ANA MAINE
AMERICAN NURSES ASSOCIATION MAINE

Journal

The Newsletter of the American Nurses Association–Maine www.anamaine.org WINTER 2008

President's Message
Thoughts on a snowy New Year's Day

Sue Henderson
President

I have just come in from taking Jake, our 10-month-old German shepherd puppy for a walk. Because he is a big, happy puppy, it has to be a pretty long walk. One of the joys of walking a dog, particularly in a place like Maine, is having time to be out outside and to experience how magnificent and amazing our planet is and to be constantly reminded of the beauty and complexity of living systems.

As the snowy New Year starts, we enter a year of presidential and other critical elections. It seems to my simple little mind that we need to vote this year, not as if our lives depend on it, but because our lives depend on it. If you ask me what I think—which, of course, you haven't, but you know I am going to tell you anyway—I would say that because we are dependent on our planet for our very lives, I would hope that we will elect people who will work to keep our world capable of supporting life and who will work to transform our economy so that the concept of economic growth is not a suicidal one.

In all the political chatter that endlessly swirls around me, I do not hear a lot of talk about what is going to be done to establish both a viable environment and a viable economy. Events like hurricane Katrina, and the tornadoes, wildfires and droughts that have recently devastated areas of our country—never mind worldwide events—are to me concrete indications that things need to change and change very soon. Yet, it is as if we are living a comedy of the absurd. The political pundits chatter as usual about who attacked whom; we are inundated with advertisements encouraging us to buy more and more superfluous things; and we fly all over the world as if we had been promised an eternity of jet fuel and an atmosphere that would be magically cleansed.

Last year, I wrote about Leah Curtin's book that discussed the children of the war in Bosnia. A year later, I remember those children and other children of "intentional violence" and others who do not have food, homes or the most basic access to health care.

Health is built on a foundation of clean air, water and pure food, a home and a nurturing environment. After those foundational necessities, access to a basic level of health care becomes critical and, as the American Nurses Association believes, a human right.

As nurses we can be very powerful. We can ask candidates what they will do to save our planet and how they will work to transform our economy. We can ask them what they will do to decrease intentional violence in the world—in other words, what will they do to make our world and our nation a less violent place and a safer place for children and other living things? We can ask candidates about what they will do to help people acquire the requisites for health such as air, water, food and a home. We can ask candidates what they will do to create a healthcare system that provides a basic level of health care to all Americans.

Nurses are the most trusted healthcare professionals, we are the most numerous of the healthcare professionals and we are demographically more like consumers of health care than other health professionals. We know the difference between a comedy of the absurd and practical problem solving. We can call/write/e-mail or visit candidates. We can work for candidates, send money, we can vote.

We are registered nurses, registered voters.

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Highlights

...and lots more!

Fall Conference Dynamic Event
Central Maine Medical Center Receives National Award at Annual Meeting

The American Nurses Association of Maine (ANA-Maine) teamed up with the Organization of Maine Nurse Executives (OMNE) to present the conference held October 19 at Verillo's Convention Center, in Portland, Maine. The conference was entitled "Maine Nursing Excellence" and included the topics: Exploring the Magnet Journey, Evidence-Based Practice, Preventing Back Injuries, Quality and Patient Safety. The ANA-Maine planning committee had been planning a conference on nursing excellence in relation to safety of nurses and patients, when they received a phone call from an OMNE planning committee member asking for support of their planned conference on developing a Maine Magnet Collaborative. The two groups decided to work together and combine the two separate events into one; a dynamic conference resulted. Gail Wolf, RN, DNS, FAAN gave the keynote address: "The Magic of Magnet."

The breakout sessions that followed had two pathways. One allowed attendees to focus on developing a Magnet Collaborative Experience. Michelle Barella, RN, BA, BSN presented the Boston Magnet Collaborative Experience followed by a workshop led by Lois Skilling, RN, MSN, CNAA, BC. The other pathway allowed attendees to focus on topics related to the Forces of Magnetism. Susan Sepples, PhD, RN discussed the implications of evidence-based practice for nursing excellence. Katherine Bonney, RN, MSN analyzed nursing leadership implications for the development of a culture of safety. Nancy L. Hughes discussed the American Nurses Association's initiatives in preventing back injuries through safe patient handling and movement. All of the speakers were excellent and the topics seemed to come together to describe a system of excellence—which is the "Magic of Magnet."

Student Attendees

As the day began with coffee and networking, Congressman Tom Allan mingled among the attendees, asking some questions, answering others. Vendors and sponsors had set up their materials. Educational Resources, Inc. was a sponsor for speaker's lunches. Vendors included Gweneth Cole of PICC a Little…TALK a Little; Richard Next of Genworth Life Insurance; Jon Ballou of New England Medical Systems; Holly White of Saint Joseph's College of Maine; and Elizabeth Lizcomb of BeautiControl.

The day also began with the opportunity to begin bidding in a silent auction to support a scholarship fund. Blanch Alexander and Penny Higgins organized this

Continued on page 2

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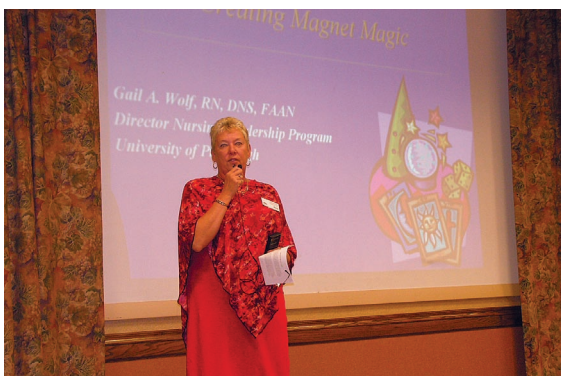
Fall Conference Dynamic Event

Continued from page 1

delightful activity. Many friends and family members donated items. Margaret Ross made another of her beautiful braided rugs. Additionally, Elizabeth Lizcomb, Vose-Smith Florists, White Rock Outboard, the Hole in the Wall of Casco, Shaws Super Markets, J.C.Pollack and Sons, Stephen King, Fore Street Restaurant, the Village Cafe and artist Lenny Hatch made donations. All of these donations allowed this to be the most successful auction ANA-Maine has ever held; over $800 was raised. We can now offer a very small amount of financial help on a yearly basis to at least one individual. A committee has been asked to begin developing criteria for how this will be accomplished.

This year for the first time, the Annual Business Meeting of ANA-Maine was held at lunch time and attended by both members and non-members. (Provisions were made to allow only members to vote.) This meeting began with the reading of the Nightingale Tribute and names of Maine nurses who had died during the year.

The work of Student Nurse Associations was recognized by awarding certificates of recognition to organization presidents. This year the following students were awarded certificates: Michelle L. Isbister, University of Maine Augusta; Megan L. Taylor, University of Southern Maine; Jonica Soules, Saint Joseph's College; Katie Firth, University of New England; Jolleen Young and Tina Charest, University of Southern Maine Lewiston-Auburn; and Heidi Smith, Northern Maine Community College.



Dottie Hill introducing guest speaker, Gail Wolf

Central Maine Medical Center Receives ANA Award

At its Annual Meeting, ANA-Maine was delighted to present the American Nurses Association's award for Best Practices in Seasonal Influenza Immunization to Central Maine Medical Center, whose program was judged to be one of the top five in the nation.

ANA developed the 2006-2007 Best Practices in Seasonal Influenza Campaign because of concern about low rates of influenza vaccination among registered nurses and other healthcare workers. The recognition campaign was designed to identify organizations most successful in increasing the rate of vaccination of their employees. Review criteria included the extent of nursing and administrative leadership in the program, measure of effectiveness, education aspects and finally analysis of data in terms of improved workplace safety and accessibility of the program.

In addition to letters of recognition, the top five programs were given a lead crystal award. Nancy L. Hughes, RN, MHA, director of the Center for Occupational and Environmental Health at the American Nurses Association, presented the award to Central Maine Medical Center Vice President of Nursing Sharron Sieleman. Also present to receive the award were: Deanna Rice, RN, BSN, MBA, director of Clinical Practice; Jennifer Messinger, RN, BSN, COHN-S, CCM-Employee Health Clinical lead RN; Joyce McPhetres, vice president of Human Resources and Organizational Development; and Clark Phinney, Employee Health and Worker's Compensation coordinator.

CMMC Award Recipients

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One Nurse's Mission in Nepal

Nursing education is alive and well in one of the world's poorest nations

by Joe Niemczura, RN, MS

During the summer of 2007 I taught at Tansen Nursing School (TNS) in the Palpa district of Nepal, the little country between India and China. I arranged this experience through United Missions to Nepal, an umbrella group of eight Christian denominations that has been active in that country for 50 years. I am religious enough I suppose, but I did not view this as a missionary experience per se. I was partly funded by money from an account I had with the University of Hawaii's International Affairs Office.

Nursing education in Nepal follows a government-specified curriculum, and the students can be admitted at the age of 16. The second year is devoted to maternal-child health and community nursing, and the other two years are hospital-based. TNS had 40 students in each "batch." There were about a dozen faculty members. The principal of the school, Shakuntala Thanju, was finishing up her PhD through a long-distance program at a school in Tokyo. She was joined by Sister Patricia Conroy, a Maryknoll Missionary nun with a PhD from Columbia (1964). There was one Australian, one Korean, and myself, but the other faculty members were Nepali. TNS courses were taught in English.

The main clinical site was Mission Hospital in Tansen, a city of 25,000 people that is the market town for a vast area with few roads. Nepal is rugged and hilly, and many patients had to walk for days to get to a paved road. The hospital had 160 beds. The senior doctors were mostly foreign missionaries, from Australia, the U.K., the U.S. and Japan.

After a few weeks of orientation, I spent the summer doing clinical supervision of students on the adult surgical ward, and also on the pediatric ward. At first, there were many unfamiliar elements to the way that nursing care was organized. But they did have a system for things, and a structured way of communicating and implementing standards. Mission Hospital is considered to be a model mission hospital, with an active community outreach apparatus.

Many of the admitting diagnoses were familiar: gallbladder disease, childbirth, orthopedics, etc. But there were specific challenges such as malaria, kala-azar, pesticide poisoning, snakebite, bites from wild monkeys, and burn injuries that were new to me. Also, there was pervasive TB, with many manifestations that I had not known could take place. I saw my first actual case of pertussis this summer, and also neonatal tetanus. Nepal has some of the poorest health statistics in the world according to the World Health Organization. The only countries with worse statistics are Iraq, Afghanistan, and Sudan. Hopefully now that there is a truce in the 11-year civil war, this will improve.

The people at the hospital and TNS were professional and dedicated. They were wonderful to me and I will cherish the friendships I made there forever. I did manage to spend a week sightseeing at the end, and the country has many wonderful customs and hospitable people. I have put many of my photos on a Facebook page, and will share the link with anybody who e-mails me at jniemczu@hawaii.edu. I have been working on a book about my experience. I'm trying to decide who will play me in the movie—maybe Brad Pitt!

Joe Niemczura, RN, MS is an instructor at the University of Hawaii at Manoa School of Nursing and Dental Hygiene.

Nurses Need a Role on Green Teams

by Bettie Kettell, RN HEM

Consider that nurses working in direct care handle a high percentage of all of the goods and materials that enter and exit a healthcare facility. This is everything from simple bedding and food to complex pharmaceuticals, cleaning agents and technological equipment that are required to provide current quality health care. With this concept we must also consider that nurses do not have a significant voice in what products enter or how products leave the facility. Frequently, environmental or waste reduction programs are initiated and administered by environmental services or facilities management. It is the exception rather than the norm that nurses are involved in recycling committees.

The challenge is to get this message to nurses and the entire healthcare industry.

Nurses need to have this voice and opportunity to know what products they use. The source and content of products can affect the patient, the community and the healthcare worker. In the course of providing care for patients, we are opening products and discarding the wrapping. The product labels may list some of the ingredients but not all. We have trusted that industry will manufacture only products that are safe for all. We have trusted our materials management departments to purchase only those products that are considered safe. The reality is that many products used in health care are either toxic or contain toxic components. Even the most diligent materials management department can miss a toxic product, and sometimes the safer alternatives cost significantly more.

Nurses also represent the largest segment of the healthcare industry.

The nurse's time is precious. There is limited time to read labels or to question the products that are ready for use. Recycling programs need to make the process simple and convenient. This is possible only if nurses are active in the process of developing the programs.

Many healthcare facilities do practice good sustainability efforts. There are an increasing number of healthcare facilities that have excellent recycling programs. Some have reached the 40 percent-50 percent recycling rates. There are many that do not.

The Luminary Project (www.theluminaryproject.org) highlights wonderful examples of nurses involved in or leading a variety of environmental health programs across the country. All areas of nursing are represented including hospital direct care, education, research, legislative and so on. This project represents a small percentage of our nation's 2.9 million nurses.

There are many organizations that are working toward the provision of "healthy health care." Included in this list is Health Care Without Harm (HCWH), which can be found at www.noharm.org. This organization has initiated landmark projects to improve the quality of health care internationally. Its sister organization, Hospitals for a Healthy Environment (H2E) at www.h2e-online.org, has a partnership program that invites hospitals to become H2E partners. Partners are then able to receive assistance for many environmental health projects. H2E offers a series of Environmental Excellence awards that are designed to encourage better recycling and waste management. A third companion is the Green Guide to Healthcare that leads and directs green building in the healthcare sector. That Web site is www.gghc.org.

A literature search of nursing and the environment is rich with many articles, books and a variety of authors. Many are Nurse Luminaries. Nursing and the environment is not a new topic. Florence Nightingale was credited for her environmental efforts. She insisted on fresh air and a clean bright surrounding for her patients.

My challenge and invitation to all is to join me on this amazing environmental journey. There are many nursing roles that will help health care become environmentally healthy and sustainable. Start or join a green team. Pick a waste stream that is bothersome and tackle it. Your journey will be rewarding and endless. I look forward to seeing you on my path.

Bettie Kettell is an operating room nurse, pollution prevention coordinator at Mid Coast Hospital in Brunswick, Maine and the H2E nurse coordinator. Her responsibility to H2E is to engage and inspire nurses to get involved in environmental health nursing issues.

7th Maine Nursing Summit

Thursday
March 6, 2008
Augusta Civic Center

Join with your nursing colleagues to create our shared future.

Sponsored by:

OMNE: Nursing Leaders of Maine
Maine Hospital Association
ANA-Maine
Maine Health Care Association
Maine Society for Healthcare Human Resources Administration
COMNO: Coalition of Maine Nursing Organizations

Summit Goals

THIS DAY-LONG SUMMIT WILL bring together nurses, employers, and educators to work together to promote and evolve nursing as a profession of choice in Maine.

The objectives of the summit include—

- exploring issues challenging nursing in Maine;
- acknowledging the role the work environment plays in nursing satisfaction and quality of care;
- learning about best practices for patient safety, quality outcomes, nurse satisfaction, and innovations in nursing excellence; and
- creating opportunities to sustain and enhance Maine's effort to address the evolving nursing shortage.

Program

8:15–9 a.m. Light Continental Breakfast and Registration
9a.m.–3:30 p.m. Program

Keynote

"Can we talk?"

Improving patient outcomes through effective communication

The complexity of today's healthcare environment creates many occasions for communication, conflict, and relationship challenges. PAUL MCMURRAY, a master certified trainer in both Crucial Conversations and Crucial Confrontations brings practical tools and strategies to improve both interpersonal and team relationships. This keynote address has timely relevance across all healthcare settings and practices.

Presentation & Posters

Examples and experiences of best nursing practices in Maine.

(Individuals interested in presenting at the Summit should complete the "Call for Abstracts" no later than January 15. 2008. The "Call for Abstracts" is available at www.omne.org.*)*

Hotel Arrangements

A block of rooms has been set aside for March 5, 2008, at the Holiday Inn-Augusta, 110 Community Drive, Augusta. Call (207) 622-4751 or 1(800) 694-6404. $70 PLUS tax single occupancy; $90 PLUS tax double occupancy.

Contact the Holiday Inn directly no later than February 27 to make your reservations. Please tell reservations that you are attending the Nursing Summit to receive this rate. A credit card is required to make your reservation.

Please keep the top portion of this flyer for your records.

2008 Maine Nursing Summit Registration Form

Registration Fee: $80 per person / $20 per nursing student or retired nurse • Deadline: February 22, 2008

Name _____ Daytime Phone _____
Institution _____ Email Address _____
Address _____ City _____ State _____ ZIP _____–____
Check one: ❑ Clinical Nurse ❑ Nurse Leader/Manager ❑ Nurse Educator ❑ Other (Specify) _____

Organizations sending five or more persons will receive the sixth registration free.
All registrations must be submitted at one time with one payment check.

Make check payable to: MHA
Mail to: Maine Hospital Association, Attn.: Leslie Gagne, 33 Fuller Road, Augusta, ME 04330;
or Fax to: (207) 622-3073 *(mail payment separately)*

This continuing nursing education activity is to be submitted for approval to the ANA-MAINE Continuing Education Committee, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Background and Talking points, Office of the National Nurse

Since the initiative's inception in 2005, ANA has held concerns about the practicality and efficacy of the proposed creation of an office of the national nurse. ANA, along with other nursing and public health organizations, developed a sign-on letter to: articulate shared concerns about the national nurse proposal; reflect our strong desire to address the very real issues facing nursing and public health; and to provide added perspective on the issue for individuals or organizations considering the merits of the national nurse initiative. This letter is the most thorough reflection of ANA's Position.

History:

- The Office of the National Nurse (ONN) initiative originated with a May 2005 New York Times Op-Ed piece by Oregon Nurses Association Member Teri Mills, MS, RN, ANP.
- Efforts to advance the proposal have included the introduction of federal legislation during the 109th Congress (H.R. 4903) and the development of a blog site (www.nationalnurse.blogspot.com) and grassroots campaign.
- Although the legislation has not been reintroduced for the current, 110th Congress, proponents continue to promote the initiative and seek support from legislators, nursing and public health organizations, and individual nurses.

ANA's past actions:

- ANA's past written responses to the ONN acknowledge the ONN proponents' motivations and aims, but also reflect a belief that the creation of new offices and structures may not be the best mechanism to achieve the goals set forth by ONN advocates.
- Both ANA's initial letter to the editor of the New York Times responding to the proposal in 2005, and the statement on the issue included in the April 2006 CEO report emphasized the need for focus on "existing, more direct avenues toward change in nursing and health care, including advancement of nursing legislation; empowerment of nurses to run for office and seek appointment to agencies and decision-making bodies at the state and federal levels; and enhanced involvement of all nurses in the legislative and political processes."

Origins of the letter of concern:

- While the ONN proposal continues to evolve, ANA's concerns that it is duplicative of, and could potentially divert funds from, the existing public health infrastructure remain.
- To continue to monitor and respond appropriately to the issue, ANA formed an informal coalition with the Association of State and Territorial Directors of Nursing (ASTDN), the Association of Community Health Nursing Educators (ACHNE), the Commissioned Officers Association (COA) and the American Association of Colleges of Nursing (AACN), the American Public Health Association (APHA), and the immediate past Chief Nurse, Mary Pat Couig.
- In response to increased inquiries from organizations and individuals, the coalition elected to craft the attached letter of concern with the goal of offering considered, comprehensive information on the initiative
- The letter articulates our shared concerns about the national nurse proposal and reflects our strong desire to address the very real issues facing nursing and public health.
- Rather than creating new, parallel offices and volunteer structures, we believe we should invest in and reinforce our existing public health infrastructure and resources. While there is no magic-bullet solution to the challenges facing our public health system, actions such as strengthening the position of Chief Nurse Officer, bolstering the existing public health nursing network, and investing in evidence-based public health education could make a real and positive impact and move us toward our common goals.

Recommendations of Organizational Affiliates

- Consider signing on to the letter.
- View ANA as a resource should they be approached for support of need further information.

ONN Concern

October 2, 2007

To whom it may concern,

As organizations and individuals engaged in improving health on a daily basis, we are deeply committed to ensuring that our nation's public health system is equipped to address both the basic health care needs of its citizens and the emergency preparedness needs of a post 9/11 world.

We believe that we share these goals with advocates for the creation of an Office of the National Nurse, an initiative which began in May, 2005, and which included the introduction of federal legislation during the 109th Congress. However, while we respect the aims of the bills' proponents and agree wholeheartedly that nurses must take the lead in addressing core challenges to nursing and health care, we hold deep concerns about the National Nurse proposal.

These concerns center on three general areas: the initiative's proposed creation of new programs that are redundant with existing public health entities and systems (such as the U.S. Public Health Service Chief Nursing Officer, Public Health Nursing and the Medical Reserve Corps); our recognition that limited resources are available to fund existing programs, let alone establish new ones and; the need to ensure that the proposal's public heath education efforts go beyond simple messages to incorporate proven, evidence-based interventions.

Rather than creating new, parallel offices and volunteer structures, we believe we should invest in and reinforce our existing public health infrastructure and resources. While there is no magic-bullet solution to the challenges facing our public health system, actions such as strengthening the position of Chief Nurse Officer, bolstering the existing public health nursing network, and investing in evidence-based public health education could make a real and positive impact and move us toward our common goals.

Recognize and Strengthen the Chief Nurse Officer (CNO)

We have a national nurse in the position of Chief Nurse Officer (CNO) of the United States Public Health Service (USPHS). The CNO provides advice to and works with the U.S. Surgeon General on policy issues related to nursing and public health, and represents the Office of the Surgeon General and the USPHS in contact with groups at the state, national and international levels and with professional societies concerned with nursing and public health issues. The Commissioned Corps of the USPHS is one of the seven uniformed federal services, with 6,000 active-duty officers. The Nurse Category is the largest with just over 1,350 Bachelor's prepared registered nurses. The Chief Nurse also represents an additional 2,650 civil service and tribal nurses.

Strengthening this office would help ensure nursing's input on important public health initiatives and serve to better coordinate existing public health nursing efforts throughout the States and Territories. A stronger and more visible Chief Nurse Officer would better highlight the roles of public health nurses, which could serve as a valuable recruitment tool.

Bolster the Existing Public Health Nursing Network

Across all fifty states and the US Territories, public health nurses are the lifeblood of state and local health departments, as well as organizations working to assure the health and safety of the public. Public health nurses collaborate with the public to prevent disease and promote health. Not only do they supply critical, gap-filling, direct, safety-net services to vulnerable populations, they also provide the education and social marketing that enables communities to create environments supportive of health and well-being. Last but not least, they partner with individuals and families to adopt healthy behaviors. It is these very nurses who are called upon to provide the surge capacity vitally needed in public health emergencies. Given this vital role, the current shortage of public health nurses and public health nursing leadership and faculty is a critical issue that must be addressed. Without attention to these workforce issues, the supply of public health nurses will remain inadequate, our communities will be vulnerable in the event of an emergency, and our goals for the nation's health will remain unmet.

Invest in Public Health Education

Health education alone has not been shown to create the behavioral changes that lead to lasting change in lifestyle, and public health education efforts must go beyond simple health messages to be effective. Health education efforts must be interdisciplinary, and they must reflect the science of population-based interventions, such as partnerships with populations and communities most at risk, and use of social marketing concepts as a basis for affecting community-wide changes that support healthful behaviors. Finally health education is only a *part* of meaningful change for individuals and communities, not a solution in and of itself. These efforts will not be fully effective unless public health workforce issues are addressed.

We welcome the added attention to the nursing profession, the current nursing shortage, and nurses' role in public health that the National Nurse initiative has fostered. We hope that the resulting dialogue will lead to a renewed, lasting investment in the existing nursing and public health network, and we look forward to working together to address our nation's public health needs.

Signed,
American Association of Colleges of Nursing (AACN)
American Association of Critical-Care Nurses (AACN)
American Nurses Association (ANA)
American Organization of Nurse Executives (AONE)
American Public Health Association (APHA)
Association of Community Health Nursing Educators (ACHNE)
Association of State and Territorial Directors of Nursing (ASTDN)
Association of State and Territorial Health Officials (ASTHO)
Association of Women's Health, Obstetric & Neonatal Nurses (AWHONN)
Commissioned Officers Association (COA)
Mary Pat Couig, MPH, RN, FAAN
National League for Nursing (NLN)
Public Health Nursing Section, American Public Health Association
Quad Council of Public Health Nursing Organizations

Book Review: An Epileptic Child Caught Between Cultures

The Spirit Catches You and You Fall Down

by Anne Fadiman
Published by: Farrar, Straus and Giroux, 1997, New York, NY
Reviewed by Penny Higgins, RN, EdD

I read this book, not because we will see a lot of Hmong patients in Maine, or even New England, but because it is beautifully written and exemplifies what is happening throughout the medical community in the United States. The author calls it the collision of two cultures, and in some ways this is true. In addition, it is a commentary on people's difficulty with communication even when almost everyone is very anxious to provide the best of care to their children or to their patients.

It is the story of a young Hmong child, Lia, who suffers from a severe form of epilepsy, the Hmong name for which means "the spirit catches you and you fall down." But in the background is the story of the Hmong people and their displacement to this country from Asia. Anne Fadiman describes the interaction between Lia's family and the nearby rural medical center. The Hmong belief that their manner of healing is more effective than modern medicine is still strong, and their suspicion of the doctors, nurses and other medical caregivers prevents them from following guidelines that might have helped them care for their child. Illiteracy and inability to learn the language compounds the communication problems. The medical personnel, on their part, never think to ask what the parents were doing to help their daughter; and, even though strong protocols and guidelines are offered and supervised with home care, the child is admitted frequently with gradually more severe seizures. At one point, the child is removed from the home, and she temporarily does improve with regular medication administration, but at great cost to the family.

Fadiman intersperses her story of the family with the story of the Hmong in Asia, and their huge contributions to our side during the Vietnam War. After the war, they were unable to return to their homes in the mountains of China and Vietnam, and had to live in unhealthy encampments in Laos or emigrate to various cities in the United States—totally unable to once more become the independent, self-sufficient farming communities that they had been for centuries. Huge numbers of Hmong settled in one small area of California, where no one knew or cared about their important role in saving American lives.

Although we have no Hmong in our midst, we are beginning to see other Asian émigrés, Somali refugees and many others who may have their own cultural values and taboos. At least at first, they also may have great difficulty understanding our language, culture and, when needs arise, our medical system. During the 1950s, Madeline Leininger, a nurse-researcher, described the imperative of examining and documenting different cultures, their differences and their commonalities, and using this information to optimize our ability to nurse within whatever community that we find ourselves.

The book is almost too rich in detail to explain here. Although it reveals a perfect example of mistakes that can be made, the compassion of those responsible for Lia's medical care clearly comes through, as does the immense love of the family for one another and this small child. It is a gripping book and I highly recommend it to nursing administrators, practicing nurses, students, and educators.

Surviving Shift Work

by Diane E. Scott, RN, MSN
Reprinted with permission from the
Center for American Nurses

"We were working night-shift together as usual: just three nurses on a busy rehab department. One morning, my co-worker was driving the short distance to her home and fell asleep behind the wheel of her car. She suffered multiple fractures and her life was never the same again." Susan, RN, Pittsburgh, Pennsylvania.

Regrettably, countless nurses who have worked shifts can relate to this true story. Shift work, generally described as working outside of daylight hours, is difficult physically and mentally, but inherent to many healthcare positions. Approximately 30% of the nursing population is employed in shift work (Hughes & Stone, 2004). Despite its difficulty, shift work is preferred by numerous nurses; some for the flexibility of their home lives, while others prefer it for the monetary benefits that often accompany working in the evening and during the night.

Regardless of the reason why a nurse chooses a position that requires shift work, working non-daylight hours can be detrimental to a nurse's health. The National Sleep Foundation (NSF, 2007) states that shift workers experience more untoward health effects such as high blood pressure, menstrual irregularities, colds and weight gain more than day shift workers.

Patient Safety

The correlation between medical errors and shift work is beginning to demand national attention. In a recent study by Dr. T. Akerstedt, over 50% of shift workers report severe decreased alertness when on the job (2005). Nurses who work successive night shifts are particularly at risk for medical errors. Findings compiled from several research studies state that the risk of medical errors compounds with each successive off-shift a healthcare provider works. On average, the error rate increases 6% after the second night shift, 17% higher the third successive night shift and an astounding 35% higher on the fourth night shift. (Folkard et al., 2005).

The Circadian Clock

Nurses need to learn as much as they can about the physiology of sleep. Learning to survive shift work starts by understanding sleep and the methods to counteract the negative affects of working while the rest of the world is asleep. Understanding the circadian clock is the first step.

The circadian clock is the human body's natural tendency to follow a 24 hour cycle; this internal pattern is strongly regulated by light and dark with most people yearning for sleep between the hours of midnight and 6 AM (NSF, 2007) The circadian clock controls the body temperature, hormones, heart rate and other body functions; as a result, 10-20% of shift workers report falling asleep on the job (NSF, 2007). The problems often extend into the daylight as many shift workers find it difficult to sleep soundly for adequate periods when returning home.

Taking Control of Sleep

The first step to taking control of sleep is to learn to make sleep a priority. Shift working nurses need to teach their bodies how to fall asleep and remain sleeping for long periods uninterrupted. Following the clues from the circadian clock, nurses can learn to counteract the effects of daylight whenever returning home after working a night shift. The NSF recommends that nurses wear wrap around sunglasses when driving home so the body is less aware that it is daylight.

Rotation Patterns.

Nurses who work in permanent off-shifts can utilize the principle of re entrainment, or training the body to be the most alert during the evening hours and into the night (Berger & Hobbs, 2006). Re entrainment may take weeks to develop and social activities may be difficult as the majority of society is awake during the daylight, not at night (Berger & Hobbs, 2006).

When scheduling shifts that rotate, nurses should consider working forward, rotating shifts whenever possible. Working in a pattern of daylight, evening then nights or, in the case of 12 hour shifts, working daylight shifts prior to nighttime shifts, helps to maintain the body's circadian rhythm. (Berger & Hobbs, 2006)

The following are tips that help set the stage for sound sleep even during daytime hours.

Bedroom Design. Design the bedroom to accommodate daylight sleeping.

- ♣ Install room darkening shades to cover all windows.
- ♣ Decrease the room temperature.
- ♣ Consider earplugs to block outside noises and eyeshades to decrease light sources.
- ♣ Place a "do not disturb sign" on the outside of the bedroom door and front door.
- ♣ Create guidelines for families to eliminate noise and interruptions during sleep such as television watching and noisy outside playing.
- ♣ Unplug the telephone.

Food and Exercise

- ♣ Avoid caffeine for at least five hours prior to sleeping. Consider all sources of caffeine, including chocolate, energy drinks, gum and sodas.
- ♣ Choose nutritious food to eat during the shift to avoid large fluctuations in blood sugar.
- ♣ Do not eat a heavy meal prior to bedtime.
- ♣ Avoid alcohol prior to sleep.
- ♣ Do not plan exercise prior to sleeping as it raises the body temperature, heart rate and tends to energize the body.

Staying Alert during Work

The National Sleep Foundation (2007) states that people who work night shift tend to be most fatigued at 4 AM, so try not to plan the most monotonous tasks during that time.

The following tips can be done to encourage alertness during night shift:

- ♣ Schedule short breaks as often as possible throughout the shift.
- ♣ Exercise when feeling fatigue, such as climbing a set of stairs or taking a walk to the cafeteria.
- ♣ Avoid unhealthy foods during the shift.
- ♣ Develop a system to monitor the fatigue levels among the members of the team.
- ♣ Never rely on dangerous medications to enhance alertness.
- ♣ Develop a partner system that serves as a check and balance when completing tasks during periods of fatigue.

The Drive Home

The danger of driving under the influence of alcohol is well known throughout the world, however, driving after shift work can be extremely dangerous as well. A 2006 Institute of Medicine report on Sleep Disorders and Deprivation stated that almost 20 percent of all serious car crash injuries in the general population are associated with driver sleepiness, independent of alcohol effects. Many nurses will open the car windows and turn the volume of the radio up to combat fatigue, but, according to the NSF, studies have proven that these methods do not work. In fact, these actions should signal that one is dangerously fatigued and needs to pull over immediately.

The NSF has offered the following recommendations for driving after shift work:

- ♣ Carpool when possible and keep a dialogue with the person who is driving.
- ♣ Take public transportation when possible.
- ♣ Drive defensively
- ♣ Don't stop for a night cap.

Ignoring fatigue signs can be dangerous. Taking deliberate steps to understand and control the bodies natural rhythms is essential to the health and wellbeing of nurses and the patients in their care.

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Confident Voices

The Q & A column for nurses facing difficult issues with communication, conflict and workplace dynamics

Welcome to a new column where communication and conflict specialist, Beth Boynton, RN, MS offers insights for nurses dealing with complex workplace dynamics. If you would like to have a situation considered for review in the next issue of ANA-Maine, contact Beth at: ConfidentVoices@verizon.net.

Dear Beth,

I am a nurse manager on a med-surg floor and have been in this position for almost two years. One of the fulltime nurses who reports to me has been employed by the organization for over 20 years and subtly creates tension and negativity on the floor almost every day. She groans, rarely smiles, and makes negative comments regarding other staff and various unit standards/procedures regularly. She shows little to no respect to the management in very careful actions which are hard to pin down. Clinically, she is a really sharp nurse and I learned a lot from her as a staff nurse.

I used to be a co-worker with her and we got along really well. I was one of her favorites then, but since I've become a manager I feel like there is constant resentment which shows up in criticism, snide remarks, and a frequent cold shoulder. Due to the way that she operates many people are forced to walk on eggshells, including myself, no matter what approach we seem to take.

As the manager, I feel I should address this with her, but dread the very thought of it—partly because some of her behaviors are so subtle that I'm not really sure they are things I can substantiate. This issue is wearing on me at work and at home. Many staff members say things about her like "Oh, deep down she has a heart of gold" or" Her bark is worse than her bite."

Another reason that I haven't addressed this is that my supervisor tolerated her behavior for many years. She tends to be a "hands-off" leader and though I have a good relationship with her, I am afraid that she'll think I can't work it out on my own and/or may feel like I am telling her that she didn't do a good job when she was in my role.

I'd appreciate any ideas you have on handling this situation.

Frustrated Nurse Manager

Dear Frustrated Nurse Manager,

Thanks for this great albeit difficult situation to discuss. Ultimately, it is your decision how to proceed and I offer the following comments for you to consider as you develop your strategy.

This nurse's behavior has become a chronic problem and one which seems to be tolerated thereby giving her permission to continue. It is always hard to change boundaries and will likely be a tricky and stressful process for you, her and anyone else involved. If it isn't addressed, however, it will likely continue and who knows the extent of damage this is causing in terms of quality, safety, morale, etc.

A two-pronged approach should be considered: one that addresses the culture of the unit and one that addresses the individual.

Addressing the Employee

Addressing the employee should include direct feedback. Think carefully about how you can frame this feedback in a kind and helpful way. Be clear in your own mind and heart. Would you want anyone to treat her the way she is treating you? Would you intervene on her behalf? She likely has an invaluable skill set in addition to a long, committed career, both of which deserve lots of respect. Finding ways to help her be more successful in her interpersonal work relationships or happier at work could be helpful frames.

'I' statements with a true spirit of ownership can be especially effective given the subtlety issue. You have a right to your feelings regardless of her intention or cleverness in disguising comments/gestures. An example might be, *"I feel frustrated when you roll your eyes and make inaudible comments with the tone you just used. It makes me feel like you don't respect me or what I am saying. I'd appreciate it if you would find a more respectful and constructive way of offering your feedback."*

I wonder if you have honored the shift in your relationship somehow. Changes in power dynamics are tough even in the healthiest of cultures. This doesn't need to be a big deal. *"Sometimes it is hard for me to be in this supervisory role and I miss our former relationship. I am committed to my new role, though, and I hope we can find a way to have a more respectful dynamic between us"*. Keep in mind that you cannot insist on her respecting you, but you can expect to be treated respectfully. If this is not successful or you do not feel safe, or she refuses to listen to feedback, then you may want to consider a progressive disciplinary approach.

Addressing the Unit Culture

At the same time, it is important that the unit begin the process of setting clear standards for interpersonal behavior. This would include creating or recreating norms and considering any training required to ensure all staff have the skills to practice them. This might include a variety of communication workshops. A plan for enforcing and monitoring new behaviors must be part of the process as well. It is helpful if the organization has consistent norms to fall back on.

I think it is critical to touch base with your supervisor somehow. Leadership commitment for any culture change is essential. You don't need to talk about why she didn't address the situation, but rather get her consent for you to. If she wants to address it, fine, but this is about moving forward and we are all learning. Another reason to talk with her about it is to consider what support you might need. You can role model an assertive approach here too. Even if she is "hands-off" in a general way, this may be an opportunity for her to actively support you and you can consider what this might look like: a dry run-though, a debriefing session after you have a conversation with the employee, a job coach (if she isn't willing/able to play this role) or maybe just asking her to check in with you every couple of weeks for a few months to discuss progress. Another thought would be to get help/support in development of a clear expectation and how that may fit in with performance issues. At any rate, think about what you need from her and then ask for it.

Finally, it is important to realize that those who are offering excuses for her are also tolerating the behavior. You will be role modeling for them too that you expect to be treated respectfully—and that you expect everyone on the unit to treat each other respectfully. The favoritism you mentioned when you were peers is probably another side of this dynamic. Perhaps there are some ways for you to get staff buy-in by asking what they need in order to get to a place where respectful verbal and non-verbal communication is the norm. In bullying school programs there is often a guideline: "No Innocent Bystanders."

This crucial work will take time and persistence. Good luck. Beth

Beth Boynton, RN, MS is an organizational development consultant specializing in communication and conflict issues that impact nurses (www.bethboynton.com). She is an adjunct faculty member with New England College's graduate program in Healthcare Administration and is currently writing a book which focuses on helping nurses to develop confident voices. She can be reached at or 207-363-5604.

Continuing Nursing Education News

by Ruta Jordans, MS, RN, BC
Chair, ANA-Maine CE Committee

Last year at this time I wrote you about the Continuing Education Committee changes and activities, especially the applications that had just been newly revised to comply with substantive changes in the 2006 ANCC manual. After a year of using the new forms, we've taken your suggestions (thanks for the input!) and updated the applications. You can find the latest version (December 2007) on the ANA-Maine Web site under continuing education (http://anamaine.org/eventappforms.htm).

Here are some of the positive comments we've gotten: "The new system is ever so much easier and less time consuming! Thanks for the overhaul!" "The online information and application forms are wonderful!" "Forms in Word and PDF on the Web site are a great help."

Thanks to Jennifer Bridge for recommending Dawn Wiers as our new CE consultant administrative assistant. Dawn started in June and has been a jewel. "Your new administrative assistant is a wonderful addition." "I have very much appreciated being involved with ANA-Maine over the last few years. Everyone has been consistently helpful and enthusiastic about continuing education."

Just to clarify an issue that has some confused: We have two different applications. One is for individual educational activities and the fee varies according to the number of contact hours, starting at $75 for one to five contact hours if postmarked more than 45 days before the activity. The other application, for provider unit approval, is now $1250 for three years for an unlimited number of contact hours. Any questions, please call Dawn at 207-938-3826 or e-mail her at anamainece@gwi.net or me at CEChair@anamaine.org.

In 2007 our volunteer committee reviewed 63 individual education activity applications (as compared to 87 in 2006 and 70 in 2005) and eight provider unit applications (as compared to two in 2006).

We welcome additional committee members. If you are an RN with at least a baccalaureate in nursing, a member of ANA-Maine, and knowledgeable about ANCC accreditation criteria (and hopefully have experience in continuing nursing education) we welcome your interest.

The ANA-Maine CE Committee is looking forward to a busy and exciting 2008!

SAVE THE DATE: ANA-Maine Awards Ceremony

MAY 1, 2008

Nominations are open for two prestigious nursing awards

The holidays have flown by, but you still have time to celebrate if you are a nurse. The 5th Annual ANA-Maine Awards Ceremony will be here sooner than you think. Mark your calendar for **May 1, 2008**, when ANA-Maine will present the **Agnes E. Flaherty Award** and the **Sister Consuela White Spirit of Nursing Award** to deserving nurses.

The **Agnes E Flaherty Leadership Award** is given annually to a registered nurse leader who demonstrates leadership, courage and dedication in his or her interactions with patients and families, staff and co-workers, the profession, and the community. I am sure you know at least one co-worker who demonstrates the ability to develop a work environment that fosters autonomy and creativity; values and empowers others; affirms the uniqueness of each individual; motivates others to work toward a common goal; identifies common values; is committed to the profession and society; thinks long term and is visionary; is politically astute; and thinks in terms of change and renewal.

The **Sister Consuela White Spirit of Nursing Award** is given annually to a registered nurse in clinical practice, nursing education or administration who demonstrates the spirit of nursing by the care, concern, respect and knowledge that he or she demonstrates in interactions with patients and families, co-workers, students, the profession, and the community. This nurse demonstrates the ability to listen on a deep level and to truly understand; to keep an open mind and hear without judgment; to deal with ambiguity, paradoxes and complex issues; believes that honestly sharing critical challenges with all parties and asking for their input is more important than personally providing solutions; is clear on goals and good at pointing the direction without giving orders; uses foresight and intuition; sees things in their entirety and senses relationships and connections.

Disappointed because your nominee didn't receive the award last year? Please do not despair. Submit the person again for an award this year. The winners are chosen strictly based on the detail that you are able to supply about why you have chosen this person as a nominee. Please try to give specific examples that relate to each defining quality required for the award. I know there are hundreds of nurses out there that deserve a nomination.

Comments from last year's winners portrayed the nominees as having "outstanding teaching skills" and a "professional relationship with physicians." Other comments: "She is aware of her employees and is intuitively sensitive to our problems." "She demonstrates compassion and empowerment through her leadership style, embracing change, facilitating communication, overcomes challenges gracefully through open discussion." "She allows the staff to develop strong autonomous nursing styles unique to each nurse." "She honors every staff member." "She is currently conducting a study." She "always thinks critically and reflectively on her practice." "She maintains the highest level of integrity and never waivers on the highest of standards she has set for herself, her students and the profession."

Log on to www.anamaine.org to fill in the ANA-Maine awards nomination form and to stay updated on information about registration for the upcoming event.

Anita Hakala, MSN, RN, Chair, ANA-Maine Annual Awards Event

Criteria for ANA-Maine Awards

The Agnes E. Flaherty Leadership Award

The Agnes E. Flaherty Leadership Award is to be given annually to a registered nurse leader who demonstrates leadership, courage and dedication in his or her interactions with patients and families, staff and coworkers, the profession and the community.

- Defining qualities include the ability to:
- Develop a work environment that fosters autonomy and creativity
- Value and empower others
- Affirm the uniqueness of each individual
- Motivate others to work toward a common goal
- Identify common values
- Be committed to the profession and society
- Think long-term and be visionary
- Be politically astute
- Think in terms of change and renewal

Defining qualities taken from: Marquis, B , Huston, C (2003) Leadership Roles and Management Functions in Nursing, 4th Edition Philadelphia: Lippincott, 2003 p 17-19, 22

The Sister Consuela White Spirit of Nursing Award

The Sister Consuela White Spirit of Nursing Award is to be given annually to a registered nurse in clinical practice, nursing education or administration who demonstrates the spirit of nursing by the care, concern, respect and knowledge that he or she demonstrates in interactions with patients and families, coworkers, students, the profession and the community.

- Defining qualities include the ability to:
- Listen on a deep level and to truly understand.
- The ability to keep an open mind and hear without judgment.
- The ability to deal with ambiguity, paradoxes and complex issues.
- The belief that honestly sharing critical challenges with all parties and asking for their input is more important than personally providing solutions.
- Being clear on goals and good at pointing the direction without giving orders.
- The ability to use foresight and intuition.
- Seeing things whole and sensing relationships and connections.

Defining qualities taken from: Marquis, B , Huston, C (2003) Leadership Roles and Management Functions in Nursing ,4th Edition Philadelphia: Lippincott, 2003 p16-17.

Please send your nominations addressing these criteria to:

Michelle Schweitzer, ANA-Maine
83 Brown Road, Raymond, Maine 04071

DEADLINE for RECEIPT of NOMINATIONS: **APRIL 1, 2008**

Celebrate Nurses Week 2008 with presentations of the AGNES E. FLAHERTY LEADERSHIP AWARD and the SISTER CONSUELA WHITE SPIRIT OF NURSING AWARD

May 1, 2008
Martindale Country Club
527 Beech Hill Road, Auburn, Maine
$45.00 per person
Cash Bar: 5:30 PM to 6:30 PM
Dinner & Awards Ceremony: 6:30 PM
Register by April 15, 2008

Name_____

City _____ State _____

E-Mail_____

Phone_____

Amount Enclosed _____
Registration fee is non-refundable

ANA-MAINE
DINNER REGISTRATION FORM

Make checks payable to: **ANA-Maine**
Mail registration form by: **April 15, 2008**
Mail to:
ANA-MAINE Awards Ceremony
c/o Michelle Schweitzer
83 Brown Road
Raymond, Maine 04071
E-Mail to: **awards@anamaine.org**

Directions to Martindale Country Club in Auburn: Take exit 75 off the Maine turnpike. At the traffic light go left and after the first overpass take the 2nd left onto Beech Hill Road. Martindale is less than a mile on the right. Parking is in the front or side of the club house. Phone # (207)782-1107.

Maine MS Chapter to Target Nurses

Program to help meet needs of MS patients

The Maine Chapter of the National Multiple Sclerosis Society serves approximately 3,000 families in Maine who are affected by MS. This is nearly one in every 400 Maine residents who have MS, one of the highest per-capita rates in the nation.

To meet the needs of the many families living with MS in the state, the Maine Chapter provides statewide programs that help people manage their disease, whether it is through financial assistance, information and referrals, care management, self-help groups, or educational programs.

The Maine Chapter also provides education and support to professionals in the state. Over the last two years, the Maine Chapter has provided professional conferences for neurologists, mental health professionals, and physical and occupational therapists. This year the Maine Chapter is targeting one of the most integral members of the healthcare team involved in managing MS: nurses.

Through the Nurse Education Program, the Maine Chapter will provide specific tips and training on how best to meet the needs of people living with MS. The program will address specific issues related to disease modifying agents and emotional and physical symptoms of the disease.

As part of our outreach into the nursing community, the Maine Chapter will present the Nurse Education Program at the 2008 Maine Nurse Practitioners Meeting on Thursday, May 22, 2008. The conference will take place at the Samoset Resort in Rockland, Maine. We hope that this workshop is both personally and professionally rewarding for all who attend.

The Maine Chapter encourages healthcare professionals to attend one of our many programs as well as seek the continued support of the National MS Society's Professional Resource Center (PRC). The PRC offers multidisciplinary expertise on MS disease process and management, health insurance issues, long-term care options, and the development of MS specialty clinics. Together, we will enhance the quality of care and increase access to care for people living with MS. To access the PRC, visit www.nationalmssociety.org/PRC.

For information about local programs and resources, or to become involved in the many volunteer and fundraising opportunities, contact the National MS Society at 1-800-344-4867 or visit us online at www.msmaine.org.

We want to do something about MS now. Join the movement.

About Multiple Sclerosis

Multiple sclerosis interrupts the flow of information between the brain and the body and it stops people from moving. Every hour in the United States, someone is newly diagnosed with MS, an unpredictable, often disabling disease of the central nervous system. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are moving us closer to a world free of MS. Most people with MS are diagnosed between the ages of 20 and 50, with more than twice as many women as men being diagnosed with the disease. MS affects more than 400,000 people in the U.S., and 2.5 million worldwide.

About the National Multiple Sclerosis Society

MS stops people from moving. The National MS Society exists to make sure it doesn't. We help each person address the challenges of living with MS. In 2006 alone, through our home office and 50-state network of chapters, we devoted nearly $126 million to programs that enhanced more than one million lives. The society also invested more than $46 million to support 380 research projects around the world.

Call For Action

Studies show that early and ongoing treatment with an FDA-approved therapy can reduce future disease activity and improve quality of life for many people with multiple sclerosis. The National MS Society's medical advisors recommend that people with MS talk with their healthcare professionals about using these medications and about effective strategies and treatments to manage symptoms. If you or someone you know has MS, please contact the National MS Society at www.nationalmssociety.org or 1-800-FIGHT-MS (344-4867) to learn more.

Mumps Outbreak in Maine

ADVISORY–Important Information

Dora Anne Mills, M.D., M.P.H., Public Health Director

November 19, 2007

Summary

Since late September, Maine CDC has confirmed seven people with mumps in central and southern Maine, and is awaiting the results of laboratory testing on other patients with clinically-suspected illnesses. Confirmed patients reside in Cumberland, Androscoggin, Oxford, and Somerset Counties and range in age from late teens to late fifties. Mumps exposures at two acute care hospitals have resulted in serological testing for immunity and/or expedited vaccine boosting of a significant number of health care workers. Although no formal epidemiological link has been made, it is likely that these infections may be associated with an ongoing outbreak of mumps in New Brunswick and Nova Scotia. The epidemiology of recent outbreaks in North America, including the current situation in Canada, suggests that college and university students and health care workers should be priority populations for vaccination initiatives.

This Advisory includes new and strengthened immunization recommendations. In addition, clinicians are being asked to immediately report all cases of parotitis that is not clearly related to another etiology through Maine CDC's 24 hour toll-free reporting line. Maine CDC epidemiologists will provide detailed guidance on the collection and submission of diagnostic specimens to Maine CDC's Health and Environmental Testing Laboratory and on recommendations for any necessary school and work exclusions and other infection control measures.

Background on Mumps

Mumps is an acute viral infection of the salivary glands. Symptoms include fever, headache, muscle ache and swelling and tenderness of the salivary glands at the angle of the jaw (parotid glands). Prodromal symptoms of mumps are non-specific, and may include myalgia, anorexia, malaise, headache, and low-grade fever. Parotitis usually occurs within the first two days of the onset of illness and is seen in 30-40% of infected individuals. Parotitis can be unilateral or bilateral with any combination of single or multiple salivary glands being affected. Approximately one-third of infected individuals do not display parotid or salivary gland swelling, and sometimes mumps manifests itself only as a non-specific upper respiratory illness. Symptoms usually improve after a week, and tend to resolve within 10 days.

Mumps infection in adults is often more severe than in children, and most deaths, although rare, occur among adults. More than 50% of mumps infections cause cerebrospinal fluid pleocytosis, and 10-15% of persons with mumps present with symptomatic meningitis. Encephalitis is very rare. Orchitis is the most prevalent complication among adult males (20%-50%). Other mumps complications are oophoritis (5% of adult women), and rarely, pancreatitis, transient or permanent deafness, and myocarditis.

Transmission occurs through direct contact with respiratory droplets from the nose or throat of an acutely infected individual such as through coughing and sneezing, contact with saliva (sharing utensils, kissing, towels, etc.) or from contact with surfaces that have been contaminated with mumps virus. Persons with mumps infection are presumed to be infectious from 3 days before the onset of symptoms through 9 days after symptom onset. The incubation period after exposure is 16-18 days.

Background on Recent Outbreaks

Since March of this year, Canada has been experiencing an outbreak of mumps. As of mid-November, over 900 confirmed cases had occurred in 13 provinces, with the outbreak activity centered in Nova Scotia and New Brunswick. Most cases in Canada have occurred in persons ages 17–37, many of whom are college or university students. http://www.phac-aspc.gc.ca/mumps-oreillons/prof_e.html

Likewise, in the United States, more than 2,500 persons became ill in 2006 during a multi-state outbreak of mumps that primarily affected young adults residing on college and university campuses in the Midwest, mostly in Iowa. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5542a3.htm?s_cid=mm5542a3_e

Before Measles Mumps Rubella (MMR) vaccine was introduced in 1967, an average of 200,000 persons were reported with mumps every year in the United States, and 20–30 of those died annually. After the vaccine was introduced, the incidence plummeted to about 8,000 per year, and after a second dose of MMR was recommended for children in 1989, the incidence again declined. From 2001-2003, fewer than 300 total cases were reported, representing a 99% decline from pre-vaccine incidence.

Although mumps vaccination is highly effective, no vaccine is 100% protective. A single dose of MMR is estimated to provide a protective efficacy of about 80%, while two MMR doses provide approximately a 90% efficacy. Factors that may have contributed to recent college and university outbreaks include the ease with which respiratory transmission can occur among persons living, studying, and socializing in close quarters; the high contagiousness of mumps; and the effect of waning immunity against mumps among students who were vaccinated only once in early childhood or at least 10 years before entering college.

Diagnosis

As noted above, mumps cases have been very infrequent in this country for the past several decades, and most clinicians have seen few, if any cases. Although parotitis may occur in fewer than one-half of all mumps cases and is not pathognomonic for mumps, it remains the most distinguishing feature of this disease. In the current epidemiological setting, clinicians should maintain a very high index of suspicion for mumps when they encounter people with parotitis, *even among persons who are over age 50, whose symptoms are mild, and/or who have a history of receiving two doses of MMR vaccine*.

Laboratory testing of suspected mumps cases is critical, but obtaining evidence of infection can be problematic, ***especially when appropriate specimens are not obtained during the first 2-3 days of illness.*** The diagnosis of mumps in persons with suggestive clinical presentation can be confirmed through viral culture of stool or saliva, by identifying mumps IgM antibody in serum, or through polymerase chain reaction (PCR) testing of saliva to amplify mumps nucleic acid early in the acute illness. The Federal CDC is also evaluating newer diagnostic methods utilizing whole blood in tests of mumps cell-mediated immunity. Attempts to demonstrate rising IgG antibody titers may also be of some limited utility.

Maine CDC epidemiologists and microbiologists have been working closely with mumps specialists at the Federal CDC in recent weeks to find ways to expedite diagnostic testing and improve the sensitivity of testing procedures. We are requesting that clinicians who see patients with parotitis or otherwise suspected mumps to do the following:

1. Immediately report suspect cases by calling the Maine CDC 24-hour disease reporting line: **1-800-821-5821.**

2. The on-call epidemiologist will provide the reporting clinician or office staff professional with instructions on collection and submission of diagnostic specimens to the Maine CDC's Health and Environmental Testing Laboratory (HETL). HETL does not charge patients for performing these tests, although offices and hospitals must use their regular courier services to get the specimens to HETL. Desirable specimens may include:

- An oral swab (with a non-cotton tip) taken from the area around Stenson's duct (at the level of the lower molars) after a 30-second massage of the parotid area. This will be used for PCR testing and viral culturing for mumps virus.
- A single red-top tube for serum collection, to be used for IgM antibody testing.

Continued on page 10

Mumps Outbreak in Maine

Continued from page 9

- Collection of 20-40 cc of whole blood in green top tubes– if possible. This will be sent to federal CDC laboratories for cell-mediated immunity testing.
- A nasopharyngeal swab to test for alternative etiologies for parotitis by PCR and viral culture, including for parainfluenza, Epstein-Barr virus, adenovirus, and influenza virus.

We will not be requesting convalescent specimen collection at this time.

3. While clinicians may wish to continue sending diagnostic specimens for mumps IgM antibody to commercial laboratories, Maine CDC requests that specimens (per above) also be sent to the HETL so that this information is available for outbreak control purposes.

Again, testing should be done within the first few days after the onset of illness if at all possible.

Treatment

Treatment is supportive.

Isolation

All Settings:

- Patients with mumps are infectious for up to **nine days** after the onset of illness and should be excluded from social events, school or employment activities for that period of time.
- Because the incubation period may be as short as 12 days and as long as **25 days**, non-immune people exposed to mumps may need to out of school, work and other high-risk settings from the 12th through the 25th day after exposure. Epidemiologists can work directly with patient and their schools/employers on an individual basis.

Healthcare Setting: In addition to standard infection control precautions, droplet precautions are recommended for hospitalized mumps patients until nine days after onset of disease.

Prevention and Control of Mumps in Healthcare Settings: http://www.cdc.gov/vaccines/vpd-vac/mumps/outbreak/control-hcw.htm

Vaccine Recommendations

The MMR vaccine is given to protect against mumps. See Vaccine Information Statement (VIS) for contraindications and other information on MMR: http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mmr.pdf

In 2006, the Advisory Committee for Immunization Practices (ACIP) recommended key changes to the recommendations on mumps:

Acceptable Presumptive Evidence of Immunity

Documentation of adequate vaccination is now **2 doses** of a live mumps virus vaccine instead of 1 dose for school-aged children (i.e., grades K-12) or adults at high risk (i.e., persons who work in health-care facilities, international travelers, and students at post-high school educational institutions).

Routine Vaccination for Health-Care Workers

- Persons born during or after 1957 without other evidence of immunity: 2 doses of a live mumps virus vaccine.
- Persons born before 1957 without other evidence of immunity: 1 dose of a live mumps virus vaccine.

For Outbreak Settings

- Children aged 1–4 years and adults at low risk: if affected by the outbreak, consider a second dose of live mumps virus vaccine (such as MMR), with minimum interval between doses of 28 days.
- Healthcare workers born before 1957 without other evidence of immunity: strongly consider recommending 2 doses of live mumps virus vaccine (MMR).

Link to Updated ACIP Recommendations http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5522a4.htm?s_cid=mm5522a4_e

Specific New Maine Vaccine Recommendations

In order to insure compliance with the above ACIP recommendations, especially in the context of the current outbreak of mumps, Maine CDC recommends the following:

K-12 Schools

- All vaccine records need to be reviewed and updated.
- Maine law requires vaccination of all school children with two doses of MMR. In outbreak situations in a school, unvaccinated children will be excluded.
- For those children who are not updated with their MMR vaccine, a letter should be given to the parents notifying them that Maine is currently experiencing an outbreak of mumps, and that if the infection is detected in their school their child will need to be excluded from school attendance for about 18 days. A sample letter will be available for use.

Maine K-12 School Immunization Requirements and School Exclusion Rules http://www.maine.gov/sos/cec/rules/10/144/144c261.doc

Colleges and Universities

- All vaccine records need to be reviewed and updates.
- All college and university students should have documentation of **two doses** of MMR unless they are born before 1957, in which case they need documentation of one dose.
- Those students who are not updated should be notified of the outbreak in Maine and possible exclusion from school.
- Colleges and universities should consider a policy to insure that faculty and staff have adequate mumps vaccination (generally, 2 doses MMR if born during or after 1957 and 1 dose if born before 1957; or if an outbreak, 2 doses MMR for everyone–seek consultation from Maine CDC).

CDC and American College Health Association Strategies to Protect College Students http://www.cdc.gov/vaccines/vpd-vac/mumps/downloads/ACHAguidance-ltr.pdf

Hospital Health Care Workers with Direct Patient Care

- All health care workers in hospitals who have direct patient contact should have their vaccine records reviewed and updated.
- Adequate mumps vaccination for those born during or after 1957 now consists of **two doses of MMR**, rather than the previous recommendation for one dose.
- Adequate mumps vaccination for those born before 1957 now consists of **one dose** of MMR, rather than no doses as previously recommended.
- If there is an outbreak of mumps in the area, a second dose of MMR should be considered for those born before 1957.

Prevention and Control of Mumps in Healthcare Settings http://www.cdc.gov/vaccines/vpd-vac/mumps/outbreak/control-hcw.htm

State Assistance

For schools, colleges, universities, hospitals, and other settings impacted by these recommendations, the Maine CDC is working to provide some assistance. Some examples:

- Maine CDC professionals are available for consultation 24 hours per day (1-800-821-5821).
- We may be able to provide Public Health Nursing staff to assist with vaccine clinics.
- Free federally-funded MMR vaccine is available through Maine CDC for children under age 18.
- We are investigating if we can provide access to the government contract price for MMR vaccine (about $18 per dose, versus $45 per dose retail).
- Please call us if you are interested in these or other possible assistance.

Surveillance

Early detection and control of individual mumps cases could result in preventing an outbreak. **Please report a suspect case of mumps to the 24-hour disease reporting and consultation line at Maine CDC at 1-800-821-5821.**

For More Information

Maine Mumps Page (clinical info, Q&A, lab testing, patient info, vaccine info, etc.) http://www.maine.gov/dhhs/boh/mumps.htm or www.mainepublichealth.gov

WGU Future of Nursing Scholarships

Western Governors University is pleased to offer the WGU Future of Nursing Scholarships to eligible candidates. These scholarships are designed to help working nurses attend college online to become educators, managers, and leaders in the vital healthcare field. Each scholarship is valued up to $5,000. The scholarship will be credited to the recipient's account at the rate of $1,000 per six-month term for up to five terms. Tuition for a six-month term is $3,250, less the $1,000 per term scholarship.

Scholarships are awarded based upon a candidate's academic record, readiness for online study, financial need, and current competency, plus other considerations. The scholarship awards are based on a reasonable experience of five six-month terms to complete a program, but may be completed sooner depending on the incoming student's prior experience, academic background, and time commitment to study.

Who Should Apply

Unencumbered (not under suspension, revocation or investigation) licensed RNs who hold a Bachelor of Science in Nursing degree and individuals interested in one of the following master's degrees: Master's of Nursing-Education and Master's of Nursing-Leadership and Management should apply as soon as possible.

These are **competitive, needs-based** scholarships. Apply now and if all your admissions information is completed in a timely fashion, and you are awarded a scholarship, you could start as early as the first of the following month. All WGU students begin classes on the first of each month, for every degree program. For detailed information about eligibility requirements and application, go to: http://www.wgu.edu/msnscholarship or call toll-free 1-866-225-5948, extension 1693.

Contact information for nursing/healthcare trade media:
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MHA Opposes State Requirement to Use Proprietary Survey

MHA testified at the Maine Health Data Organization's (MHDO) public hearing on proposed amendments to Chapter 270.

The Resolve, To Further the Collection of Hospital Quality Data Regarding Nurse Staffing, directs the MHDO in consultation with the Maine Quality Forum (MQF) to collect nursing satisfaction measures using only metrics with national benchmark data.

The MHDO proposed mandating use of the American Nurses Association's "NDNQI RN Survey with Job Satisfaction Scales."

MHA explained its concerns with the NDNQI tool and recommended that the MHDO replace the NDNQI survey in its proposed rule with the Culture of Safety survey developed by the Agency for Healthcare Research and Quality (AHRQ).

Mary Finnegan, director of performance improvement at Goodall Hospital; Lisa Harvey-McPherson, vice president of continuum of care at Eastern Maine Medical Center; Susan Campbell, administrative director resource management, at MaineGeneral; and Donna Libby, past president of OMNE, Nursing Leaders of Maine, also testified.

Finnegan explained the link between the AHRQ survey and nurse satisfaction and testified that the survey has been invaluable and helped the hospital win a prestigious grant to improve patient safety.

Harvey-McPherson also praised the AHRQ survey, saying that it addressed the concerns expressed by the nurses union when the original staffing ratios bill was being discussed. The AHRQ Culture of Safety Survey is available at no cost through the QIO and is a computer based tool thus allowing ease of completion, she said.

Campbell described the NDNQI staff as inflexible and unable to provide actionable detail about the survey responses. She explained that MaineGeneral is being billed as two hospitals this year, despite the fact it's licensed as one. And NDNQI also arbitrarily increased the applicable fees, causing the hospital to be charged $3,000 more this year than last year.

Libby testified that the NDNQI tool has not been particularly helpful in developing quality plans that would enhance nurse satisfaction. Indeed, staff were dissatisfied with the survey and found it difficult to use, she said.

Josh Cutler, MD, acting director, MQF, submitted written testimony in opposition to the proposed rule, recommending use of the National Quality Forum endorsed Practice Environment Scale—Nursing Work Index or the AHRQ Culture of Safety Survey.

MHA's testimony can be found at www.themha.org

Inland Hospital in Waterville, Maine is Pleased to Welcome Two New Staff Members:

Rick Barry, RN is Inland's new Vice President of Patient Care Services and Chief Nursing Officer. Barry comes to Waterville from Newport, Vermont, where he was Chief Nursing Officer and Vice President of Patient Care Services at North Country Health Systems. He has over 26 years in healthcare and holds a Bachelor of Science in Nursing from the University of Texas at San Antonio.

Ralph Falvo, PhD, RN is Inland's new Director of Surgical Services. Falvo joins Inland with an extensive background in peri-operative nursing and operating room management. Most recently he was with The Aroostook Medical Center in Presque Isle as Senior Manager of Surgical Services. Falvo holds a Bachelor of Science in Nursing, a Master's degree in Healthcare Education, and a PhD in Healthcare Administration. He is a certified nurse in Peri-Operative Nursing and Nursing Administration.

Inland Hospital is a member of EMHS.

Rick Barry

Ralph Falvo

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Continuing Education Calendar for Maine Nurses

Although we attempt to be as accurate as possible, information concerning events is published as submitted. We do not assume responsibility for errors. If you have questions about any event, please call the event planner directly.

If you wish to post an event on this calendar, **the next submission deadline is April 4 for the Spring issue**. Send items to publications@anamaine.org. Please use the format as you see below: date, city, title, sponsor, fee and contact information. There is no charge to post an educational offering.

Advertising: To place an ad or for information, contact sales@aldpub.com.

ANA-Maine is the ANCC-COA accredited Approver Unit for Maine. Not all courses listed here provide ANCC-COA credit, but they are printed for your interest and convenience. For more CE information, please go to www.anamaine.org

To obtain information on becoming a ANCC-COA CE provider, please contact anamaine@gwi.net

USM/CCE indicates the class is offered through University of Southern Maine/Center for Continuing Education. For course descriptions, visit www.usm.maine.edu/cce or call 207-780-5900 or 800-787-0468 for a catalog. Most classes are held at the new Abromson Community Education Center in Portland, conveniently located just off I-295. Free parking nearby.

CCSME indicates class is held by the Co-Occurring Disorder Collaborative of Southern Maine.

PESI HealthCare seminars in Maine, visit http://www.pesi.com

January 2008

24 Portland, PESI. **Current Management Strategies for Neuromuscular & Neurodegenerative Disorders.** $169. For additional discount info: 800-843-7763 or www.pesi.com

31 South Portland, PESI. **Legal Issues in Wound Care: Competence or Courtroom?** $169. For additional discount info: 800-843-7763 www.pesi.com

February 2008

8 Saco, Sweetser Training Institute. **Ethics of Multiple Relationships.** $84, 9a.m.-4p.m. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

13 Bangor, PESI. **Infectious Diseases.** $169. For additional discount info: 800-843-7763 www.pesi.com

14 South Portland, PESI. **Infectious Diseases.** $169. For additional discount info: 800-843-7763 www.pesi.com

28 Brunswick, Sweetser Training Institute. **Working with Substance Abuse.** 9a.m.-noon, $50. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

29 Brunswick, Sweetser Training Institute. **Clinical Supervision & Ethic of Self Care.** 9a.m.-noon, $50. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

29 South Portland, PESI. **Forensic Issues in Healthcare: Caring for Victims of Violence & Injury.** $169. For additional discount info: 800-843-7763 www.pesi.com

March 2008

10-11 Clearwater Beach, Fla., PESI. **2008 Cardiac Essentials Conference.** $379. For additional discount info: 800-843-7763 www.pesi.com

13 Portland, PESI. **High Risk Obstetrics: Current Trends, Treatments & Issues.** $169. For additional discount info: 800-843-7763 www.pesi.com

14 Bangor, PESI. **High Risk Obstetrics: Current Trends, Treatments & Issues.** $169. For additional discount info: 800-843-7763 www.pesi.com

18 Saco, Sweetser Training Institute. **Expressive Therapy: A Clinician's "Toolbox."** 9a.m.-noon, $55. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

21 Brunswick, Sweetser Training Institute. **Suicidal Behavior: Considerations for Assessment & Interventions.** 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

26 Bangor, PESI. **Skin & Wound Care.** $169. For additional discount info: 800-843-7763 www.pesi.com

27 Portland, PESI. **Skin & Wound Care.** $169. For additional discount info: 800-843-7763 www.pesi.com

28 Freeport, Sweetser Training Institute. **Creative Arts Modalities in Working with Trauma & Traumatic Grief with Children & Adolescents.** 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

28 Saco, Sweetser Training Institute. **DBT Overview**. 9a.m.-noon, $59. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

April 2008

5 Portland, USM Continuing Education. **Reiki Level 2**. Contact 207-780-5900 or www.usm.maine.edu/cce

8 Portland, USM Continuing Education. **Somali: An Introduction.** Contact 207-780-5900 or www.usm.maine.edu/cce

9-10 Portland, USM Continuing Education. **Mindfulness-Based Stress Reduction: A Two-Day Intensive.** Contact 207-780-5900 or www.usm.maine.edu/cce

11 Augusta, Sweetser Training Institute. **Brief Solution-Focused Treatment.** 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

12 Bangor, Eastern Maine Medical Center/American Radiological Nurse Association-Maine Chapter. **Imaging Seminar-2008.** $75, EMMC Mason Auditorium. 6.0 contact hours will be awarded. Contact: Ellen Beauchaine, RN, BSN, CNOR, Staff Developer/EMMC, 207-973-4652 or ebeauchaine@emh.org

18 Portland, USM Continuing Education. **Certificate Program in Case Management.** Contact 207-780-5900 or www.usm.maine.edu/cce

28-29 Portland, USM Continuing Education. **The Practice of Supervision/Coaching Staff Using Motivational Interviewing.** Contact 207-780-5900 or www.usm.maine.edu/cce

May 2008

1-June 14 Portland, USM Continuing Education. **Putting It All Together! An RN Refresher Course.** Contact 207-780-5900 or www.usm.maine.edu/cce

Session 1: Neurological System—Thursday, May 1, 6–9 p.m.
Session 2: Vascular System—Thursday, May 8
Session 3: Respiratory System—Thursday, May 15
Session 4: Cardiac System—Thursday, May 22
Session 5: Cardiac System—Thursday, May 29
Session 6: Gastrointestinal System—Thursday, June 5
Session 7: Renal System—Thursday, June 12
Session 8: Skills Lab—Saturday, June 14, 9 a.m.–4 p.m.

2-3 Portland, USM Continuing Education. **The Chakra Dance: An Intensive Exploration of Energy, Emotions and Illness.** Contact 207-780-5900 or www.usm.maine.edu/cce

3-5 Portland, USM Continuing Education. **Certificate Program in Holistic Health Care/Session 1.** Contact 207-780-5900 or www.usm.maine.edu/cce

Continuing Education Calendar for Maine Nurses

ANA MAINE
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5 Portland, USM Continuing Education. **Certificate Program in End-of-Life Care.** Contact 207-780-5900 or www.usm.maine.edu/cce

5-6 Portland, USM Continuing Education. **DBT: Training for Therapists—How to Teach the Skills.** Contact 207-780-5900 or www.usm.maine.edu/cce

5, 12 and 19 Portland, USM Continuing Education. **Resolving Workplace Conflict: A Three-Day Intensive.** Contact 207-780-5900 or www.usm.maine.edu/cce

9 Saco, Sweetser Training Institute. **Supporting Families in "Raising Up" Children.** 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

12-13 Portland, USM Continuing Education. **Using Motivational Interviewing with Chronically Ill Patients.** Contact 207-780-5900 or www.usm.maine.edu/cce

14-15 Portland, USM Continuing Education. **A Holistic Approach to Psychological Trauma and Addiction Treatment.** Contact 207-780-5900 or www.usm.maine.edu/cce

16 Portland, USM Continuing Education. **Certificate Program in Case Management.** Contact 207-780-5900 or www.usm.maine.edu/cce

16 Brunswick, Sweetser Training Institute. **Dealing with Resistance to Change.** 9a.m.-noon $55. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

19-20 Portland, USM Continuing Education. **Mindfulness, Interpersonal Neurobiology and the Work of Byron Katie: Clinical Application.** Contact 207-780-5900 or www.usm.maine.edu/cce

23 Saco, Sweetser Training Institute. **Sleep Disturbances & Psychiatric Disorders in Children & Adolescents.** 9a.m.-noon $55. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

30 Brunswick, Sweetser Training Institute. **Forgiveness: The Missing Peace.** 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

June 2008

5-6 Portland, USM Continuing Education. **Beginning Nursing Leadership and Management Concepts: Tools and Practical Strategies for Everyday Success.** Contact 207-780-5900 or www.usm.maine.edu/cce

6 Saco, Sweetser Training Institute. **Cutting.** 9a.m.-1p.m., $64. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

13 Brunswick, Sweetser Training Institute. **CBT (Cognitive Behavior Therapy)**. 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

13 & 27 Portland, USM Continuing Education. **Certificate Program in Case Management.** Contact 207-780-5900 or www.usm.maine.edu/cce

25-27 Portland, USM Continuing Education. **Sport Psychology Institute**. Contact 207- 780-5900 or www.usm.maine.edu/cce

July 2008

9-11 Portland, USM Continuing Education. **Health Psychology Institute.** Contact 207-780-5900 or www.usm.maine.edu/cce

16-18 Portland, USM Continuing Education. **Adult Psychopathology Institute.** Contact 207-780-5900 or www.usm.maine.edu/cce

23-25 Portland, USM Continuing Education. **Childhood Psychopathology Institute.** Contact 207-780-5900 or www.usm.maine.edu/cce

Communicating Critical Test Results

Statement of Problem and Impact:

Timely, accurate, and effective communication to the ordering health care practitioner of significantly abnormal laboratory values and/or diagnostic interpretations *(critical values/results)* is essential to ensure appropriate care and to prevent adverse outcomes from delays in treatment *(1-3)*. The timely, accurate, complete, and unambiguous communication of high priority laboratory or diagnostic tests *(critical tests)* is equally necessary. Diagnostic tests may include for example x-rays, computer tomography (CT) scans, or electrocardiograms. The term *critical test results* refer to both *critical values/results and critical tests*.

In the United States the Clinical Laboratory Improvement Act requires that laboratories and hospitals have procedures in place for the immediate communication of critical test results to the ordering practitioner. Despite these regulations and recommendations, problems communicating critical test results to the ordering practitioner persist in the United States. There is a paucity of similar legislation from other countries.

One study found that only 51% of potentially "life-threatening" critical test results received appropriate attention *(4)*. An audit of patient charts revealed that 15% contained no documentation that clinicians were ever aware of the critical test result or that any corrective action was taken *(5)*. Another study found that although critical test results were reported promptly by the laboratory, treatment delays were still common. The median time interval until appropriate treatment was ordered was 2.5 hours, with a delay of greater than five hours in 27% of the cases *(6)*. In the ambulatory care setting studies suggest that the majority of adverse events are caused by missing critical tests that result in missed or delayed diagnoses leading to potential harm *(7,8)*.

Associated Issues:

Ineffective communication is the most frequently cited category of root causes of serious adverse events in health care. Effective communication of critical test results is determined by the information transmitted being timely, accurate, complete, unambiguous, and understood by the recipient. Delays in reporting critical test results relate primarily to communication issues and process complexity. One study found that a common cause of failures or break-downs in communication is insufficient ownership of the process by the laboratories, nursing units, and on-call physicians involved in the process. *(8)*. A multi-institutional longitudinal study was undertaken to evaluate communication patterns of critical test results and to examine the practice patterns and demographic factors associated with sustained improvement in communication of critical test results. In this study significant and progressive improvement in communicating inpatient and outpatient critical test results, specifically lab values, was associated with continued participation in a research intervention indicating that improvement can occur *(9)*.

Organizations should make a distinction between the following:

a) Critical *values/results*–those abnormal findings that always require rapid communication of results, even if based on routine tests, and

b) Critical *tests*–those tests whose results always require rapid communication, whether normal or abnormal (commonly ordered as "stat" exams).

c) For critical *values/results*, measurement and assessment activities should focus on the interval from the time the result is first known to be critical to the time it is reported to the ordering practitioner (result known-to-reporting interval). As it is not known ahead of time which tests (stat, timed, routine, etc.) could produce a critical value, the ordering-to-testing timeframe is usually not relevant.

If critical results are reported within the organization by the diagnostic service to an authorized surrogate of the ordering practitioner (rather than directly to the ordering practitioner), measurement and assessment activities need to include the interval from the time the critical value/result is initially reported to that agent to the time that person reports it to the ordering practitioner. It follows that organizational leadership will need to support a collaborative interdisciplinary review process and to be aware that it is not the exclusive responsibility of the diagnostic service to monitor and manage those aspects of the reporting process that are beyond its control.

For critical *tests*, organizations should define which tests are to be included in this category and stipulate the ordering-to-testing time frame. This interval is often included in the measurement of turn-around-time (TAT) and is important for evaluating the processes of providing timely test results.

For reporting outside of the organization of both critical *tests* and *values/results*, organizations may be limited in their ability to measure reporting to the ordering practitioner, such as when reporting results to physician office staff. Organizations should therefore measure timeliness to initial reporting in this event.

Critical test results include not only laboratory tests, but also imaging studies, electrocardiograms, and other diagnostic studies. Until recent years, most studies have focused on laboratory values that exceed a pre-designated upper or lower threshold, or reflect rapid changes within these thresholds signifying important clinical situations that if not immediately addressed, may lead to an adverse outcome. The timeliness and effectiveness for communicating results is however important for all types of diagnostic testing.

Suggested Actions:

The following strategies should be considered by WHO Member States.

1. Ensure that health care organizations implement a standardized approach to communication of critical test results *(1,8,10,11)*. Suggested elements of this approach include:
   a. Identify who should deliver and who should receive the critical test results *(1)*.
      - The primary responsibility for receiving and following up on critical test results lies with the ordering practitioner,
      - Critical test results transmitted from the diagnostic service should be reported directly to a practitioner who can take action. The results may be conveyed through an authorized surrogate of the ordering practitioner if this will not result in a significant delay in the prompt treatment of the patient.

   b. Identify who should receive the critical test results when the ordering practitioner is not available *(1)*.
      - Develop a procedure to link each patient with either a practitioner or a surrogate practitioner at the time of admission.
      - Create a call schedule/system that specifies to whom the results should be sent when the ordering practitioner is not available.
      - Empower the hospital or practice call (communication) center to serve as the centralized repository of all call schedule and notification operations.

   c. Define what critical tests and critical values/results require timely and reliable communication *(1,12)*.
      - Maintain a prioritized list of critical values/interpretations and critical tests that require accelerated notification systems.
      - Define a set of "high alert" values/results that always take reporting precedence.
      - Limit the number of tests categorized as highest priority.

   d. Specify when critical test results are to be actively reported to the ordering practitioner and establish explicit time frames for this process *(1)*.
      - Define appropriate notification time parameters for communicating critical test results according to urgency, e.g. within 1 hour, within the shift (target 6-8 hours), within 3 days.
      - Maximize efficiencies of workflow and synchronize calls with other existing systems, e.g. changes of shift.
      - Avoid redundant or duplicative calls late at night, unless absolutely necessary.
      - Describe explicit steps in the notification system; describe when reporters should initiate, and follow up on, notice to the ordering practitioner about critical test results.
      - Develop a fail-safe backup plan for communicating critical test results when the ordering or surrogate practitioner cannot be contacted within the designated time frame.

Continued on page 15

Communicating Critical Test . . .

Continued from page 14

e. Determine how to notify the ordering practitioner(s) *(1)*.
   - Identify and utilize the communication techniques that are most appropriate for the particular clinical situation, e.g. active "push" system for results requiring a prompt clinical response.
   - Ensure acknowledgement of receipt of test results by a practitioner who can take action for all critical test values/interpretations.

f. Establish a shared policy for uniform communication of all types of test results (laboratory, cardiology, radiology, and other diagnostic tests) to all recipients *(1)*.
   - Make the notification system explicitly clear to all stakeholders.
   - Encourage and foster shared accountability and teamwork across and between clinical disciplines.
   - Decide what information should be included as a minimum data set to be communicated to the ordering practitioner.
   - Develop a process for being able to recognize that the critical test result has been acknowledged and taken care of at the patient level.

2. Design reliability into the system *(1,10)*.
   a. Utilize forcing functions at the point of test ordering to identify the ordering practitioner and his or her complete contact information, including pager or beeper number *(1)*.
   b. Utilize forcing functions at the point of test ordering to assure that the order includes a minimum data set of clinical information to support the interpretation of diagnostic tests *(1)*.
   c. Create tracking systems to assure timely and reliable communication of test results *(1)*.
   d. Create a monitoring system that recognizes and acknowledges that the patient has been managed in a timely fashion in response to the critical test results *(1)*.
3. Support and maintain systems *(1)*.
   a. Provide orientation and ongoing education on procedures for communicating critical test results to all health care practitioners *(1)*.
   b. Provide ongoing monitoring of the effectiveness of relevant systems (e.g. weekly failure rates, tests of call systems, and response times) and initiate process improvements when appropriate *(1)*.

Looking Forward:

- Point of care testing can shorten reporting turnaround time but is currently more costly, and may be subject to significant result variability. Reliability and accuracy will improve as the technology improves *(9)*.
- Automated electronic notification of critical test results with the capability for requiring the ordering practitioner to document receipt of the information could in the future ensure accurate and immediate delivery of the critical test results *(4,5,12)*.
- Adoption and use of advanced communication technologies such as intranet, secure internet, and other digital messaging methods can improve the speed of test results notification *(1)*.

Applicability:

- Ambulatory care, behavioral health care, acute care hospitals, laboratories, physician offices.

Opportunities for Patient and Family Involvement:

- Partner with patients in communications about test results. Increased access of patients to results facilitates patient-centered care by treating patients and their caregivers as partners in the patient's medical care *(1,13)*.
- Engagement of patients as partners in their care can help to ensure timely caregiver follow-up on test results.
- Patients should be encouraged to maintain documentation of and be proactive in obtaining their test results.

Potential Barriers:

- Resistance of caregivers to change behaviors.
- Time pressures of patient care needs and other responsibilities.
- Outpatient critical tests present unique challenges because of different approaches in varying practices for caregiver coverage.
- Training costs and time expended in implementing new notification processes.
- Cultural and language differences among patient population and workforce.
- Lack of financial resources and staffing shortages.
- Lack of knowledge about how to establish and improve systems.
- Failure of organization leaders to require implementation of new systems and behaviors.
- Lack of information technology interoperability and infrastructure to support reporting.

Risks for Unintended Consequences:

- Frequent critical alerts may diminish the impact of alerts. Periodically evaluating the list of critical test values/interpretations and working to create the right balance of notification requirements and criticality of test results will help mitigate this risk *(14,15, 16)*.

Solution at a Glance
Communicating Critical Test Results

Organization	Standardize the approach to communication of critical test results to the ordering practitioner or the designated surrogate.	» Define which critical tests and critical results require timely and reliable communication. » Specify when test results should be actively reported to the ordering practitioner and establish explicit time frames for this process. » Specify a uniform method for notification of the ordering practitioner.
Practitioner	Ensure timely and reliable communication of critical test results	» Ensure that a ordering practitioner has been identified for receipt of the test results » Ensure that an alternate is identified if the ordering practitioner is not available » Ensure that the method for test result communication is defined » Acknowledge receipt of the test results » Ensure timely adjustment of patient care based on results communicated
Patient Practitioner	Engage patients and family members in decisions about their care at the level of involvement they choose	» Provide patients with information about the test is being ordered and the meaning of the results in a way that is understandable to the patient
Organization	Evaluation/ Monitoring	» For critical values/results, measurement and assessment activities should focus on the interval from the time the result is first known to be critical to the time it is reported to the ordering practitioner (result known-to-reporting interval). » For critical tests, organizations should define which tests are to be included in this category and stipulate the ordering-to-testing time frame.

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Other Selected Resources:

- The Joint Commission. National Patient Safety Goals. http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/
- Massachusetts Coalition for the Prevention of Medical Errors. Toolkit: Communicating Critical Test Results. http://www.macoalition.org/Initiatives/CCTRToolkit.shtml

Put a Little GRRRR in Your SBAR for GRRREAT Communication

by Beth Boynton, RN, MS

GRRRR for Great Communication is a training model I developed to improve the listening side of structured communication. As a nurse, teacher and organizational development consultant, I want to help replace the "grrrr" of frustration with a communication system that provides safer and more effective and creative healthcare solutions.

Research shows that effective communication skills and collaborative work cultures are essential for the delivery of safe and high-quality health care. We also know, intuitively, that we can expect increased job and customer satisfaction, as well as creative problem-solving, when effective communication and collaboration are integrated into our work environment.

Clinicians and administrators need to understand that effective communication affects every level of health care. A breakdown in communication can result in tragic consequences for patients, practitioners and facilities. According to *The Joint Commission (TJC) Guide to Improving Staff Communication, JCAHO (2005)*[i]*:*

- Between 44,000 and 98,000 people die each year as a result of health care-related errors.
- Communication failure was the leading root cause in 66 percent of the sentinel events reported to the Joint Commission from 1995-2004 and was the leading root cause for medication errors, delays in treatment, and wrong-site surgeries.

The search for models that enhance communication in healthcare settings is leading to the development of new, integrated communication guidelines that comply with TJC's requirement for structured communication techniques. As the new guidelines are developed and implemented, there is a wonderful opportunity for organizations to shed light on both sides of the communication process.

SBAR: Is it enough?

SBAR (Situation, Background, Assessment and Recommendation) is a popular model being introduced into healthcare organizations. SBAR has its origins in the military and attempts to standardize and clarify communication efforts where critical information is being transmitted. One drawback with the SBAR model, in my opinion, is that there is little attention on how information is received.

Communication in its simplest state includes three components: sender, message and receiver. Organizations that wish to minimize barriers to communication can be even more effective if they find ways to allocate responsibility to recipients. Also, if other barriers to communication are present, such as verbal abuse, stress, and intimidating power differences, then creating a safe environment is crucial. Finally, it's necessary to have a process that addresses how critical reports are received.

Consider the ramifications when individuals in any team are taught and expected to speak up, without putting the same effort into listening. How far can strategies geared to speaking up go if we are not paying attention to how communication is received? We commonly think of assertiveness as a process of expression, yet we may have much to gain if we consider it a mindset. An assertive mindset creates room for respecting and developing skills for speaking up and listening. Both skills are essential for a safe environment and collaborative work culture.

In their article, *SBAR: A Shared Mental Model for Improving Communication Between Clinicians,* authors Kathleen Haig, RN, Staci Sutton, RN and John Whittington, MD[ii] describe the process used at St. Joseph's Medical Center (Bloomingdale, Ill.) for implementing SBAR. They cite the need to address communication barriers, and discuss such issues as lack of structured technique, confusion about roles and responsibility, hierarchy, sex, ethnic background and difference in communication styles between physicians and nurses. Education for SBAR was incorporated into team resource management training and general orientation, and the model was initially introduced in a few selected units, and gradually to others. The leadership team developed tools, including pocket cards, posters and laminated reminders on phones. They created a social system for spreading the concept, beginning with targeted key players from nursing, pharmacy, and so on.

What was the outcome? The number of untoward events went from 89.9 per 1000 patient days in October 2004 to 39.9 per 1000 patient days in FY 2005. An exciting improvement, for sure, and yet there is room for more.

Before introducing the GRRRR model, here is a brief case study to illustrate SBAR. (Keep in mind that clinical hand-offs are not necessarily nurse to physician.)

Mrs. Smith is a 74-year-old patient of Dr. Jones hospitalized for an exacerbation of COPD. Nurse Slate has noticed that Mrs. Smith's condition has become acutely worse.

SBAR

Situation: Include identifying information of nurse, unit and patient and a brief description of what and how serious the problem is. *"Dr. Jones, this is Nurse Slate from ABC hospital, med-surg unit, respiratory wing. I'm calling about Mrs. Smith, a 74-year-old patient admitted yesterday for exacerbation of COPD. Her condition has worsened. She is in severe respiratory distress.*

Background: Include brief history leading up to situation. *"Her condition was stable this morning during the first part of my shift. In the last four hours her RR has gone from 20-32, O2 sat from 92 percent to 84 percent, HR from 92 to 108. I heard breath sounds bilaterally but now nothing on the left."*

Assessment: Clinician's conclusion about what the problem is. *"I think she has a pneumothorax."*

Recommendation: Clinician's ideas about what should happen next. *"I need you to evaluate her right away, I believe she needs a chest tube."*

As you can see, the format for SBAR organizes the reporting of information. Nurses who are working in organizations that are using or gearing up to use SBAR can advocate for a focus on how information is received. If you are in a formal leadership position, you likely know that it can be very powerful to invite input from staff on what they need for successful application of a standard communication technique. Simply asking the question may result in increased buy-in, decreased resistance to the new approach, and an overall healthy communication culture. In fact, leaders who ask, and listen to, the answers can role-model a two-way approach. If you are a staff nurse, consider or create opportunities to make suggestions, especially if you work in an environment where assertiveness is promoted.

Facilitated focused groups, team champions, customized training, or individual coaching can all enhance outcomes. If you are a staff nurse and a process such as SBAR is being implemented in your organization, consider asking to include a component which focuses on listening. The model I propose, GRRRR for Great Communication, can serve as a sample.

GRRRR for Great Communication

Greeting: Recipients can set the tone for a professional dialogue with a kind "Hello" and use of the caller's name. *"Hi, Beth, this is Nursing Supervisor Jones or Dr. Smith, how can I help?"* This is a simple, quick and respectful way to begin a stressful conversation.

Respectful listening: Allowing clinicians to finish sentences without interruptions, occasional acknowledgments such as, "Okay" or "hmmmm." A brief pause between pieces of information can decrease anxiety and allow the reporting professional an opportunity to think and transmit critical information. If in person, eye contact and nodding with receptive body language can promote a calm rapport even in the middle of an emergency. When a supervisor or physician is receiving a hand-off from a clinician with lesser power, it may be helpful to realize that there may be some anxiety about bringing a concern up the ladder. Yet, this is exactly what clinicians are supposed to do.

Review: A quick summary of the information can clarify the reporter's concerns and allow for additional thoughts without being intimidating or humiliating. In addition to getting the message straight, there is enormous value in validating. A few seconds here can lead to clinicians feeling heard, respected and ultimately understood. This can be a challenging process, as it requires listeners to separate their perspective and response from receiving the clinician's report. The ability to do this effectively can be influenced by an array of variables such as time, stress, tradition, skill, training, mood and even the weather! Doesn't it seem prudent to establish an organizational norm rather than try to work around all of these variables?

Recommend or request more info: At this stage in the communication the responder has enough information to either initiate an order or gather more information. This may involve agreeing or disagreeing with the clinician's recommendation, but a team approach to the communication process is still important. Listeners should avoid put-downs. *"A chest tube is a reasonable suggestion and the objective information you've provided is great. This patient has some CHF too and that could be part of the problem. Let's do a CXR and ABGs stat. Take a minute and get those tests ordered then let's review her med list."*
Organizational leaders have opportunities here to teach and build relationships when presenting this aspect of the GRRRR model. As they do this, they can help communication recipients learn to steer away from difficult dynamics and shift towards collaboration.

Reward: "Thank you for your attention to this patient's needs," "I appreciate your call" or "Call me if problems persist" can help the reporter feel like a respected team player. Inviting further discussion, if needed, is an empowering communication strategy. It reduces any reluctance to call in the future and contributes to a collaborative problem-solving environment.

Effective listening is sometimes simple, and sometimes complex—but always essential. Organizational leaders can emphasize the listening aspects of critical communication, and provide training and attention to re-enforce its importance. As a result, a respectful, assertive mindset and collaborative culture can begin to thrive. And from this newly created culture of communication and respect, leaders can expect to see that their team is providing safer, higher quality and more creative health care.

Beth Boynton, RN, MS is an organizational development consultant specializing in communication and conflict issues that impact nurses, www.bethboynton.com. She is an adjunct faculty member with New England College's graduate program in Healthcare Administration and is currently writing a book which focuses on helping nurses develop confident voices. She can be reached at bbbboynton@verizon.net *or 207-363-5604.*

[i] The Joint Commission (TJC) Guide to Improving Staff Communication, JCAHO, (2005)

[ii] The Joint Commission Journal on Quality and Patient Safety, Kathleen Haig, RN, Staci Sutton, RN and John Whittington, MD March 2006, Volume 32, Number 3, pages 167-175.

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New Trends in Foreign Nurse Recruitment

by Diane E. Scott, RN, MSN

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Last year, the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, released the 2004 National Sample Survey of Registered Nurses, which collected data on the actively licensed Registered Nurse population as of March 2004. This most recent edition of the survey revealed that over 100,791 (3.5 percent) of the Registered Nurses (RNs) practicing in the United States received their basic nursing education outside of the U.S. While this percentage reflected only a slight increase since 2000, foreign-educated nurses are now licensed in all 50 States and the District of Columbia.

According to the American Hospital Association, 17% of hospitals recruit from abroad to fill nursing vacancies. While the percentage of hospitals looking toward employing foreign-educated nurses (FENs) as part of the solution for the nursing shortage is increasing, questions still arise over the best means to recruit and orient this unique nursing population.

To address some of these issues, the Center for American Nurses interviewed Wanano "Winnie" Fritz, RN, MS, the Chief Nursing Officer and Director of International Operations of HCCA International, a company which specializes in international nurse recruitment and hospital management.

Ms. Fritz's experiences, both domestic and international, have given her a wealth of cultural and clinical expertise in nursing and management roles in the United States, Thailand, Germany, Russia, and Vietnam. Notably, she was employed for nearly 17 years by King Hussein of Jordan as both the Dean of a School of Nursing and a Health Systems Planner before joining HCCA in 2005.

The Center: Are there ethical issues involved with recruiting foreign educated nurses?

Ms. Fritz: The answer is yes, there can be ethical concerns for both the nurse and the nursing profession. Professional nursing organizations appropriately caution us to not deplete resources in specific countries where there are already serious shortages. For example, in the U.S., we have 8-10 RNs per 1000 population. In South African nations, there are only 1 to 1000. But as a general position, the International Council for Nursing states: "Nurses have a right to migrate and denounces unethical recruitment." In addition many of the foreign-educated nurses genuinely want to work in the United States.

The Center: What are the reasons that foreign educated nurses want to come work in the United States?

Ms. Fritz: With the increased accessibility to the internet and other media from the United States, foreign-educated nurses are much more exposed to the potential personal and financial benefits and mechanisms to become a nurse in the United States. Many of the foreign-educated nurses obtain a U.S. nursing license to fulfill multiple professional and personal goals. Numerous foreign-educated nurses desire the opportunity to work in clean, safe high-tech hospitals.

The economic advantage for nurses working in the United States usually goes beyond their personal financial gain; it carries through to their extended families back in their home country. It has been my experience that most foreign educated nurses will send up to 33% of their salary back to their home country to support their parents, siblings, and other family members. The governments of the foreign countries welcome the influx of financial assistance and are often very accommodating in assisting the nurses who are seeking to enhance their careers in the United States.

The Center: Where do most of the foreign-educated nurses come from?

Ms. Fritz: According to the U.S. Department of Health and Human Services, 50% come from the Philippines, 20% from Canada and 8% from the United Kingdom. 22% come from all other sources. In addition, over half of the foreign-educated nurses were estimated to have baccalaureate or higher degrees.

The Center: What are the advantages of hiring a foreign-educated nurse?

Ms. Fritz: Many (FENs) are highly motivated to be a nurse in the U.S. and usually have dedicated from 2 to 4 years of their lives to reach this goal. In addition, the nurse usually has already demonstrated persistence and adaptability in navigating the immigration and licensure processes.

As U.S. hospitals care for an increasingly diverse patient population, the foreign-educated nurse is also an asset as we work to be culturally competent and provide culturally appropriate care. Finally, the foreign-educated nurse can be a more permanent solution than temporary staffing options since many want to integrate permanently into a hospital and community, resulting in retention rates as high as 85%.

The Center: How would a prospective employer approach the recruitment of foreign-educated nurses?

Ms. Fritz: When choosing a recruitment partner, choose carefully. In the past, there were only about 30 or 40 companies recruiting nurses from overseas, now there are over 200. The Joint Commission has implemented a certification process which is helping to address some of the quality issues in selecting a reliable recruiting partner, so I highly recommend making sure the recruitment company is certified.

It behooves a healthcare organization to know how long the agency has recruited internationally and learn how many nurses they have brought to work in the U.S. It is just as important to learn the satisfaction rate of their client hospitals as well as their ethics in their practices. I also believe it is important for a recruiting organization to "give back" to the countries of origin.

Some large health care systems recruit directly; but most use third-party recruiters because of the complexity of the credentialing, education, licensure, and immigration processes.

The Center: What are the types of FEN recruiters?

Ms. Fritz: With either model, the commitment period for the nurse typically ranges from 2 to 3 years. When choosing a recruiter, there are two general models:

(1.) Direct Placement: 55-60% of recruiters pay up front for recruitment and immigration fees to fill a specific "order" in terms of quantity and specialty. The hospital employs the nurse immediately and assumes the risk of hiring them without previously working with them.

(2.) Lease to Hire: 40-45% of recruiters pay no upfront costs to the recruiting agency; instead, they pay an hourly rate for nurses' shifts worked for the contract period. The hospital then hires the nurse after having experienced the quality of their work in the hospital for several months.

The Center: What are keys to success in working with these nurses?

Ms. Fritz: One of the most important components of a successful long-term placement of a foreign-educated nurse is the extent to which the recruiting company chooses and prepares the candidates. A simple phone interview and skills check list is not enough to ensure success and recruiters should meet potential candidates face-to-face in their country of origin.

The interviewing and preparation phase of the placement should be done with extreme caution and by using various tools to determine the level of critical thinking and decision making. Each nurse that I place in the United States completes a survey tool to determine how she makes decisions. I want to find out how she will accommodate unconventional and unique patient situations, physician interactions, and peer relations, and having a well designed tool can help predict how they may react when encountering real patient situations in this culture.

While all foreign-educated nurses must also take the NCLEX exam for licensure, simply passing the test does not always determine critical thinking skills. My team uses patient vignettes in our verbal interviews with the nurses to get a much deeper assessment of their ability to critically think through situations. The face-to-face interviews are also very helpful in determining the extent of her English speaking skills as well.

The Center: How can a FEN be best oriented after she arrives to the United States?

Ms. Fritz: The greatest challenge for a foreign-educated nurse is clarity of speech. While all are required to pass an English exam, accent reduction is also sometimes needed. Recruiters and hospitals assist the foreign-educated nurse by coaching her to listen to talk radio and audio books. Preceptors and colleagues can also help by monitoring phone calls or having the foreign-educated nurse take formal accent reduction courses.

As for clinical competencies, it is important to choose a recruitment company that assesses and validates competency of the individual foreign-educated nurse prior to their arrival to the United States, including clinical skills, equipment familiarly, and U.S. cultural practice.

The Center: What about orientation to the community?

Ms. Fritz: The orientation to the community is important and should include, at minimum, securing and settling in a safe, appropriate, and furnished apartment; organizing transportation; teaching shopping, taxes, and banking; and processing payroll and benefits documents. An experienced recruitment company will provide this as well teaching U.S. culture, laws, and manners.

The recruitment and integration of the foreign-educated nurse can truly be a win-win situation for all concerned if the above elements are considered. Foreign-educated nurses benefit from their professional "dreams being fulfilled" and their families receiving funds to improve their lives in the home countries. Our diverse patient populations benefit by the culturally diverse nurse population. And healthcare organizations gain permanent staff members who remain as flexible, confident, and competent nurses.

*The Center for American Nurses is committed to helping nurses develop both professionally and personally. The Center offers solid evidence-based solutions-powerful tools-to navigate workplace challenges, optimize patient outcomes, and maximize career benefits. Whether it's learning how to handle conflict, gaining continuing education credits, knowing your legal rights, or skillfully managing your money, The Center's resources add traction, moving you toward the best life a career in nursing can offer.

Just a Bath

More than simple hygiene, bathing a patient is an act of compassion and comfort

by Jenny Radsma, PhD, RN

Bathing is certainly about cleansing and attending to one's need for hygiene; however, as an intervention, giving a bath epitomizes the integration of nursing as art and science. Many pooh-pooh giving a bath as a nursing role, dismissing it as a task suitably delegated to a nurse's aide. After all, I hear nursing colleagues say, anyone can do a bath. Really? I've never been convinced of that way of thinking. True, basic hygiene care can be taught to and completed by most anyone, but to give a bath is so much more than merely washing a patient. Bathing is a daily ritual that both cleanses and comforts, and to give someone a bath is to literally and figuratively touch another being. In this very personal embodied experience, a relational narrative (Bergum, 2004) or right relationship (Sarrano, 1966) commences when the nurse is fully present to the patient in a conscious and purposeful way.

Giving a bath is one of the first skills taught to nursing students, so perhaps it's not surprising that my thoughts should turn to the impressions I still hold of the first patient bath I gave when I was a nursing student. For reasons I hadn't previously explored with any depth, this experience has been scored in my memory, and I retell it from time to time as an encounter that was more than just memorable: It shaped how I approached patient care situations, especially the difficult ones, throughout my nursing career.

Idealist that I was, and long before I knew anything about nursing theory, Jean Watson (1979), or her work around the essence of care as foundational to nursing, I had a strong sense that being attentive or connected was a significant component of nursing care. So, as a student, I became mindful that my presence with patients influenced in some way the interaction I had with them, but I attributed this to what I assumed were good communication skills. Without formal instruction, I could apply what I understood about comfort and comforting to patient care, but I knew nothing of the concept of embodiment, much less what embodiment meant in terms of what is clinically referred to as a therapeutic relationship. These many years later, I now prefer to think of embodiment as part of the mindful healing presence the nurse brings to each patient care encounter. As a student, it soon became clear to me that being present while providing conscientious, skilled care was easier with some patients than with others. While verbal interactions are useful for the nurse to engage with patients, my nursing education taught me that a reciprocal relationship does not hinge on it. Nonetheless, to revere the embodiment of a patient who responds only to painful stimuli poses its own challenge, particularly for the novice nurse.

The first patient to whom I was assigned as a diploma nursing student was an elderly, comatose woman whose arthritic limbs were severely contracted. I presented myself to her bedside that particular morning, began to talk to her, and made my initial observations. I introduced myself while making note of the dark, amber urine filling the urinary catheter bag suspended from the bed rail. A musty, acrid smell was prevalent, testament to the bodily functions that continued while she slept. Drab hospital sheets covered the woman, who was lying on her side, a pillow propped behind her back, one arm resting on a cushion above the pallid covers. Thin blue rivulet veins were apparent through the skin on her hand. Her soft skin was pale and cool, and her inability to move from side to side alerted me that meticulous hygiene and careful turning were essential to prevent her fragile integument from breaking down. The woman's eyes were sunken and closed, dark circles marking each orbit. Her gaunt cheeks puffed slightly with each breath she took. She was a mouth breather and a soft sonorous grunt accompanied each inhalation, aggravated, no doubt, by the naso-gastric tube inserted to deliver nourishment. White skin flakes were beginning to form on her drying lips, the mucous membranes in her mouth were parched and dull, no longer moist and shiny.

On that first clinical day I began my care for this woman by bathing her, following all of the instructions I had been taught for giving a complete bed bath, inclusive of a change of linen, and all the while subconsciously aware that though my care was thorough, I was removed, detached. I was bathing a woman's body that still had breath and bodily functions, but the vitality and life force seemed to be all but extinguished. While I knew the woman couldn't engage with me, I also knew I should be feeling something, whether compassion, aversion, or sympathy, but not this nothingness. I didn't know how to cross what felt on a gut-level like a void, a disconnection from me to her.

Out of politeness, because that's what I'd been taught in my skills labs, I spoke to the woman, calling her by name, but feeling like I was telling a woman's body that I'd be bathing it. She gave no response, not so much as a flicker across her hollowed eyes. From the linen cart in the hallway now humming with the routines of a.m. care, I gathered towels, a couple of facecloths, a flannelette bath sheet, and a gown along with a fresh change of bed linen, their stiff bleached smell adding to the mixture of breakfast trays and clinical odors on that medical ward. In the patient's room, I filled the stainless steel wash basin with warm water, added a capful or two of Alpha Keri—not too much—and watched as the water took on a milky color. I tested the temperature of the water with the inside of my wrist, and placed the basin on the bedside table. I pulled the curtain around the woman's bed and adjusted it to ensure her privacy. I lowered the side rail and pulled back the soiled white sheets while simultaneously covering the woman with the bath sheet.

Technically, the bed bath I gave that morning was just as I'd been taught, textbook perfect, and I was as efficient and as competent as could be. I dipped the face cloth in the warm water, wrung it out, and formed a bath mitt over my hand. I drew the face cloth gently across the woman's brow, her eyes, removing the secretions from the inner canthus of both eyes, and then drawing it over her cheeks, her lips, her chin, her thin neck. I cleansed her trunk, her arms, her legs, and massaged her stiffened limbs with lotion. A momentary grimace crossed her face as I positioned her onto her side to wash her back and to give her what I hoped would be a soothing back rub. I eased her onto to her back and administered peri-care, separating the labia as I'd been taught, washing in single strokes downward to prevent unnecessary contamination of the urethra or the catheter that wended its way into her bladder.

When the bath was completed, I sought out a classmate to assist me with making an occupied bed. We were conscientious in making sure the woman was covered and warm as we replaced the soiled linen with fresh, clean sheets, loosening what were now dirty sheets and remaking with the new ones, first on one side of the bed and then the other. We were careful about how we rolled the woman over the ridge of linen, tugging rather than abruptly pulling the sheets beneath her so as not to cause any undo discomfort or shearing of her skin. In muted voices, we shared brief tidbits from our first bath experience, interspersing our comments more loudly with, "We're just going to turn you to your other side now," and "How's that feel? We're all done."

Before leaving to document the woman's bath, I made a mental survey of the room: The bed was made, the side rails were up, the catheter bag had been drained, the used sheets and towels had been removed to the laundry hamper, and the lavender scent of the powder dusted under her arms lingered in the air. With her hair combed, my patient, as I had begun to think of her, was washed and resting in a clean bed. She looked comfortable, her lips glistening with the petroleum jelly I had just applied. Blue sky was visible through the window, and I noted that were she to open her eyes, she'd see the fresh bouquet of garden flowers someone had recently left her, their fall colors a vibrant and warm contrast to the sterile white of the sheets and the beige walls.

Doing things "right" is obviously important in the provision of safe and competent nursing care. And while I could document that all of the right things had been done for this patient that morning, an important ingredient was missing. I had bathed the patient and had endeavored to promote her comfort, but with the wisdom gleaned over some 25 years or more, I realize I wasn't comforting — to her or myself. How could I be? I was disengaged from my patient, and disembodied from the care I was giving. My compassion for and being with the patient was lacking, and not because I was uncaring or unfeeling. No, I was young, inexperienced, and had not yet learned what it was to dwell with someone. According to the Oxford English Dictionary (OED, 2006), to *dwell* is a verb, meaning to abide or continue for a time in a place, state, or condition, and one of the meanings *of abide*, also a verb, is to remain, without going away. In a metaphorical sense, I had never arrived so could not abide with this woman. However, I knew that whatever was lacking on a spiritual or an emotional level was important, that the nurse-patient relationship I did have with this woman was tenuous and incomplete, and that even in her comatose state I should be feeling something more than professional obligation. I needed to feel an emotional connection with this woman, my patient.

Later that day, someone came to visit the woman. The visitor held and caressed the woman's waxen hand between her own, turning her gaze fully toward her friend's face. My cheerfulness sounded forced even to myself as I recited all of the encouraging things I could think to relay about the few hours I'd spent with the woman. When I finished speaking, the visitor looked first at me and then back at her friend. She continued to stroke the woman's hand and said, "She was such a friend; I really miss her. She was an elementary schoolteacher, but she was also a talented painter. When she wasn't teaching she painted, and she was particularly adept at landscapes, especially of prairie scenes. She continued to paint for as long as she could, but finally had to put down her paint brushes when her arthritis wouldn't let her continue." Over the next minute or two, the friend shared a few anecdotes about the woman, and I began to see this patient for who she was before I'd met her.

Only a brief interchange, but the something I needed took hold within me with an almost audible "click." I was no longer a technically proficient automaton. The woman, my patient, was no longer just a body, but an embodied person. Since she was no longer able to do for herself as Virginia Henderson (1966) described, my role was to enhance this woman's being, to be with her, to honor her personhood through the nursing care I provided her. She had lived a full life, been vital in the lives of people I would never meet; she had influenced children to become

Continued on page 22

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WORKSHOPS

*****FULL** An Integrated Approach to Trauma and Addiction Treatment***–Patricia Burke, MSW
January 25, 2008 8:30am–4:00pm
Keeley Banquet Center, Portland
$55 CCSME members/$67 non-members

Spirituality in Clinical Practice–Paul Simons
February 29, 2008 8:30am–4:00pm
Augusta Civic Center, Augusta
$55 CCSME members/$66.00 non-members

Recovery for Young Adults with Co-Occurring Disorders: Addressing Trauma and Identity Issues
MaryJean McKelvy, MA, LCPC
March 21, 2008 9:00am–4:30pm
Keeley Banquet Center, Portland
$65 CCSME members/$78 non-members

The Elephant in the Room: Grief, Loss and Co-Occurring Conditions–Deirdre Curran Felton, MA, CT
April 17, 2008 9:00am–4:00pm
Keeley Banquet Center, Portland
$55 CCSME members/$66 non-members

The Elephant in the Room: Grief, Loss and Co-Occurring Conditions–Deirdre Curran Felton, MA, CT
April 18, 2008 9:00am–4:00pm
Augusta Civic Center, Augusta
$55 CCSME members/$66 non-members

Dr. David Mee-Lee Workshop–TENTATIVE
Coming in June 2008 Time TBD
Location TBD
Price TBD

Criminal Justice Workshop–Fred Osher
May 5, 2008 8:00am–11:30am
Augusta Civic Center, Augusta
Price TBD

Psychopharmacology Workshop–Fred Osher
May 5, 2008 1:00–4:30pm
Augusta Civic Center, Augusta
Price TBD

*****FULL** An Integrated Approach to Trauma and Addiction Treatment***–Patricia Burke, MSW
May 30, 2008 8:30am–4:00pm
Maine Principals' Association, Augusta
$55 CCSME members/$67 non-members

VIDEO CONFERENCE SERIES
THE CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS CURRICULUM
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January 8, 2008 Session 12: **Psychopharmacology** 11:30am–1:00pm
Dr. Cindy Boyack

February 5, 2008 Session 13: **Ethical and Risk Management** 11:30am–1:00pm
Peter Wohl, MA, LADC, CCS

There is no charge for the IVC series, however pre-registration is required to receive handouts and directions. Please contact CCSME for a brochure or more information.

TELECONFERENCE SERIES
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COSII Teleconference Series

January 10, 2007 **Gender Diversity: The Gay and Lesbian Community** 12:00–1:00pm
Sarah Parker-Holmes, Coordinator, Center for Sexuality and Gender Diversity, USM

February 7, 2007 **Native American Experience in Maine** 12:00–1:00pm Roger Paul

February 21, 2007 **On Being African American** 12:00–1:00pm
Jessica Loney, RN

This teleconference series is $45.00 for the first person and $20.00 for each additional person on the same phone line. Pre-registration is required to receive handouts and teleconference pass codes. Please contact CCSME for a brochure or more information.

ISSUES IN ADOLESCENT CO-OCCURRING CONDITIONS
Teleconference Series

January 29, 2008 **Developmental Issues related to Co-Occurring Disorders** 12:00–1:30pm
Christie A. Cline, MD, MBA

February 13, 2008 **Encompass: Integrated Treatments for Adolescents & Young Adults** 12:00–1:30pm
Paula DeGraffenreid Riggs, MD

March 29, 2008 **Youth with Co-Occurring Disorders and the Correctional System** 12:00–1:30pm
Michele Hylen, LCSW

This teleconference series $30.00 for the entire three-part series. Pre-registration is required to receive handouts and teleconference pass codes. Please contact CCSME for a brochure or more information.

ON-GOING STUDY/CLINICAL CONSULTATION GROUPS For COSII Agencies

Region I: Facilitated by Andrew Loman, LCSW, LADC, CCS
4th Thursday of each month 12:00–1:00 pm, Maine Medical Center, 131 Chadwick Street, Portland

All programs sponsored by CCSME with funding from the Office of Substance Abuse, DHHS, except where noted.

ANA News

Chemical Exposures On The Job May Be Linked To Diseases In Nurses

First ever national survey finds widespread exposure to chemicals and radiation and almost no mandatory workplace health protections.

SILVER SPRING, MD–A first ever national survey of nurses' exposures to chemicals, pharmaceuticals and radiation on the job suggests there are links between serious health problems such as cancer, asthma, miscarriages and children's birth defects and the duration and intensity of these exposures. The survey included 1,500 nurses from all 50 states.

The results were released online today at, http://www.ewg.org/reports/nursesurvey, by the Environmental Working Group, the American Nurses Association, Health Care Without Harm, the Environmental Health Education Center at the University of Maryland School of Nursing. The survey was extremely detailed and is the first of its kind, but it was not a controlled, statistically designed study.

Every day, nurses confront low-level but repeated exposures to mixtures of hazardous materials that include residues from medications, anesthetic gases, sterilizing and disinfecting chemicals, radiation, latex, cleaning chemicals, hand and skin disinfection products, and even mercury escaping from broken medical equipment. There are no workplace safety standards to protect nurses from the combined effects of these exposures on their health.

"Nurses are exposed daily to scores of different toxic chemicals and other hazardous materials whose cumulative health risks have never been studied," said Jane Houlihan, Vice President for Research at Environmental Working Group. "Nurses ingest, touch or breathe residues of any number of these potentially harmful substances as they care for patients, day after day and face potential but unstudied health problems as a result."

"This survey is a call to action for nurses to demand the use of safer products and protective measures to control exposures to hazardous agents in the workplace," said Anna Gilmore Hall, RN, executive director of Health Care Without Harm, an international coalition working to reduce the environmental impact of the health care sector.

The Centers for Disease Control proposed a National Occupational Exposure Survey for the health care industry in 2002. To date, no such survey has been initiated to better understand the range of potentially hazardous chemical exposure in the health care industry and related illnesses.

"For many of the toxic chemicals in hospitals there are safer alternative or safer processes. We must make these healthier choices for the sake of our patients, nurses and all hospital employees," said Barbara Sattler, RN, DrPH, FAAN, Professor and Director of the Environmental Health Education Center at the University of Maryland School of Nursing.

"ANA is dedicated to ensuring the health and safety of nurses and their patients," said Rebecca M. Patton, MSN, RN, CNOR, President, American Nurses Association. "We are pleased to work with our partners to bring attention to the growing concern over chemical exposures in the workplace, and ANA will continue its efforts on behalf of the nursing profession to create healthier working environments."

Environmental Working Group is a nonprofit research organization based in Washington, DC that uses the power of information to protect human health and the environment.

Health Care Without Harm is an international coalition of over 460 organizations in more than 50 countries, working to transform the health care sector so it is no longer a source of harm to people and the environment.

The Environmental Health Education Center at the University of Maryland School of Nursing engages in education, practice, research, and policy regarding the relationship between the environment and human health. The School of Nursing, founded in 1889, is one of the oldest and largest nursing schools, and is ranked seventh nationally. Enrolling more than 1,600 students in its baccalaureate, master's, and doctoral programs, the School develops leaders who shape the profession of nursing and impact the health care environment.

American Nurses Association is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses through its 54 constituent member nurses associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

ANA News

ANA Launches New Safe Staffing Website

Education, Resources for Nurses

SILVER SPRING, MD–The American Nurses Association (ANA) has launched a new web site dedicated to the issue of safe staffing. The new site educates nurses about ANA's history of advocacy on the issue, provides updates on the newest information and developments, and gives nurses tools to get involved.

The site allows nurses to share their own stories and concerns and invites them to help strengthen the case for safe staffing legislation by completing a survey. Through the site, nurses can also stay informed about the latest developments on Capitol Hill and contact their members of Congress to urge their support.

"ANA has been a persistent driving force in the efforts to make safe staffing legislation a reality," said Linda J. Stierle, MSN, RN, CNAA,BC, CEO of the American Nurses Association. "This site gives nurses a stronger voice, and empowers them to take an active role in impacting their workplace environment."

"Safe staffing saves lives," added Rebecca M. Patton, MSN, RN, CNOR, President, American Nurses Association. "There is a growing body of evidence that demonstrates adequate nurse staffing improves the health outcomes of patients, resulting in fewer inpatient days, complications and deaths. Implementing safe staffing levels should be seen as a critical investment in quality, cost effective care, and ANA's goal with this web site is to establish staffing levels that promote a safe and healthy working environment for nurses, and ensure the highest possible patient care."

Visit www.safestaffingsaveslives.org to get involved in ANA's safe staffing campaign.

The ANA is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses through its 54 constituent member nurses associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

In Memory

It is with deepest sadness that we inform you of the passing of our revered colleague, Dr. Imogene M. King, EdD, MSN, RN, FAAN. Dr. Imogene King died December 24 at the age of 84. Dr. King is universally recognized as a pioneer of nursing theory development and theory-based nursing practice. She served in elected and appointed positions as a voice for the profession at international, national and state levels and has made invaluable contributions to the nursing profession.

For her outstanding legacy of service, Dr. King was inducted in the American Nurses Association's Hall of Fame and the Florida Nurses Association Hall of Fame, and was a recipient of the 1996 ANA Jessie M. Scott Award.

In lieu of flowers, donations may be made to the Florida Nurses Foundation for the FNF Imogene M. King Research Grant, or to the American Nurses Foundation. A memorial Mass will be held at 10am, January 4 at St. John Vianney Catholic Church, St. Pete Beach, FL. www.beachmemorial.com

Our deepest sympathies are with Dr. King's family, and our hope is that they derive some comfort from the great affection and respect felt for their beloved family member by the nursing community.

Seasonal Influenza Immunization Programs Recognition Campaign

01/11/08

ANA is pleased to announce that we are now accepting applications for the **2007-2008**.

Best Practices in Seasonal Influenza Vaccination Campaign. In order to support increased vaccination rates among health care professionals, the goal of this second season of this campaign is to build on the lessons learned in the past successful recognition campaign in 2006-2007.

The 2007-2008 "Best Practices in Seasonal Influenza Vaccination Campaign" initiative is a recognition campaign that is designed to identify the organizations that have the most successful programs and outcomes for increasing the seasonal influenza vaccination rates of their employees. Success stories will be compiled into an article describing the most successful strategies utilized by these organizations in their seasonal influenza vaccination programs to achieve a significant increase in the seasonal influenza vaccination rates among registered nurses and other HCP. Recognized facilities will be presented with an award by ANA commending the excellent leadership demonstrated in increasing influenza vaccination rates of registered nurses and other HCP.

The application deadline is **April 18, 2008**.

Lawmakers To Vote On Increased Funding For Nursing Workforce Development Programs

Silver Spring, MD, The American Nurses Association is pleased to announce that nurses have made their voices heard on Capitol Hill. A budget battle between Congress and the White House threatened vital funding for nursing workforce development programs. ANA urged nurses to call and write lawmakers to urge them to invest in nursing. A year end spending package set to be voted on this week includes a $6.4 million increase in FY 2008 funding for the Title VIII nursing workforce development programs.

ANA has been a driving force in efforts to increase funding for the Nursing Workforce Development programs administered by the Health Resources and Services Administration (HRSA) under Title VIII of the Public Service Act. HRSA administers the nation's nursing education programs that are designed to recruit new nurses into the profession, promote career advancement within nursing, and recruit nurses into critical shortage areas.

For more information on this vote, and on how you can join ANA's fight for nursing issues on Capitol Hill, please visit http://rnaction.org/politicalpower/home.tcl

Good News! RN Safe Staffing Act Reintroduced In House

On Friday, November 9, Reps. Capps (D-CA) and Brown-Waite (R-FL) introduced ANA's safe staffing bill, The RN Safe Staffing Act (HR 4138/ S 73). HR 4138 would hold hospitals accountable for the development and implementation of unit-by-unit RN staffing plans, in direct coordination with direct care nurses and based on each unit's unique needs. The bill was introduced with 16 co-sponsors (listed below) including a second Republican, Rep. LaTourette of OH. You can read ANA's news release on the bills introduction here:

http://nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/2007/SafeStaffingLegislationIntroduced.aspx

Safe Patient Handling

New Jersey is celebrating two legislative wins with both houses having passed two pieces of legislation in the past week affording healthcare workers added protections: **"Safe Patient Handling Act"** and **"Workplace Violence Prevention in Health Care Facilities Act"**. The New Jersey State Nurses Association is optimistic the Governor will sign these bills into law.

The **safe patient handling** legislation will require licensed health care facilities, state developmental centers, and state and county psychiatric hospitals to establish a safe patient handling program to reduce the risk of injury to both patients and health care workers at the facility within 18 months of the bill's enactment. Each facility would be required to maintain a detailed written description of the program and its components and provide a copy to the Department of Health and Senior Services or Department of Human Services, as applicable, and make the description available to health care workers at the facility and to any collective bargaining agent representing health care workers at the facility. A facility would also be required to post its safe patient handling policy in a location easily visible to staff, patients, and visitors; and to designate a representative of management at the facility who will be responsible for overseeing all aspects of the program. Within 12 months following enactment, each facility must establish a safe patient handling committee, responsible for all aspects of the development, implementation, annual evaluation and revision of the facility's safe patient handling program, including the evaluation and selection of patient handling equipment and aids and other appropriate engineering controls. At least one-half of the members of the committee shall be health care workers who provide direct patient care to patients at the facility or are otherwise involved in patient handling at the facility. The remaining members of the committee shall have experience, expertise, or responsibility relevant to the operation of a safe patient handling program. The bill provides that a health care facility shall not retaliate against any health care worker because that worker refuses to perform a patient handling task due to a reasonable concern about worker or patient safety, or the lack of appropriate and available patient handling equipment or aids.

Workplace violence prevention legislation calls for select health care entities to establish violence prevention programs to protect workers. Essential provisions of the program include: creation of a violence prevention committee including a member of management, responsible for all levels of the program and with at least one half of the committee's membership to be that of direct care workers with the remaining members having relevant experience, expertise or responsibility at the facility; performance of an annual comprehensive assessment that includes facility layout, crime rate of the surrounding area, **adequacy of staffing levels**, presence of individuals who may pose a risk and a review of violent incidents at the facility at the very least; and development of a written violence prevention plan that identifies workplace risks and provides specific methods to reduce identified risks.

This is indeed good news for NJ nurses. Congratulations NJSNA.

ANA-MAINE MEMBERSHIP

MEMBERSHIP BENEFITS

The American Nurses Association-Maine (ANA-Maine) is part of the federation of Constituent Member Associations (CMAs) of the American Nurses Association. Therefore, your membership in ANA-Maine becomes part of an influential and effective national network of registered nurses who impact the nursing profession.

When you JOIN ANA-MAINE, you join with nurses around the country in speaking with one strong voice on behalf of your profession and health care. Together we can make a difference! As a full member—you are a full voting member in ANA-Maine and the American Nurses Association and entitled to valuable products and benefits that help you:

Be heard: Advocating for nurses where it matters

- Federal lobbying on issues important to nursing and health care—issues such as safe staffing, nursing workforce development, overtime pay and access to care.
- State-wide phone or e-mail campaigns on issues vital to your scope of practice and support of your efforts as a Legislative Buddy with your Maine State Legislator.
- Representing nursing where it matters on a national level, including the Environmental Protection Agency, Department of Labor, the U.S. Department of Health and Human Services and many others, right up to the White House.
- Speaking for nursing through the media including stories in the Wall Street Journal, Chicago Tribune, USA Today, 60 Minutes, NBC Nightly News, CNN, and NPR to name a few.
- Speaking for U.S. nurses as the only U.S.A member of the International Council of Nurses and attending meetings of the World Health Organization.

Guide the Profession: Ensuring nursing quality and safety

- Maintaining the Code of Ethics for Nurses which was first developed by ANA in 1926.
- ANA develops and publishes the Scope and Standards of practice for nursing and many of its specialties.
- Through the National Database on Nursing Quality Indicators, ANA is collecting data that link nurse staffing levels to quality nursing care.
- Addressing workplace hazards such as back injuries, latex allergies, safe needles and workplace violence.

Influence Decisions: Becoming involved

- Join one of the many committees and boards at the national, state and local level that are shaping the direction of the association and the profession.
- Participate in member surveys that let you influence the association's agenda.

Promote yourself: Professional development tools and opportunities

- Members save up to $140 on certification through ANCC.
- Online continuing education available at a discount or free to members.
- Conferences and educational events at the national and local level offered at a discount to members.
- Member discounts on nursesbooks.org—ANA's publications arm.
- Up to 60% savings on regular monthly dues with GlobalFit Fitness program.
- Find a new job on Nurse's Career Center—developed in cooperation with Monster.com.

Stay informed: Publications that keep you current

- Free subscription to The American Nurse—a $20 Value.
- Free online access to OJIN—the Online Journal of Issues in Nursing.
- Free subscription to The Journal, ANA-Maine's state newsletter.
- Free access to ANA's Informative listserves including—Capitol Update and Members Insider.
- Access to the new Members Only web site of NursingWorld.org.

Save money: Discounts and privileges for members

- Professional Liability Insurance—a must have for every nurse, offered at a special member price.
- Introducing ANA Nursing Rewards+, the rewards credit card that designed just for nurses. Developed by the American Nurses Association and National City Bank, the ANA Nursing Rewards+ Visa earns points with every purchase you make—and those points can be redeemed for travel, cash and rewards unique to the nursing profession! Combine that with a low interest rate—0% for the first six months—and you have a credit card that fits in anyone's wallet. Apply Now.
- Marsh Affinity Group Services—Major Medical, Dental Insurance and Best Benefits—Marsh Affinity Group Services can help you find and compare major medical plans, and tailor a plan to your needs. Our new Dental Insurance program covers not only the cost of routine care, but also special services. And the Best Benefits program provides discounts on such services as eyewear, prescription drugs, chiropractic and hearing services.
- Dell Computers—ANA is pleased to announce a new member benefit. ANA members can now receive 5%-10% off purchases of Dell Computers. To take advantage of this valuable offer, or for more details, call 1-800-695-8133—refer to code HS45927362, or visit Dell's web site.
- CBCA Life and Health Insurance Plans—Disability Income, Long Term Care, Medical Catastrophe, Medicare Supplement, Cancer Insurance and Life Insurance Plans provided by CBCA Insurance Services.
- Walt Disney World Swan and Dolphin Hotel
- GlobalFit Fitness Centers—Save up to 60% savings on regular monthly dues at GlobalFit Fitness Centers.
- Nurses Banking Center—free checking, online bill paying and high yield savings all available to you 24/7 to fit any shift or schedule.
- Avis and Budget Car Rental—Discounts on auto rental through Avis and Budget: Call Avis 1-800-331-2212 and give ID# B865000 Call Budget—1-800-527-0700 and give ID# X359100
- VPI Pet Insurance Pet Insurance helps you take care of the other members of your family—your pets. A VPI Pet Insurance policy provides affordable health coverage to help you pay the treatment costs for your pet's accident, illness and routine medical care. As a member of the ANA, you are eligible to receive a discount off the base premium, which makes a VPI Pet Insurance policy even more affordable.
- Save on your hotel stays at Days Inn, Ramada Inn, Howard Johnson and more.
- Online discounts on all your floral needs through KaBloom.

WAYS TO GET INVOLVED

Your Participation is the Key to Higher Standards of Nursing Practice

Members of ANA-Maine have the power to influence nursing practice in Maine by their involvement in a number of ways within the association, which include:

- **ATTEND THE ANNUAL ANA-MAINE BUSINESS MEETING**. Many decisions are made at the annual meeting. This is a great time to learn about the work or your organization and meet other members from across the State as well as pick up a few contact hours.

Continued on page 22

ANA Cash Rewards Mall

Learn How to Use the ANA Cash Rewards Mall

The ANA Cash Rewards Mall is a **new free benefit** available exclusively to all American Nurses Association **members**! Now, whenever you are shopping online, find your favorite stores at the ANA Cash Rewards Mall and earn cash back for the online purchases you make at participating retailers.

It's easy:

Login to "Members Only" and select the **ANA Cash Rewards Mall button**.

- If this is your **first time shopping** at the ANA Cash Rewards Mall, **make sure you register** on the **ANA Cash Rewards Mall homepage** to receive your Rebate Dollars.
- **Once you're registered** and logged in click on a store name (e.g. Nordstrom.com) and start shopping! You will earn a percentage of rebate dollars for every purchase you make.
- Your **account** will **automatically** be **credited** with Rebate Dollars based on the amount of your purchase.
- Your **Rebate Dollars** from the ANA Cash Rewards Mall will appear in your Mall account within 45 days.
- On a **quarterly** basis, if you have accumulated at least $10 in Rebate Dollars, we'll convert the Rebate Dollars to a check and mail it to you.
- Once you receive your rebate check the point total will go back to zero. You will have 120 days to cash your rebate check or the amounts will be forfeited.
- Check your **"My Account"** page to track your Rebate Dollars total.

The ANA Cash Rewards Mall has plenty of money saving discounts, so **come back often** and look under the **Special Offers** section. It's a win-win-win situation—you save money and earn a cash back bonus all at the same time. Every purchase brings you closer to your rewards!

SHOPPING TIPS

1. Always start your shopping at the ANA Cash Rewards Mall to earn Rebate Dollars.
2. Make sure you are logged in to your ANA Cash Rewards Mall account before you shop.

What's New in Online CE

What Every Nurse Needs to Know About Breast Cancer

For you and anyone else newly diagnosed with breast cancer—and for everyone who cares for them—this continuing education module from the pages of *American Nurse Today* promotes a better understanding of the disease. It gives a general overview of breast cancer screening, diagnosis, and treatment, highlighting information about new diagnostic and therapeutic developments you might not be familiar with.

Read the article and take the post-test.

Free CE for ANA Members

ANA members can now get a wide selection of our continuing education modules FREE ALL THE TIME in the new **Members Only** section of this site. All membership categories can take advantage of this new ANA membership benefit.

- If you are already an ANA member, **Log into the Members Only Home** page and click on the "Free CE link on the left side menu.
- If you are not an ANA member, **Learn more about Membership Options Now** (see membership pages in this publication)

Upcoming Offerings

Here is a partial listing of what we've got planned for upcoming CE online:

From *American Nurse Today*

- Atrial Fibrillation–November, 2007
- Herbal Therapy–December, 2007
- Infusion Therapy–January, 2008

The American Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

ANA is approved by the California Board of Registered Nursing, Provider Number CEP6178.

ANA-MAINE MEMBERSHIP APPLICATION

P.O. Box 3000 • PMB #280 • York, ME 03909 • www.anamaine.org
info@anamaine.org

_____ Last Name First Name MI

_____ Credentials

_____ Home Address

_____ Home Address

_____ Home City State

_____ County

_____ Employer Name

_____ Employer Address

_____ Employer City State

(___)_____-_____ Home Area Code/Phone

(___)_____-_____ Ext._____ Work Area Code/Phone

(___)_____-_____ Home Fax Number

(___)_____-_____ Work Fax Number

_____ Home Zip Code

_____ Home E-Mail

_____ Work E-Mail

_____ Employer Zip Code

_____/_____/_____ Date

_____-_____-_____ Social Security Number

_____ Basic School of Nursing

_____/_____ Graduation (Month/Year)

_____ RN License Number

_____ License State

ANA-Maine Membership Dues

Membership Category (check one)

M **Full Membership Dues**
- ❑ $240—Employed Full Time
- ❑ $240—Employed Part Time

Available to any registered nurse in a US state, territory or possession and whose license is not under suspension or revocation in any state.

R **Reduced Membership Dues**
- ❑ **$120—New Graduate** of a basic nursing education program provided the application is initiated within 6 months after graduation.
- ❑ **$120—62 years of age or over** and not earning more than **Social Security** allows.
- ❑ **$120—62 years of age or over** and **not employed.**

ANA-Maine dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, that percentage of dues used for lobbying by ANA-Maine/ANA is not deductible as a business expense and changes each year. Please contact ANA-Maine for the correct amount.

"NOTE" *By signing the Monthly Electronic Deduction Authorization, or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA-Maine/ANA to change the amount by giving the above-signed thirty (30) days advance written notice. Above signed may cancel this authorization upon receipt by ANA-Maine/ANA of written notification of termination twenty (20) days prior to deduction date designated above. Membership will continue unless this notification is received. ANA-Maine/ANA will charge a $5 fee for any returned drafts or chargebacks.

Choice of Payment (please check)

❑ **E-Pay (Monthly Electronic Payment)**
This is to authorize monthly electronic payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize ANA-Maine/ANA to withdraw 1/12 of my annual dues and any additional service fees from my account.
- ❑ **Checking:** Please enclose a check for the first month's payment; the account designated by the enclosed check will be drafted on or after the 15th of each month.
- ❑ **Credit Card**: Please complete the credit card information below and this credit card will be debited on or after the 1st day of each month.

_____
Monthly Electronic Deduction Authorization Signature
SEE "NOTE" BELOW

❑ **Full Annual Payment**
- ❑ Check payable to "ANA-MAINE"
- ❑ Visa ❑ MasterCard

CREDIT CARD INFORMATION

_____/____
Bank Card Number **Expires: Month/Year**

_____
Signature for Bank Card

_____
Printed Name

AMOUNT $ _____

❑ **Automated Annual Credit Card Payment**
This is to authorize annual credit card payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize ANA-Maine/ANA to charge the credit card listed in the credit card information section for the annual dues on the 1st day of the month when the annual renewal is due.

_____
Annual Credit Card Payment Authorization
Signature **SEE "NOTE" BELOW**

Please mail your completed application with payment to:

ANA-MAINE
c/o American Nurses Association
Customer & Member Billing
P.O. Box 17026
Baltimore, MD 21297-0405

Or you may fax this completed form with your credit card payment to:

ANA-MAINE
c/o American Nurses Association
Fax: **(301) 628-5355**

TO BE COMPLETED BY ANA-MAINE

Employer Code _____ 8/31/2005

Maine _____ _____
STATE DISTRICT REGION

_____
Approved by Date

Sponsor, if applicable:
_____

Expiration Date _____/_____

_____
Amount Enclosed Check #

ANA-Maine membership #

Just a Bath

Continued from page 18

adults and citizens, she had served as a mentor, been a friend to many; and her appreciation for the beauty and forces of nature would speak through her paintings long after she died. She had been a daughter and a sister; she had loved, and been loved in return. Most importantly, she continued to be loved for who she had been and who she had become.

My interactions with this patient on my second clinical day continued to be thoughtful, efficient, and technically correct, but they were now imbued with a genuine sense of compassion for this woman's well being and comfort. The twist in the pit of my stomach on the previous day had evaporated. In fact, when I bathed and cared for her a second day I felt intact and whole as I engaged in a right relationship with this woman, whose life was coming to a close.

Giving a bath. It's a daily ritual in the provision of nursing care, and its relational significance is easily overlooked if viewed as a task that anyone can do. But this patient, with her absence of consciousness and her body knotted with arthritis, and to whom I gave my first bath, taught me a great deal about what it is to give care and offer comfort. To *give*, according to the OED (2006), is to make another person the recipient of something that is in the possession of or at the disposal of another. Theoretically, the patient was the recipient of the care that I provided; in reality, however, I became the recipient, and the woman, in presenting her comatose and contracted body, became the giver and teacher. While I offered her what comfort I could, she in essence, supported, assisted, and aided me so I as a nurse could better comfort those whose pathways would intersect with mine.

Just a bath? Not if one is open to the relational possibilities it affords both nurse and patient.

Jenny Radsma is an associate professor, Division of Nursing, University of Maine at Fort Kent. She can be reached at radsma@maine.edu.

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ANA Membership Benefits . . .

Continued from page 21

- **SERVE ON ONE OF ANA-MAINE'S MANY STANDING COMMITTEES**. This is a great way to influence the direction of the organization and nursing practice in Maine.
- **BECOME POLITICALLY ACTIVE**. Share your e-mail address with us (send it to info@anamaine.org) and become an active part of the many legislative e-mail campaigns. In this way you can have an opportunity to influence legislation impacting on nursing practice, the nursing profession and the people receiving health care in this great State. Learn how to go about being a legislative buddy and let your legislator know how his or her decisions impact nursing care in Maine. Get involved with the ANA Political Action Committee. Follow candidates for political office and discover their views on issues that affect nursing in Maine.
- **COMMUNICATE YOUR VIEWS AND THOUGHTS TO NURSES WHO ARE OFFICERS OR COMMITTEE MEMBERS**. ANA-Maine can only speak for the nurses of Maine if Maine nurses speak up. Contact one of the officers or committee members you know or e-mail us at info@anamaine.org.
- **RUN FOR ELECTED OFFICE**. Member participation in leadership positions is essential for the success of ANA-Maine. Find out more . . .

ANA-MAINE MEMBERSHIP CATEGORIES

There are two categories of membership (full and reduced membership categories) in ANA-Maine and three types of memberships to choose from:

Full Dues Membership: Available to any registered nurse in the State of Maine whose license is not under suspension of revocation.

- **Active Member**—Dues $240

Reduced Dues Memberships:

- **Active Member Retired**—Available to any registered nurse, 62 years of age, not earning more than the maximum Social Security system allows, or 65 years of age and not employed. Dues $120.
- **Active Member New Graduate**—Available to any graduate of a basic nursing education program provided the application is initiated within six months after graduation. Dues $120.

ANA-Maine dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense.

JOIN ANA-MAINE ONLINE

To join ANA-Maine online go to the online membership form.

ANA-MAINE MEMBERSHIP APPLICATION [PDF]

Download Application—If you don't want to join online, you may download a PDF file of membership application form, complete and return by mail with a check.

COMPLETE APPLICATION AND MAIL WITH PAYMENT TO:

American Nurses Association-Maine, c/o American Nurses Association

Customer & Member Billing, P.O. Box 17026, Baltimore, MD 21297-0405

Or fax completed form with credit card payment to: (301) 628-5355.