Executive Director’s Column

Palliative Care and Hospice Care

Dr. Marge White attended Rockland State Hospital School of Nursing and graduated with a diploma in nursing in 1971. She began her career in Nyack Hospital, Nyack New York where she worked in medical surgical nursing for 10 years. Determined to further her abilities through education, she went on to earn her BSN, MS, and ultimately her PhD in nursing research. With each degree she also ascended the administrative ladder, eventually holding positions such as Vice President Operations and Vice President of Patient Care and Chief Nursing Officer. Dr. White enjoyed her time in administration because it allowed her to represent her fellow nurses on a broader scale.

After 30 years in acute care, Dr. White became increasingly uncomfortable with end-of-life treatments and the way she saw patients dying. Her goals were changing, and she wanted to help people find a more peaceful and dignified death. She joined Delaware Hospice in February of 2008, and serves as the Chief Operating Officer. On any given day more than 700 patients and families rely on Delaware Hospice to provide quality care and support services.

It is such a pleasure for me to serve as your guest editor in this edition of the DNA Reporter. This issue centers around that which we hold very close to our hearts-patient care. Palliative Care and Hospice Care are frequently confused. We have some great authors in this issue that will clear that confusion for us. These authors range from executive management to clinical informatics. They represent Delaware from all areas, Sussex to New Castle County.

Both palliative care and hospice care use that fine art of a working team, dedicated to the goals of the patients and their families, not the clinician’s goals for those goals. The interdisciplinary team members include nursing assistants, nurses, bereavement counselors, physicians, volunteers, chaplains, dietitians and social workers. Each discipline uniquely represents needs of the patient at that team table. Is the patient’s priority need to have medications adjusted, or to connect with that child lost to the prison system? Is the priority to be totally pain free or to be fully alert for those family exchanges, pain be damned?

My point here is that palliative care and hospice care both speak to the very heart of nursing; to prevent suffering and offer the best possible quality of life. Palliative care is appropriate at any point in a life threatening illness, it is not dependent on prognosis. Hospice care always provides palliative care, however hospice is focused on the terminally ill. Still confused? Read on, my friends! This is a great issue, our Delaware Nurses Association works hard to give us this forum to discuss nursing issues pertinent to the care you provide across the state every day!!

Sarah J. Carmody
Executive Director

Hello Everyone!

The DNA welcomes its newest organizational affiliate the Delaware End-of-Life Coalition. The DEOLC mission is to strengthen collaboration between the public and professional communities of Delaware regarding end-of-life issues. If your organization is interested in participating in the DNA organizational affiliate program, please call the DNA office at (302) 998-3141.

The official RN license plates are also available. The funds generated from the license plates will go toward the development of the Delaware Nursing Foundation and scholarships. In order the plates to go into production, the DNA must have 200 applications. The numbers 1-20 are being held for a silent auction to be announced at a future date. To access the application, visit www.denurses.org.

The DNA has hired a new part-time executive assistant to help in the office. Cindy Lynch will be a great asset in supporting the goals and activities of the association. To contact her via email, send to cindy@denurses.org.

September 10th, a day after President Obama delivered his healthcare address to Congress, over 60 ANA nurses stood with the President at the White House to support health reform plans.

The official RN license plate has been launched. The funds generated from the license plates will go toward the development of the Delaware Nursing Foundation and scholarships. In order the plates to go into production, the DNA must have 200 applications. The numbers 1-20 are being held for a silent auction to be announced at a future date. To access the application, visit www.denurses.org.

The DNA has hired a new part-time executive assistant to help in the office. Cindy Lynch will be a great asset in supporting the goals and activities of the association. To contact her via email, send to cindy@denurses.org.

September 10th, a day after President Obama delivered his healthcare address to Congress, over 60 ANA nurses stood with the President at the White House to support health reform plans.

The official RN license plate has been launched. The funds generated from the license plates will go toward the development of the Delaware Nursing Foundation and scholarships. In order the plates to go into production, the DNA must have 200 applications. The numbers 1-20 are being held for a silent auction to be announced at a future date. To access the application, visit www.denurses.org.

The DNA has hired a new part-time executive assistant to help in the office. Cindy Lynch will be a great asset in supporting the goals and activities of the association. To contact her via email, send to cindy@denurses.org.

September 10th, a day after President Obama delivered his healthcare address to Congress, over 60 ANA nurses stood with the President at the White House to support health reform plans.

The official RN license plate has been launched. The funds generated from the license plates will go toward the development of the Delaware Nursing Foundation and scholarships. In order the plates to go into production, the DNA must have 200 applications. The numbers 1-20 are being held for a silent auction to be announced at a future date. To access the application, visit www.denurses.org.

The DNA has hired a new part-time executive assistant to help in the office. Cindy Lynch will be a great asset in supporting the goals and activities of the association. To contact her via email, send to cindy@denurses.org.

September 10th, a day after President Obama delivered his healthcare address to Congress, over 60 ANA nurses stood with the President at the White House to support health reform plans.

The official RN license plate has been launched. The funds generated from the license plates will go toward the development of the Delaware Nursing Foundation and scholarships. In order the plates to go into production, the DNA must have 200 applications. The numbers 1-20 are being held for a silent auction to be announced at a future date. To access the application, visit www.denurses.org.

The DNA has hired a new part-time executive assistant to help in the office. Cindy Lynch will be a great asset in supporting the goals and activities of the association. To contact her via email, send to cindy@denurses.org.
House to show ANAs continued support for his efforts. ANA President Rebecca Patton, introduced the President, prasing him for his understanding of the role nurses play in the health care system. DNA was fortunate to be able to participate in this very exciting event. DNA member and ANA delegate, Nate’ Guyton stood on stage along with two other nurses as the President addressed those in attendance. The DNA delegation included Nate’ Guyton, Mooneyen “Kloppy” Klopfenstein, Bonnie Osgood, Michelle Lauer, Evelyn Hayes, Jane Taylor, Marianne Poard, Heidi LeGates and Bonnie Perrato.

Legislation moves very fast and sometimes it is hard to keep up with it all. National healthcare legislation is the foremost on people’s minds. As nurses, you are the cornerstone of the healthcare system. Nurses and nursing should be viewed as an asset, not an expense. I urge you to make your opinions/ideas count. Stay on top of the latest news and contact your state representative with your thoughts. Healthcare reform is too important an issue not to have a strong nursing input!

Have a safe and happy holiday season!

H1N1 Updates

American Nurses Association
http://www.nursingworld.org/MainMenuCategories/Healthcare/flu/n1H1Infor...mation.aspx

Center for Disease Control
http://www.cdc.gov/h1n1flu/

Delaware Division of Public Health
http://dhss.delaware.gov/dhss/dph/index.html

National Institute of Health
http://www.nih.gov/

Know what to do about the flu
http://www.flu.gov/

Know what to do about the flu
http://www.nih.gov/

Professional Development Committee

Chair–Karen A. Carmody, RN, MSN, FNP-BC

The October 22, 2009 DNA fall conference, Promoting Best Practices in the Nursing Profession, was a great success thanks to our partnership with the nursing department at the Delaware Technical Community College Owens Campus in Georgetown, DE. Participants in this 2-track program explored best practices in the nursing profession, discussed current trends in nursing practice, and advanced their knowledge and skills regarding nursing leadership while networking with their peers. This continuing nursing education activity offered 6.25 nursing contact hours of which 3.0 pharmacology hours were available.

Save the date, Friday March 12, 2010, for the DNA Spring Conference. This one will be in partnership with the nursing department at Wilmington University New Castle Campus. Three tracks will be offered, one entire track for Pharmacology Updates. Mark your calendars and plan to attend.

The Professional Development Committee meets regularly to design and implement continuing nursing education programs for all professionally licensed nurses. The Delaware Nurses Association is accredited as a provider of Continuing Nursing Education by the American Nurses Credentialing Center Commission (ANCC) on accreditation. Continuing nursing education programs are planned and implemented in accordance with the policies of ANCC. In keeping with these standards, all planners and faculty participating in Delaware Nurses Association sponsored events are expected to disclose to the participants any real or apparent conflicts of interest related to the content of their presentation. We are always interested in new faces and fresh ideas. If you have a special interest in nurses’ continuing education, please consider volunteering to work with the planning committee to implement these and other Professional Development programs. Contact the DNA office at 302-998-3141.

Mit and Wisdom

Sometimes you need a little crisis to get your adrenaline flowing and help you realize your potential.

~author unknown

I always believe that ultimately, if people are paying attention, then we get good government and good leadership. And when we get lazy, as a democracy and civically start taking shortcuts, then it results in bad government and politics.

~Barak Obama
Volunteer Practice Hours

Program for retired nurses or those about to retire or stay at home nurses. We are exploring a possible program for nurses to obtain volunteer practice hours (using the nursing process) in specific volunteer job categories. If you are interested or have ideas about the program, please contact DNA at (302) 998-3141 or send an email to volunteerpractice@dna.org

DNA/APN Council on Facebook

The Delaware Nurses Association and the APN Council of Delaware has launch their new Facebook online community group, providing nurses with access to popular social networking sites that offer fast, free, and convenient new ways to share information and make professional connections online. By signing up to become a ‘fan’ of DNA at www.facebook.com/denurses, users will be able to post news, get the latest Association news and events/meeting info and join in on discussion boards to post news, get the latest Association news and events/meeting info and join in on discussion boards online community group, providing nurses with access to popular social networking sites that offer fast, free, and convenient new ways to share information and make professional connections online. By signing up to become a ‘fan’ of DNA at www.facebook.com/denurses, users will be able to post news, get the latest Association news and events/meeting info and join in on discussion boards.

Welcome our New Organizational Affiliate!

The DNA welcomes its newest organizational affiliate, Delaware End of Life Coalition. The DNA Board of Directors unanimously approved their application in August 2009.

Save the Date!

March 12, 2010
Spring Conference 2010
Wilmington University,
New Castle campus

Topics:
Keynote Title: The Future of Nursing
Bariatric Surgery 10 Years Later
How the Mouth Can Make You Sick
Breath Actuated Nebulizer Technology
Analgic Overdose (Rx)
Scalies & Other Funky Skin Conditions

To view full agenda and register, visit www.denurses.org

President’s Message

Did you know that October 9, 2010 is World Hospice and Palliative Care Day?

The reason this day is set aside to honor and promote palliative care is to create an opportunity to raise awareness and understanding of the needs—medical, social, practical, spiritual—of people living with a life limiting illness and their families. It is important to note that palliative care is not the same as hospice care. The goal of palliative care is to relieve the pain, symptoms and stress of serious illness—whatever the prognosis. It is appropriate for people of any age and at any point in an illness. It can be delivered along with treatments that are aimed at a cure. While the objective of hospice care is to enable patients to continue an alert, pain-free life and to manage other symptoms so that their last days may be spent with dignity and quality, surrounded by their loved ones. Life limiting illnesses impact all age groups; therefore nurses from every practice environment will benefit by increasing their awareness of the importance of hospice programs and palliative care and the supportive services that can be provided. Once again I am impressed by the vision and insight of the Managing Editors for the DNA Reporter, Bonnie Osgood, MSN, RN and Heidi Legates, MSN, RN for planning for the theme of this DNA Reporter to coincide with World Hospice and Palliative Care Day. It takes smart nurse leaders like these two to ensure that our professional nursing organizations stay both connected and relevant.

Speaking of smart nurse leaders on September 10th, at President Obama’s healthcare address ANA President, Becky Patton gave opening remarks and members of Delaware Nurses Association stood with the President to show their strong support for Healthcare reform. Nat’e Guyton, DNA member and our ANA Delegate was right up on the stage with the President. Becky message included this passage, “As nurses, every day we see first-hand the heart-breaking consequences of our nation’s flawed system. We see patients in danger when they can’t access or afford the care they need. We hold a patient’s hand when they learn that their health insurance coverage has been denied or cancelled.” How well this statement captures the nurses’ experience coordinating the patient’s healthcare experience. I am grateful to all of the nurses that attended this important event for offering their time and devoting their considerable talents to ensuring the professional nurses’ perspective is included in the national healthcare debate. To read more about this event and see some of President Patton’s remarks visit the ANA website, Nurse World at http://www.nursingworld.org/ or the DNA Facebook page.

Delaware RN License Plate

The Delaware Nurses Association is proud to offer the first ever Delaware license plate celebrating nursing. The funds generated from the license plates will go toward the development of the Delaware Nursing Foundation and scholarships. In order for the plates to go into production, the DNA must have 200 applications. The numbers 1-20 are being held for a silent auction to be announced at a future date. Visit www.denurses.org to download the application form.
Misconceptions About Hospice/Palliative Care Nursing

Nancy Farmer, RN, CHPN

Nancy Farmer, RN, CHPN, is a Registered Nurse employed with Delaware Hospice, Inc. and serves patients in New Castle County, Delaware. She holds an Associates Degree in Nursing from Delaware Technical and Community College in Stanton, Delaware. She has enhanced her education with experience from Christiana Care. Nancy is certified as a Hospice and Palliative Nurse from the National Board for Certification of Hospice and Palliative Nurses. Nancy recently received the “Delaware Excellence in Nursing Practice Award” for hospice care, awarded by the Delaware Organization of Nurse Executives and the Delaware Nurses Association. She can be reached at Delaware Hospice at 302-479-5707 or nfarm26@live.com

If I had a nickel for each nurse who cringed or shook his or her head upon hearing that I work in hospice/palliative care, I would have my beach house by now. A type of reaction is very common among those who do not fully understand the type of care hospice/palliative care nurses provide. In fact, there are several misconceptions I hear as I interact with nurses in a variety of settings.

One of the most widespread misconceptions about hospice/palliative care is that it is all about dealing with death. On the contrary, the main focus is on maximizing the quality of life for the patient while they are still with us. With the understanding that all patients are capable of accepting hospice/palliative care, nurses devise a plan of care to assist with symptom management so patients can reach their goals.

A Delaware Valley Chapter Care Certified. She is a hospice nurse, Lisa Wheeler, RN, BSN, CHPN is the Patient Care Administrator for the Delaware Organization of Nurse Executives and the Delaware Nurses Association. Nancy is confident in the plan of care. Educating the family about the hospice/palliative nurse’s care, teaching them how best to tend to their loved one empowers the family to feel comfortable in their role. The hospice/palliative nurse’s task is to know what to expect during the final stages of a disease can ease their fears and allow them to focus on enjoying what time they have left.

It is true that hospice/palliative nurses do not have the opportunity to save lives, but they can and do enhance the quality of their patients’ lives while supporting them and their families with compassion and presence.

Many believe that medication administration is the only use for nurses in hospice/palliative care, and nurses only need to know one medication for end of life: morphine. In truth, many hospice nurses remain involved in their patients’ care every day of their remaining life, including treatment for agitation/restlessness, uncontrolled pain, nausea, and dyspnea, to name a few. There are over five hundred medications listed for comfort care in the “Medication Use Guidelines” from ExcelRx, a popular drug guide used by many hospices nationwide. A hospice/palliative care nurse’s job is to avoid overmedication and provide just enough treatment to alleviate patients’ symptoms.

Some skills required in this field certainly do not end with the administration of medication. Hospice/palliative care nurses are case managers and use a wide range of skills in their efforts to manage patients’ care. In addition to pain management, examples might include PICC lines, CADD/PCA pumps, parental nutrition, pluress drains, chest tubes, Foley catheters, nasogastric tubes and suction. As many patients do not have a “Do Not Resuscitate” order and request full life-saving measures, nurses must be prepared for emergency care. As case managers, the hospice/palliative nurse orders the necessary medical equipment, schedules education sessions for both the patient and family, and keeps a record of all treatments and number of days a home health aide is needed to assist the patient and caregiver.

A hospice/palliative care nurse must also be able to integrate some very special nursing skills such as therapeutic communication, knowledge of resources for complementary therapy (including “field,” guided imagery, and massage), knowledge of ethical issues surrounding end of life care, and strong patient advocacy skills.

Another common misconception is that the patient and family rely too heavily on the hospice/palliative care nurse, which then causes undue stress on the nurse, leading to “burnout”. While patients and families do seek the nurse in turn relies on the interdisciplinary team (IDT) to assist in patient care. The IDT is designed to provide physical, spiritual, and emotional support during end of life care. Included in this team are not only the nurse but the physician, social worker, chaplain, home health aide, bereavement counselor, and volunteer.

The physician certifies a patient as hospice appropriate and orders for care are written. Many physicians will require a consultation with the hospice/palliative care nurse for recommendations on medications proven useful for symptom management at end of life and end of life care. The hospice/palliative care nurse is likely to prescribe what the hospice nurse suggests.

Visits to the patient by the social worker can assist with the many family dynamics and psycho-social issues surrounding end of life, including nursing home placement and advanced directives as needed. The chaplain assists with the spiritual aspects of care and offers support to alleviate fears. Working with the family on a daily basis is the home health aide, providing personal care to the patient and end of care.

As a whole, the IDT works closely together to care for the mind, body, and spirit of hospice patients and their families so that they can celebrate the life rather than focusing on the death.

Hospice/palliative care is rewarding in many ways. Not only is it an opportunity to reframe nursing work, to enhance end of life care, but there is the honor of getting to know the patients and their families. During such a personal and vulnerable time, it is a privilege to sit with them and listen as they share stories about their lives and their goals for the time they have left.

Each patient is a gift, and nurses are quickly humbled by their wisdom, courage and hope. Not for hospice/palliative nurses, these patients’ wishes to have comfort measures only and die at home or in other residential facilities surrounded by their friends and family would not be possible.

Families are grateful for the support from the IDT members and want to share the patient’s care and compassion that was given long after their loved one has passed. To take the time to know a patient, to help them accomplish their last wishes, to manage care so well as to give them a peaceful dignified death, is truly a profound experience.

Palliative Care Provides a Higher Quality of Care

Lisa Wheeler, RN, BSN, CHPN

Lisa Wheeler, RN, BSN, CHPN is the Patient Care Administrator for the Delaware Chapter of the National Board for Certification of Hospice Care, Delaware. She received a BSN degree in 1990 from the University of Delaware. With 17 years experience as a hospice nurse, Lisa is Hospice and Palliative Care Certified. She is a member of the Greater Delaware Valley Chapter of the HPNA. She can be reached by e-mail at Lisa.Wheeler@vitas.com.

I remember when I found myself to it. All of a sudden everything made sense. And I could almost hear the proverbial “click” that came with finally incorporating quality of life interventions into my care plans. I also began to tap into the talents and expertise of my fellow team members. Working with the social worker, chaplain, and aide, as a team, we were able to turn both of these final wishes into realities. Our young gentleman did have his cheese steak, thanks to a strategically placed wheater basket where he could expectorate into it. And for our lady with ovarian cancer, not only were we able to get her up the stairs to her porch, we were invited to stay for tea. Today I am inquiring how the new nurses to the specialty of hospice and palliative care. I teach them that every day brings an opportunity to make a difference. I am still amazed to find something I share with them the story of Helen, and the role she played in my transformation to hospice nurse. Then I send them out to find a Helen of their own.

For one young gentleman suffering from obstructive colon cancer, it was having one last Capriotti’s cheese steak. For another patient with advanced ovarian cancer, it was visiting with friends and family on her back porch one more time. I began to incorporate quality of life interventions into my care plans. I also began to tap into the talents and expertise of my fellow team members.
Hospital can save $279 daily for patient who are discharged and $850 daily for patients who have expired while in acute care settings. This length of stay savings can be attributed to the presence of palliative care. Prior to a decade ago, palliative care programs were not yet rooted in acute care settings to provide the savings. Palliative care programs focus upon providing specialized medical care, drug, or therapies with a goal of enhancing the quality of life for patients with chronic and advanced illness. Palliative care allows for an interdisciplinary type of care focused on relief of suffering. Palliative care teams can act as consultants to primary care physicians as they strive to bring comfort to patients with enduring chronic pain and severe illnesses. In addition to providing potential pain and suffering release, palliative care programs hold the ability to significantly decrease cost of patient care within acute care settings.

Many times patients and their families are under the misconception that palliative care is the same service as hospice. Unlike hospice, non-hospice palliative care can be offered at any point in a serious illness along with life prolonging treatment. Palliative care can also be provided to patients with curative and life prolonging treatment. Through palliative treatment the prevention and/or ease of suffering, while providing best quality of life for patients and their family. Many patients and their families are not aware patient prognoses does not dictate the implementation of comfort care. Palliative care patients can expect relief from symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and swallowing difficulty. Palliative care programs have doubled their patient care programs have attributed to decreased length of stay within the acute care setting. In addition to patient care cost reductions, palliative care programs decrease ancillary charges, and pharmaceutical cost as well. Comprehensive palliative care programs can save revenue within the acute care setting, while significantly enhancing quality of care for a number of Americans. Through the delivery of highly-effective, rigorously coordinated, palliative care programs, a direct impact on the reduction of health care spending can be proven. This reduction can be documented by; decreased hospital re-admissions, lowering of hospital costs through decreased lengths of stay and unnecessary tests, and efficiency coordinated care transitions. Approximately $4908 has been documented as savings when comparing palliative patient care to the non-palliative patient care. Most insurance payer sources, including Medicare and Medicaid, cover all or part of the palliative care treatment you receive in the hospital. Coverage is reimbursed for palliative care treatment the same as other medical services. Since 70 percent of the Medicare budget is spent on the 10 percent of our country’s sickest patients, palliative care has also become a model for high-quality, fiscally responsible care. Finally, the association between the prevalence of palliative care programs and lower Medicare spending for the seriously ill is an intriguing finding that would benefit from further studies.

Acute care settings show improvement in patient satisfaction can be attributed to palliative care programs. As patients become more comfortable throughout their illness a known correlation can be linked to increased patient satisfaction within the acute care setting, Due to the evolving demographics of our aging population, palliative care programs are not optional they are a must.

Palliative Future Recommendations

Delaware hospitals fall within the 60th percentile national of hospital with operating palliative care programs. The grade C given to Delaware hospitals by Center to Advance Palliative Care speaks to the challenge for improvement in palliative care. Palliative care treats the pain and other debilitating symptoms of serious and chronic illness. By efficiently improving quality of care geared to our sickest, most vulnerable patients, palliative care is emerging as a critical component of health reform. What actions can be initiated to increase palliative care program in the acute care setting? A key component to occur on the federal level is the promotion and passing of legislation. This legislation should require all hospitals to offer palliative care services as a condition of Medicare and Medicaid reimbursement. Secondly, the creation of loan-forgiveness programs for nurses and physicians seeking postgraduate palliative care training. How can nurses impact the destiny of palliative care through state legislation? On a state level, nurses can develop and support legislation that addresses funding to be made available to develop, train, and technically assist palliative care programs within hospitals. State legislation could allow for the creation of a statewide resource center for promotion of access to quality palliative care services. Lastly, the development of palliative care programs in public and sole community provider hospitals should be ensured as these hospitals provide care to the underserved and most vulnerable patient populations.

References

Pediatric Palliative Care

Ruth Lebet, RN, MSN, CCNS

Ruth Lebet. RN, MSN, CCNS, Clinical Nurse Specialist, PICU Nurse Pavilion Hospital for Children 1600 Rockland Road Wilmington, DE 19803 302-651-5592 rlebet@nemours.org fax: 302-651-5460

Ruth Lebet is the Clinical Nurse Specialist in the PICU at Nemours/AI du Pont Hospital for Children. She has been a pediatric nurse for 30 years, and has functioned as a bedside nurse, nurse manager, pediatric pain service nurse practitioner and nurse educator. She has published in the areas of pediatric critical care and pediatric emergency care.

Pediatric patients have unique needs with regard to palliative and end-of-life care. There has been much interest in this topic demonstrated by an increase in the literature in the last 10 years, much of it sparked by the release of the Institute of Medicine report When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families (Field MJ, Behrman RE, eds., 2003). The report indicated that frequently children with life-threatening or life-limiting conditions and their families do not receive appropriate care that meets their physical, spiritual and emotional needs.

Palliative care requirements for children are unique in many ways. One aspect that must be considered is that most children are not able to advocate for themselves. The child's family serves as the surrogate advocate and decision maker and must rapidly become "experts" on their child's disease. Many children will grow from infancy to adolescence with a life-limiting or life-threatening disease. Diagnoses may include cancer, cystic fibrosis, Spinal Muscular Atrophy, HIV infection, sickle cell disease, cerebral palsy or chronic lung disease requiring long-term mechanical ventilation. The severity of the disease and the child's illness trajectory is highly variable, emphasizing the need for an individualized plan of care that takes into account the child's changing growth and development needs, including participation in decision making. It is very common for a child with a life-limiting disease to have frequent exacerbations of their disease followed by periods of stability. Exacerbations often require hospitalizations, which are disruptive for the family as a whole. The entire family experiences the illness and its effects and the challenge is to acquire the knowledge and skills to care for the child as a family needs to function as a cohesive unit in the face of crisis and at outpatient visits in order to provide optimal care, ensuring the family understands that palliative care is different from end of life care and the ways in which palliative care can improve comfort and communication (Davies B, Sehring SA, Partridge JC, Cooper BA, et al, 2008). Prior to developing a pediatric palliative care program at a children's hospital, Contro et al performed a needs assessment by surveying hospital staff members, community pediatricians and families of deceased children (Contro NA, Larson J, JcScofield S, Sourkes B, Cohen HL, 2004). Family needs identified most consistently were confidence in the treatment team, need for information, consistent message from all caregivers, sensitivity and compassion in communication and pain management. Staff identified the need for more education and programs that provided staff with support systems.

Fueurter et al looked at the comfort level of the nursing staff at a large children's hospital in providing pediatric palliative care (Feudtner C, Santucci G, Feinstein JA, Snyder CR, et al, 2007). The authors found that many years of nursing practice, greater number of hours of education related to pediatric palliative care and a hopeful attitude were associated with a higher palliative care competency score. Most predictive of the score was the number of hours of palliative care education, suggesting that nurses who seek out education on this topic will feel more prepared to deliver pediatric palliative care.

Need for education regarding pediatric palliative care is a consistent theme cited by staff in two of the studies discussed. An excellent educational option, developed by the American Association of Colleges of Nursing (AACN) in conjunction with several organizations with a vested interested in pediatric palliative care and end-of-life care, is the End-of-Life Nursing Education Consortium for Pediatric Palliative Care (ELNEC-PPC) curriculum (Malley et Sumner E, Virani R, Ferrell B, 2007). This program is available as a 2-day course in many regions of the country. Available courses can be found by accessing the ELNEC website: http://www.aaacn.nche.edu/ELNEC/Upcomingtrainings.htm#pediatric. There is also an online version of the course, found at www.cure4kids.org. A list of most recent palliative care resources are listed below.

Delivering excellent palliative care is very challenging and requires many resources, including well-prepared care providers with strong communication skills and knowledge of available resources. Excellent resources are being developed and the evidence base to define best practice is growing daily. Hopefully this will allow to children to, as one pediatric palliative care team's mission statement states, "live as well as possible for as long as possible" (Duncan J, Spengler E, Wolfe J, 2007).

Pediatric Palliative Care Resources


3. Initiative for Pediatric Palliative Care www.ippc.org: IPPC is a project of the Center for Applied Ethics in Public Affairs, a division of Education Development Center, Inc. (EDC), working in collaboration with the National Association of Children's Hospitals and Related Institutions (NACHRI), the Society of Pediatric Nurses (SPN), the Association of Medical Schools Pediatric Department Chairs (AMSDPC), and the New York Academy of Medicine (NYAM).


References


7. Malley R, Virani R, Ferrell B. End-of-Life Nursing Education Consortium for Pediatric Palliative Care (ELNEC-PPC) curriculum (Malley et Sumner E, Virani R, Ferrell B, 2007). This program is available as a 2-day course in many regions of the country. Available courses can be found by accessing the ELNEC website: http://www.aaacn.nche.edu/ELNEC/Upcomingtrainings.htm#pediatric. There is also an online version of the course, found at www.cure4kids.org. A list of most recent palliative care resources are listed below.


9. Sumner E, Virani R, Ferrell B, 2007). This program is available as a 2-day course in many regions of the country. Available courses can be found by accessing the ELNEC website: http://www.aaacn.nche.edu/ELNEC/Upcomingtrainings.htm#pediatric. There is also an online version of the course, found at www.cure4kids.org. A list of most recent palliative care resources are listed below.


12. National Consensus Project for Quality Palliative Care, second edition sponsored by the National Hospice and Palliative Care Organization (NHPCO), the Society of Pediatric Nurses (SPN), the Association of Medical Schools Pediatric Department Chairs (AMSDPC), and the New York Academy of Medicine (NYAM).


A Nurse’s Argument to Introduce the Concept of Palliative Care Sooner

Clare Matis, RN, BSN, CHPN

Graduated from New York University in 1979 with a BS degree in Nursing. She worked as a public health nurse for the Visiting Nurse Service of New York in Queens, then in 1983 as a community health nurse for Essex County Nursing Service in Elizabethtown, NY. She began working in hospice care for High Peaks Hospice in Mineville, NY in 1993. She moved to Delaware Hospice in 2000 serving in the admissions department. She is certified in hospice and palliative care, a member of the Greater Delaware Valley Chapter of HPNA, serving as secretary/treasurer, and a member of the Delaware Diamonds Chapter of ONS.

"The angel of death." That was how I was greeted while responding to a hospice consultation in a local hospital. A gentleman had been told only a few hours earlier that he was too weak to undergo any more chemotherapy. His physician recommended hospice. As I entered his room, the patient greeted me with these words.

Recently I admitted a gentleman to our hospice program that had been diagnosed one month earlier with metastatic gall bladder cancer, after a 90 pound weight loss in 6 months. His wife called hospice herself, telling me, ‘I threatened him with hospice if he wouldn’t get out of the bed.’

The stigma of hospice remains despite intensive efforts to educate both the community and health care professionals. Countless times I have been asked by families, “don’t say the word hospice”, “don’t wear your name badge”, “say you are the visiting nurse”, “if he knows you are from hospice he’ll give up.”

Part of the problem is that palliative care, in the form of hospice, is usually introduced too late to patients and their families, when treatments have been exhausted or failed, after patients are told, “there’s nothing more we can do.” It’s no wonder that patients and families who have not been given appropriate information earlier in the course of the illness often cringe when the word hospice is mentioned. It sounds like a death sentence.

Palliative care and the hospice option need to be emphasized as care that is focused on helping people with serious and progressive illness to live as long as they can and as well as they can. Goals of care are to relieve suffering, provide symptom management, patient and family education, and emotional and spiritual support.

By its very nature, all physicians and nurses practice palliative care. It makes sense that advance care planning would start earlier in the natural history of a disease trajectory, even as soon as a diagnosis such as Alzheimer’s, ALS, COPD, or any other serious life limiting illness is made. Discussion of treatment options and goals for care should include palliative care, so that patients and their families get familiar with the concept and comfortable with the words.

As disease progresses, this comprehensive, interdisciplinary approach will let families know they are not alone on their journey. If cures fail, palliative care, including the call to hospice, will not be as dreaded since the proper education and discussions have already taken place.

The difficult work we do involves accurately identifying when a person goes from being gravely ill to dying. We then compassionately and sensitively help our patient and his or her family make that transition. If we freely talked to them about the value of palliative care and hospice care from the start, that transition would be much easier.

A lot of the difficulty stems from the fact that people do not want to die before their time and there is often uncertainty as to when that time is at hand. We tend to overmedicalize dying in this day and age, offering too many (often false) choices for treatment when a cure is no longer realistic. As a result, our patients and families alike become overwhelmed when they could be focusing on various important tasks at the end of life with the help of a palliative care plan of care.

We should also let our patients know the facts about hospice care and the admission criteria much sooner in the disease progression. Hospice begins when prognosis is 6 months or less and when specific disease criteria are met. Here are three examples:

Dementia
Dementia may afflict an individual for 10 years or more. Hospice is appropriate when there is dependence in all ADLs, incontinence, inability to speak or communicate meaningfully, as well as pneumonia, UTI, septicaemia, weight loss, or stage 3-4 decubitus ulcers.

ALS
ALS can mean a prognosis of 5 years or more. Hospice guidelines are met when there is critically impaired breathing capacity, critical nutritional impairment, or life threatening complications such as sepsis, stage 3-4 decubitus ulcers, pyelonephritis, or aspiration pneumonia.

COPD
COPD can last many years, with acute exacerbations followed by periods of relative stability. Hospice care can begin when there is disabling dyspnea at rest, decreased functional capacity, poor bronchodilator response, increased ER visits, frequent pulmonary infections, hypoxemia, hypercapnea, or cor pulmonale.

The hospice community aggressively educates about appropriateness, but the fact remains that the mean length of a hospice stay is 25 days. Some individuals have had hospice care for just a few days, or even a few hours, before dying. This is a great disservice to the patient and the family alike.

Education about hospice and palliative care can help minimize the many misconceptions about these important services. Some physicians and nurses believe that patients must agree to a DNR order, that they must have a caregiver, that consults, such as physical therapy or nutrition, are always contraindicated, or that they need to be 100% accurate in predicting life expectancy. They have concerns that they will be scrutinized for prescribing “extreme” quantities of opioids and that their patients will become addicted. The aggressive pursuit of a cure may translate to the notion that death is a failure. Some patients and families believe their physicians will abandon them, or that their death will be hastened if they accept hospice.

These misconceptions often mean late or absent referrals to hospice programs. Education for health care professionals should begin when we are students and continue throughout our careers. For the patient and his or her family it should begin at the diagnosis of a potentially life limiting illness.

The utilization of palliative care teams in hospitals can help with this education. Many acute care facilities have identified the need for palliative care and developed palliative care teams to work in conjunction with primary care physicians. At times, however, they are consulted only when curative treatments are no longer effective, if the attending physician feels uncomfortable speaking with patients and families about what comes next, or when death is imminent.

The palliative care team is often the first to initiate frank discussions about goals for care. Dr. John Goodill, head of the Palliative Care Team at Christiana Hospital in Newark, Delaware, often introduces the difficult discussion of dying without taking away hope by using the phrase, “hope for the best, plan for the worst”. Remember that these are parents, children, siblings, and spouses making heart wrenching decisions about feeding tubes, ventilators, and the duration of life, and prolongation of death. Often the patient is himself too critically ill to participate and families are emotionally and physically exhausted. These discussions need to begin much earlier with our patients and families. In that way they can make informed choices that they are comfortable with, allowing us to direct our efforts appropriately.

Comfort care for the sick and dying is not a new concept. In the hospices of the 19th century, respect for the person and personal worth was of utmost importance. Palliative care and hospice care still hold a rightful place in the medical world of the 21st century. Our patients and their families benefit from this approach, and deserve to be made aware of its value from the start of their journey clear to the end.

*quoted with permission from Palliative Care: CAPC. July 3, 2009 <www.getpalliativecare.org>.

Delaware’s ELNEC Project: A Model for the Other 49 States!

Madeline Lambrecht, Ed.D., R.N., F.T.

The End-of-Life Nursing Education Consortium (ELNEC) is a national education initiative designed to improve end-of-life (EOL) care in the United States. The project was initiated in 2000 funded by a grant from the Robert Wood Johnson Foundation with additional funding provided by the National Cancer Institute and others. The project has provided EOL education to more than 5,000 US nurses and is now offered internationally. The ELNEC project is managed by the American Association of Colleges of Nursing, Washington, DC and the City of Hope, Los Angeles, CA. Detailed information is available at www.aacn.nche.edu/ELNEC.

Phase I

In fall 2008, nurses and cancer coordinators in all Delaware hospitals were invited to participate in the ELNEC Train-the-Trainer Program provided through the Delaware End-of-Life Coalition (DEOLC). Funding for the project was provided by the Delaware Cancer Consortium. A total of 395 individuals volunteered to participate.

Recognizing the impossibility of asking nurses to leave their units for extended periods of time to attend CE training, the DEOLC chose to provide the ELNEC Super-Core Curriculum in a distance learning format. All video lectures were recorded by the Division of Special Programs at the University of Delaware and replicated on DVDs so that busy nurses could watch the presentations according to their individual schedules. Dr. Madeline Lambrecht, 2008 President of the DEOLC, coordinated the project. Each participant received a large tote bag containing the 1000 page ELNEC syllabus, CD and DVD, pen, and a wealth of resources to teach the material to others after completion of the course. All who agreed to participate did so with the understanding that they would be responsible for the future dissemination of EOL information, both within their respective hospitals and with the public.

Faculty who volunteered to tape the ELNEC content modules and monitor coordinated sections of the course web site were all nationally trained ELNEC Trainers. Each was responsible for one or two modules as shown below:

- Palliative Nursing Care
  - Nancy D. Robbins, EdD, RNC
  - Professor of Nursing and BSN Program Director
  - Wesley College, Dover, DE
- Pain Management and Cultural Considerations in EOL Care
  - Muriel Foss, RN
  - Staff Educator
  - Delaware Hospice, Milford, DE
- Symptom Management and Final Hours
  - Robert Contino, EdD, RN
  - Professor of Nursing
  - Wesley College, Dover, DE
- Ethical Issues in Palliative Care Nursing
  - Barbara A. Wanta, EdD, RN, CAN
  - Adjunct Faculty
  - Wilmington University, Wilmington, DE
- Communication
  - Lucille Gambardella, PhD, RN, CS, APN-BC, CAN
  - Professor and Chair, Department of Nursing
  - Director of Graduate Nursing Program
  - Wesley College, Dover, DE
- Loss, Grief, and Bereavement
  - Madeline E. Lambrecht, EdD, RN, FT
  - Professor of Nursing, Former Director-Division of Special Programs
  - University of Delaware
  - Newark, DE

Each faculty utilized basic ELNEC content and added her/his own updates including the latest research data. In addition to the content modules, several videoconferences were held to connect participants from the various hospitals. During those sessions, presenters discussed additional teaching/learning strategies which could be used by the participants as they developed plans to share the information with their peers. The faculty also fielded questions and encouraged the sharing of experiences among the participants. The interactivity was appreciated by all as shared in their evaluations. For those unable to attend one of the videoconferences, they were taped and made available on the course web site.

As noted previously, all participants had access to a pass word protected course web site developed by the UD Division of Special Programs. The site contained the following sections: faculty, calendar for program completion, module descriptions, resources, evaluation form, and technology assistance. The site also included a Discussion Forum inviting participants to share experiences and pose questions to course faculty. Successful completion of the program involved scoring 75% or higher on each of the eight quizzes (one associated with each content module), completion of the evaluation form, plus submission of 6, 12, and 24 month goals related to dissemination of ELNEC content. Follow-up on goal progress is an ongoing activity provided by the DEOLC.

Phase II

In spring 2009, additional funding was provided by the Delaware Cancer Consortium to expand the initiative to long term care facilities within the state. With the support of Yrene Waldron, Executive Director of the Delaware Health Care Facilities Association, information about the ELNEC Project was shared with facilities in the three counties. Thirty-four facilities chose to participate enrolling 64 nurses and social workers. In addition to the Super-Core Curriculum, this group also received a copy of the ELNEC Geriatric Curriculum. A luncheon was held at Dover Downs Hotel for all enrollees to discuss the program and distribute materials. This final phase of the ELNEC Project concluded in May 2009.

Conclusion

In summary, Phase I (hospital participants) shows a total of 207 of the 395 nurses and cancer care coordinators successfully completed all program requirements. Phase II (long term care facilities) shows 22 of the 64 individuals enrolled completed the program.

All nurses who successfully completed the program earned 18 nursing contact hours provided by Bayhealth Medical Center, an approved provider of continuing nursing education by the Delaware Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. Some who did not complete all parts of the program indicated that they felt the information was very pertinent, but they did not need additional contact hours for relicensure.

Clearly, Delaware residents will benefit from the increased EOL knowledge provided to nurses and others through the ELNEC Project. The DEOLC would like to express thanks to the hospitals, long term care facilities and their staff whose cooperation made this program possible. The program drew praise from ELNEC at the national level where project director, Pam Malloy called it “a model for the other 49 states.”
Oh Yes—Oh No
The Art and Science of Self-Care when Working with the Dying

Murt Foos R.N., C.H.P.N

Muriel E. “Murt” Foos RN, is a Hospice nurse of 25 years, founder and CEO of Hospice of Prince George’s County, Md 1983-2003. As a Hospice Administrator carried the responsibility for all aspects or orientation and training for the organization. Also, in this capacity served as Education Chairperson for Hospice Network of Maryland and facilitated annual in-services and education conferences in varying capacities for last 20 years. Currently position as Staff Educator for Delaware Hospice involved the development and delivery of a continuous orientation program and ongoing clinical education opportunities for all hospice personnel. A nurse first last and always, serving the dying has helped to live fully and richly. Murt can be reached at mfoos@delawarehospice.org.

Nurses become nurses because we want to help people. Helping people can be exhausting, fatiguing, and stressful at times. This is especially true for nurses. As a Palliative Care Nurse working in a hospice setting, I know this to be true.

What makes the difference between Palliative Care Nurse longevity and burnout? What makes the difference when so many of our patients die in a very short period of time? The answer to these questions can be summed up with, “self-care”.

There have been times when I have said, “Oh no, I am so stressed! I can’t think clearly and I can’t keep going at this pace”. That is a common reaction to stress. A reaction, I am sure, we can all relate to. The secret, as I have found, is to develop in my life the “Oh yes, I have a revitalizing habit of rest, relaxation, and rejuvenation.”

Here is an expanded “Oh No, Oh Yes” exploration of the art and science of self-care when working with the dying.

Oh Yes- you will know the experience of truly living a “purpose driven life” and
Oh no- you won’t be depressed all the time as a result of all your patients dying.

Oh Yes- you must keep up your clinical skills—especially your assessment knowledge—to ensure you will never miss the signs and symptoms of an impending end-of-life emergency, that if unattended, may greatly increase the pain and suffering of your patient.

Oh No- you won’t have to continue the medically aggressive and futile treatment protocols on the 89 year old who told you she just wants to go home to her rose garden for whatever time she has left. You can make those arrangements and even make a home visit and see the rose garden for yourself.

Oh Yes- you will cry and laugh, both at the same time, while sitting at the bedside of a dying man whose grandchild did something funny making the patient smile as he takes his last breath. You will get angry and sad when you weren’t able to get the patient’s pain under better control or get a son to make a meaningful last visit to say goodbye. You will get tired after a busy weekend of on-call and then renewed when the loveliest card comes from a family you served.

Oh No- you won’t forget to be at the bedside of your own loved one when the time comes or make that last visit home to say goodbye to your own mother-in-law. You won’t forget to make that phone call to a dear friend or send a special thank-you card when she was there for you at a bad time.

Oh Yes- years of hospice work takes it’s toll when you get tired and sad at the same time but
Oh No- it doesn’t make you want to quit.

Oh Yes- you must embrace every tender moment that exudes tears of joy and tears of sadness all at the same time like when you make that late night on-call visit to a lovely family saying goodbye to grandfather while remembering all the fun at every family reunion because of his practical jokes.

Oh No- you won’t ever miss one of your own family reunions or the chance to play a practical joke on your loved one because you witnessed the richness of living fully and having fun.

Oh Yes- you will always volunteer to take on one more visit that day, or one more on-call night but,
Oh No- you won’t ever miss a soccer game of your first born or grandparents day at the first grandchild’s preschool two hours away.

Oh Yes- you will stop at nothing to teach the family and get your patient the pain medicine she needs for a good night’s rest but,
Oh No- you won’t sacrifice your own need for rest and restoration so you can “keep-on keeping-on”, as they say.

Oh Yes- you will get frustrated at the physician reluctant to prescribe sufficient medication, or the long-term care nurse hesitant to give the “last” dose of morphine for fear of the last breath but,

Oh No- you will not forget to call or write and tell them “thank you” when the goal of hospice care has been met and a peaceful comfortable dying in place was achieved.

In hospice work the highs are high and the lows are low and there are lots and lots of moments that take your breath away. The same is true in our personal lives. The Oh Yes, Oh No struggle is to find our own way to live all these moments both professionally and personally as richly, intensely, and completely as we can so we don’t miss a thing.

As we watch the dying we learn a lot about living—then the trick is to make sure we apply it. All of us have taken the courses and we even teach the art and science of self-care to our patients and families every day but we must truly learn to know ourselves, our own needs, and how to meet then so the perils of compassion fatigue and professional burnout will avoid us. We need to learn how to restore our selves and how to have fun.
You may have heard of the Delaware End-of-Life Coalition (DEOLC) before and wondered about its purpose. This coalition is comprised of a group of professionals who are interested in educating individuals confronted with end-of-life and palliative care issues in acute care, long-term care, hospice, and community settings. Our mission includes sharing resources and information, promoting public and professional education, fostering innovations in provision of care, addressing public policy, and networking with other end-of-life groups. The coalition also recognizes health care professionals who make a difference. We will host the 2nd annual “Physician Excellence Award for End-of-Life Care” celebration on November 3, 2009 from 5:30-8:00 PM at the Dover Sheraton Hotel. This event recognizes Delaware physicians who have gone above and beyond in teaching others about the end of life issues and expectations. Nomination and dinner registration forms are located on our website at www.deolc.org.

 borough - Northern Research Science "Kloppy" Klopfenstein, Nate' Guyton, Heidi LeGates, DNA members. Attending were: Jane Taylor, Evelyn To access ANA's "PubMed Citations for You" publication records are displayed for each record. New bookmarking features will automatically display biomedical articles back to 1948. ANA's "PubMed Citations for You" feature, an automatic literature search that will display to ANA members how the coalition works with the Hospice Foundation of America to provide a local program with a common theme. Next year's program is scheduled for March 24, 2010 and will focus on “Living with Grief: Cancer and End-of-Life Care.” It will be held at the University of Delaware and also aired at two host sites: Bayhealth Medical Center and the Delaware Hospice Center. We are currently looking for potential panel members for this event. We welcome new members to the DEOLC. If you are interested in joining as an affiliate member, then contact Eric Cacase for membership information at 302-202-9988. For current information, if you are interested in participating on the legislative committee, please visit the DNA website for posted dates.

To remain current on the rapidly changing legislative issues, please review the following links for current information. If you are interested in the position of advocacy, please review the following links for current information. If you are interested in participating on the legislative committee, please visit the DNA website for posted dates.

ANA Health System Reform Agenda
www.nursingworld.org/MainMenuCategories/ HealthcareAndPolicyIssues/HealthSystemReform/ Agenda/ANAHealthSystemReformAgenda.aspx

Frequently Asked Questions ANA’s Positions and Advocacy on Healthcare Reform
www.nursingworld.org/MainMenuCategories/ HealthcareAndPolicyIssues/HealthSystemReform.aspx

RN Action Site
www.rnaction.org

Side-by-Side Comparison of Major Health Care Reform Proposals
www.kfi.org/healthreform/sidebyside.cfm

Focus on Healthcare Reform
www.kfi.org/healthreform/upload/healthreform_trifold.pdf

Legislative Update

President Barack Obama continued to rally nurses to support his health care reform plans during a meeting at the White House on Thursday, September 10, 2009, following his national televised speech to Congress on Wednesday night. He told the group of ANA nurses they have "a lot of credibility," adding, "Few people understand as well as you why today's health care system so badly needs reform." ANA President Becky Patton delivered the opening address. Delaware Nurses Association was fortunate to participate in this event by sending delegation of DNA members. Attending were: Jane Taylor, Evelyn Hayes, Bonnie Osgood, Michele Lauer, Moosie "Kloppy" Klepfenstein, Nate' Guyton, Heidi LeGates, Marianne Foard, and Bonnie Perrutto.

New Member Benefit

The American Nurses Association announced that it has launched a valuable new members only online feature, "PubMed Citations for You," an automatic literature search feature that will display to ANA members current articles of interest to nurses.

Pubmed is a U.S. National Library of Medicine database that includes over 18 million citation records from MEDLINE and other life science journals for biomedical articles back to 1948. ANA's "PubMed Citations for You" feature will automatically display new bibliographic records added to the PubMed database via RSS feed, so ANA members will have easy access to the latest citations in eleven different areas: Ethics, Standards, Education, Informatics, Environmental Health, Quality, Safety, Autonomy, Workplace, Occupational Health, and Professional Practice. Full citations and abstracts when available are displayed for each record.

To access ANA’s "PubMed Citations for You" feature, visit http://www.nursingworld.org/Members/ExclusivelyForYou/PubMed-Citations.aspx.

President Barack Obama continued to rally nurses to support his health care reform plans during a meeting at the White House on Thursday, September 10, 2009, following his national televised speech to Congress on Wednesday night. He told the group of ANA nurses they have “a lot of credibility,” adding, “Few people understand as well as you why today’s health care system so badly needs reform.” ANA President Becky Patton delivered the opening address. Delaware Nurses Association was fortunate to participate in this event by sending delegation of DNA members. Attending were: Jane Taylor, Evelyn Hayes, Bonnie Osgood, Michele Lauer, Moosie “Kloppy” Klepfenstein, Nate’ Guyton, Heidi LeGates, Marianne Foard, and Bonnie Perrutto.

New Member Benefit

The American Nurses Association announced that it has launched a valuable new members only online feature, “PubMed Citations for You,” an automatic literature search feature that will display to ANA members current articles of interest to nurses.

Pubmed is a U.S. National Library of Medicine database that includes over 18 million citation records from MEDLINE and other life science journals for biomedical articles back to 1948. ANA’s “PubMed Citations for You” feature will automatically display new bibliographic records added to the PubMed database via RSS feed, so ANA members will have easy access to the latest citations in eleven different areas: Ethics, Standards, Education, Informatics, Environmental Health, Quality, Safety, Autonomy, Workplace, Occupational Health, and Professional Practice. Full citations and abstracts when available are displayed for each record.

To access ANA’s “PubMed Citations for You” feature, visit http://www.nursingworld.org/Members/ExclusivelyForYou/PubMed-Citations.aspx.

President Barack Obama continued to rally nurses to support his health care reform plans during a meeting at the White House on Thursday, September 10, 2009, following his national televised speech to Congress on Wednesday night. He told the group of ANA nurses they have “a lot of credibility,” adding, “Few people understand as well as you why today’s health care system so badly needs reform.” ANA President Becky Patton delivered the opening address. Delaware Nurses Association was fortunate to participate in this event by sending delegation of DNA members. Attending were: Jane Taylor, Evelyn Hayes, Bonnie Osgood, Michele Lauer, Moosie “Kloppy” Klepfenstein, Nate’ Guyton, Heidi LeGates, Marianne Foard, and Bonnie Perrutto.
## Membership Benefits

### Full DNA/ANA Membership
- $829 per year/$89.59 monthly, electronically
- Employed-full time/part time
- Save up to 45% on conference registration
- Save on ANCC certification fees
- Save 10% on professional liability insurance with Marsh
- Free and discounted online continuing education
- Save 10% on personal accounting fees
- Discounts to insurance programs such as life, disability, job loss
- Email alerts
- Online networking-DNA Facebook page and ANA Nurse Space
- Publishing opportunities and discounts
- National and State leadership opportunities
- Much more!

*Must hold certification from ANCC; one-time savings.

### Delaware State-Only Membership
- $149 per year
- Employed-full time/part time
- Save up to 45% on conference registration
- Free and discounted online continuing education
- Save 10% on personal accounting fees
- Discounts to personal insurance such as life, disability, job loss
- Email alerts
- Online networking-DNA Facebook page
- Publishing opportunities and discounts
- State leadership opportunities
- Much more!

### American Nurses Association Only Membership
- $179 per year
- ANA Smart Brief
- ANA Nurse Space
- Federal lobbying
- Discount to national conferences
- Save on ANCC certification
- Free and discounted publications
- Much more!

Coming soon!
Delaware license plates for registered nurses. Only available to full and state-only members.

DNA has partnered with the following organizations for member discounts and programs.

### Delaware Nurses Association/American Nurses Association Membership Application

<table>
<thead>
<tr>
<th>Name</th>
<th>Credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone</td>
<td>Work Phone</td>
</tr>
<tr>
<td>Home Email</td>
<td>Work Email</td>
</tr>
<tr>
<td>Mailing Address</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
<tr>
<td>RN License #</td>
<td>State</td>
</tr>
<tr>
<td>Employer/Address</td>
<td></td>
</tr>
<tr>
<td>Position/Title</td>
<td></td>
</tr>
</tbody>
</table>

Permission to print name in the Reporter as a new member?  [ ] Yes  [ ] No

School

Highest level of education

Return form to:
Delaware Nurses Association
Orchard Commons Complex
5586 Kirkwood Highway
Wilmington, DE 19808

## Membership Category (check one box)

- **Full DNA/ANA Membership Dues**
  - $829 per year/$89.59 monthly, electronically
  - Employed-full time/part time

- **DNA State-Only Membership Dues**
  - $149 per year
  - Employed-full time/part time

- **ANA National-Only Membership Dues**
  - $179 per year

### Reduced Membership Dues
- $114.50 per year/$10.40 monthly, electronically
  - Full-time Student
  - New graduate from basic nursing education program, within 6 months after graduation (first membership year only)
  - 62 years old or over and not earning more than Social Security allows
  - Not employed

### Special Membership Dues
- $57.25 per year/$5.27 monthly, electronically
  - 62 years of age and not employed

### Dual Membership Due
- $95.00 per year
  - RN holding membership in ANA through another state; proof of membership required

### 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)

<table>
<thead>
<tr>
<th>Visa/MC Number</th>
<th>Expiration</th>
</tr>
</thead>
</table>

**Authorization**

This is to authorize DNA 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. DNA is authorized to change the amount by giving the undersign thirty (30) days written notice. The undersign may cancel this authorization upon receipt by DNA 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