally lapse into their native language due to the challenge of answering questions.

A world leader in various areas of practice presented at each morning's Keynote Address. For example, the first day's Keynote Speaker was a director at the World Health Organization; her topic was pandemics. The second day, the presenter, a nurse leader from Virginia, discussed practice excellence. Imagine my surprise as she discussed the American Nurses Credentialing criteria for achieving Magnet status. Breakout sessions each had 2-3 presenters from a variety of practice areas and countries. In addition, there was a wide variety of sightseeing opportunities for conference attendees.

Listening to the speakers and those attendees who raised questions after the lectures, clearly emphasized that despite the far different health care systems in each country, nursing has many of the same struggles, no matter where in the world a nurse practices. Nurses are concerned about violence in hospitals, quality of care, pandemics of untreatable nature, and about their own labor shortage. The bonus of attending an international conference is the opportunity to not only enjoy the experience of foreign travel, but to enjoy the opportunity to participant in the emerging globalization process of nursing.

Welcome New Members

Marilyn Barnes
Dover

Jennifer Beare
Seaford, DE

Stephanie Bolden
Dover

Sandra Cahall
New Castle

Michelle Cammisa,
Felton, DE

Alisa Clark
Chadds Ford, PA

Michele Campbell
Wilmington, DE

Sharon Contini
Laurel

Rachel Dalien-Meister
Dover, DE

Stephanie Fegley
Wilmington, DE

Chris Foard
Magnolia, DE

Linda Gogola
Dover

Janice Greene
Milford

Katherine Griffith
Newark, DE

Joyce Hill
Dover

Kathleen Ingram
Smyrna

Jessey Jennings
Newark, DE

Denise Jones
Middletown

Anne MacKenzie
Dagsboro, DE

Carol McCrery
Wilmington, DE

Vicki Mcleod
Rockland

Daryl Miller
Wilmington

Michelle Mistichelli
Pennsville, NJ

Mary Newman
Chadds Ford, PA

Bonnie Osgood
Newark, DE

Thelma Parker
Wilmington

Heidi Pettyjohn
Lincoln

Tara Pezzuto
Ocean View

Rebecca Rementer
Delmar, DE

Shirley Seward
Ridgey, MD

Morgan Scott
Bridgeville, DE

Ramona Vasquez
Bridgeville, DE

Shelli Wagner
Middletown, DE

Andrea Walker
Milford, DE

Dianne Yasik
Newark, DE

DELAWARE NURSES ASSOCIATION

Delaware Nurses Association Introduces State-Only Membership!

Join the Delaware Nurses Association for only $149! Now is the time to make it happen. Save up to 45% on conference registration, support local legislative activities, and make a difference in your state nurses' association.

Spring APN Update-Members saved $59
Spring DNA Conference-Members saved $90
Total Conference Registration Savings-$149

Join online at www.denurses.org

Join the Delaware Nurses Association and support a stronger nursing presence in our state. Become an organizational affiliate!

The purpose of the Delaware Nurses Association's Organization Affiliate Program is to create a formal relationship with other nursing and healthcare organizations. Together we can:

- Strengthen nursing and healthcare in Delaware through education, knowledge and information dissemination;
- Provide opportunities for networking with other nurses and healthcare organizations;
- Support learning and the professional development of nurses;
- Provide a greater voice for the nursing profession and healthcare in the legislative arena- both locally and nationally.

Visit www.denurses.org for additional information.

Upcoming Events

DNA DELAWARE NURSES ASSOCIATION Meetings & Conferences

Excellence in Nursing Practice Awards—due May 2, 2008

It's time to nominate the nurse you think exemplifies Excellence in Nursing Practice. The Nurse Excellence Award is to recognize those in the nursing field who consistently promote, excel, and bring a positive approach to their area of practice.

The seven award categories are: Acute Care, Long-term Care, Community-based, Advance Practice, Nurse Leader/Manager, Nurse Educator, New Nurse Graduate. This is a blind review process.

Visit www.denurses.org to download the application. The due date for application submission is May 2, 2008.

The awards ceremony is scheduled for July 17, 2008 at the Modern Maturity Center in Dover.

Nurses Making a Difference Every Day

May 10-11, 2008

Nurses Week at the Blue Rocks! Join us May 10th and 11th at Frawley Stadium for Nurses Weekend with the Wilmington Blue Rocks. Bring your family and friends out to the ballpark for an action packed baseball game and enjoy the fun, family atmosphere of Blue Rocks baseball while we celebrate nurses. Visit www.denurses.org to download flyer and order form.

October 13, 2008

Fall APN Update
Sands Hotel and Conference Center

November 7, 2008

DNA Fall Conference-Special Needs Population
Clayton Hall, University of Delaware

Key Legislative Issues to Watch

Ann Darwicki R. N.

State Level

- HB 128- Extends Delaware's Children's health insurance program (CHIP) to reduce the cost of health insurance coverage for children of families with income up to 300% of the Federal poverty level.
- SB/SA1- Bill creates a statewide health insurance purchasing pool to allow individuals and small business to obtain the most favorable premiums from the private insurance market.
- HR38- Creates a health insurance pool task force to analyze different insurance pool models and make recommendations to the General Assembly.
- SB 200- Bill would eliminate premiums parents pay to enroll their children in Delaware (CHIP) with household incomes 100-200% of the Federal poverty level.
- SB 177- Delaware Health Security Act- A nongovernmental, single payor health care system financed through taxing employers and employees a health security tax.
- HB 217- Bill that would allow small business to participate in the state's group health insurance plan at no cost to the state.
- SB 37- Bill that would allow the Delaware Insurance Department the ability to review (regulate) health insurance premium rates the same way it now can for auto, homeowners, and all other insurances.
- HB 65- Bill to prohibit public schools, charter schools, and school districts from making available or serving food with more than 0.5 grams of artificial trans fatty acids to students grades K-12.
- HB 124- Bill permits minors 16 and older to donate blood without parental consent.
- HB 167- Bill allows each adult patient to receive hospital visits from any individual from whom the patient chooses, subject to certain restrictions contained in the hospital's visitation policy related to the patient's medical condition, the number of visitors simultaneously and the hospital's visiting hours. Requires hospitals to honor advance health care directives .
- HB 322- Bill provides that vaccines containing mercury may not be given to children under 8 years of age or to pregnant women except in special circumstances.
- HCR 16- Establishing the child poverty task force to study the incidence, causes and effects of child poverty in Delaware and develop a plan to reduce child poverty in Delaware by 50% in the next 10 years.

Federal Level/ ANA

- Rebecca Patton MSN, RN, CNOR President of the ANA endorses Hillary Clinton for President February 8, 2008
- S59/ HR 2066- Medicaid Advance Practice Registered Nurse (APRN) Access Act changes Federal Medicaid law to improve the recognition of health care services provided by APRNs. Increases access to essential health care services and increases state flexibility while removing current legal barriers to APRNs.
- HR 1424- Bill ends longstanding insurance discrimination and removes barriers to care for those facing mental illness.
- HR 1108- Bill passed to give the Food and Drug Administration authority to regulate tobacco products.
- HR 2122/S 1842- Prohibit the use of mandatory over time as a staffing tool ensuring that nurses cannot be required to work beyond their scheduled shift and in excess of 12 hours in a 24 hour period or 80 hours in a consecutive 14 day period. Does not impact voluntary over time and provides exceptions for emergency situations.
- HR 4138/ S 73- Legislation that would hold hospitals accountable for the development and implementation of safe staffing systems bases on unit by unit needs and the input of direct care Rns.
- 3/14/2008- ANA issues a policy paper with guidelines and recommendations for all healthcare professionals who respond to emergencies, disasters, or pandemics. For more information go to www.nursingworld.org
- 3/17/2008-World Health Day 2008 Focusing on World Climate Change. Visit www.who.int/world-health-day/en/index.html

Sources

- www.legis.state.de.us
- www.acscan.org/site/pageserver?actioncenter_de
- www.capitolupdate.org/newsletter/index.asp?nlid=2008nlaid=946

Delaware Nurses Association/American Nurses Association Membership Application

Name _____ Credentials _____

Home Phone _____ Work Phone _____

Home Email _____ Work Email _____

Mailing Address _____

City, State, Zip _____

RN License # _____ State _____

Employer/Address _____

Position/Title _____

Permission to print name in the *Reporter* as a new member? ❑ Yes ❑ No

School _____

Highest level of education _____

Return form to:
Delaware Nurses Association
2644 Capitol Trail, Suite 330
Newark, DE 19711
Apply online at www.denurses.org

Membership Category (check one box)

Full Membership Dues
- ❑ Employed – Full-time
- ❑ Employed – Part-time

$229 per year, $19.59 monthly, electronically

Reduced Membership Dues
- ❑ Not Employed
- ❑ Full-time Student
- ❑ New graduate from basic nursing education program, within 6 months after graduation (first membership year only)
- ❑ 62 years of age or over and not earning more than Social Security allows

$114.50 per year, $10.04 monthly, electronically

Special Membership Dues
- ❑ 62 years of age or older and not employed

$57.25 per year, $5.27 monthly, electronically

Dual Membership
- ❑ RN holding membership in ANA through another state
  A copy of ANA membership card must accompany your application.

$95.00 per year
–State Only Membership $149.00

Methods of Payment
- ❑ Full Annual Payment: Cash, Bank Card or Check made payable to the American Nurses Association
- ❑ Electronic Withdrawal: Monthly electronic withdrawal from checking account (Authorization form on ANA application—includes $6 service charge)

Visa/MC Number _____ Expiration _____

Authorization
This is to authorize ANA to withdraw 1/12 of my annual dues from my checking account each month on or after the 15th day of each month, which is designated and maintained as shown by the enclosed check for the first month's payment. ANA is authorized to change the amount by giving the undersign thirty (30) days written notice. The undersign may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date as designated above.

Signature for EDPP authorization _____

Apply online at www.denurses.org

Wit & Wisdom

Insist on yourself. Never imitate
~Ralph Waldo Emerson

When you're curious, you find lots of interesting things to do.
~Walt Disney

The Benefits of Being a DNA Leader

The benefits of being a DNA leader can be both personal and professional, and can provide you with skills that can be applied to many areas of your life. Here are just a few to think about:

- Increase your opportunities to mentor, to be mentored, to gain peer recognition and to share your expertise and ideas;
- Enhance your development as an individual and as a professional through strengthened communication and organizational skills;
- Be on the cutting edge of a new and better health care for our state; and
- Develop marketable campaign skills while articulating your views, engaging with a diverse membership and speaking publicly.

We know you have the ability to be a leader; what better way to serve your profession than to become active in your state nurses association. The Delaware Nurses Association (DNA) represents nurses and nursing in Delaware through action, service, education and leadership.

Open positions for 2008 Election:

- Three ANA at-large alternates
- Treasurer
- Three members of the nominating committee, one from each county

Complete details and information on each position can be found on our website at www.denurses.org under the about tab.