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NHNA

# Nursing News

*Quarterly Circulation 23,000 to Registered Nurses, LPNs, LNAs, and Student Nurses in New Hampshire.*

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# HOT TOPICS in Clinical Practice–A Big Hit!

Church Landing on Lake Winnipesaukee in Meredith proved to be a wonderful setting for our June 8th HOT TOPICS conference. It was a gorgeous day–lovely lakeside location–comfortable accommodations–great food–all of which enhanced this full day program presented by another group of wonderful guest speakers. As somewhat of a sequel to Hot Topics in *Professional* Practice in March, this session focused on a variety of *clinical* topics:

**Pain Management–Look How Far We've Come** was presented by a panel of specialists from the Center for Pain Management at Wentworth-Douglass Hospital: **Valerie Keefe-Vincent**, RN-BC; **Claudia Hunt**, RN-BC; and **Christine Wyrsch**, M.Ed., BSN, RN. The panel discussed their innovative multidisciplinary model for comprehensive assessment, interventions and treatment of both chronic and acute pain. Some modalities employed: epidural steroid injections, radiofrequency lesioning, cryoablation, trial spinal stimulators, and IV regional blockades, as well as many complementary therapies such as massage, meditation, Reiki, acupuncture, etc.

**Heart Failure Management–the Five Point Approach**, was offered by **Marilyn Daley**, MSN, APRN from the New England Heart Institute at CMC. She presented a detailed look at this complex clinical syndrome including: 1) incidence & prevalence [500,000 new cases annually in the U.S.]; 2) identification & etiology; 3) signs, symptoms & compensatory mechanisms; 4) current assessment & treatment modalities, and 5) mechanical treatment of the heart failure patient (CRT–Cardiac Resynchronization Therapy).

**Bridget Mudge**, RN, MS. of Dartmouth Hitchcock taught her group how to **Be Prepared for Pediatric Emergencies**–focused on changes in pediatric resuscitation methods and geared to nurses who don't see many pediatric patients. Bridget also discussed pediatric HERT (hospital emergency response training) and creation of Rapid Response Teams to better deal with this type of crisis situation.

**Respiratory Distress in Adults** was shared by **Jean Proehl**, RN, MN, CEN, CCRN, CPEN, FAEN also from Dartmouth Hitchcock, and author of Emergency Nursing Procedures. Jean's information packed session covered recognizing respiratory compromise, identifying causes and appropriate interventions for: anaphylaxis, asthma, COPD, pulmonary embolism, congestive heart failure, thoracic trauma, pneumonia, and epiglotitis.

**Current Issues in Wound Care**, was presented by **Thomas Szopa**, MS, RN, CWOCN from Elliot Hospital–covering nursing interventions for a wide range of skin issues from surgical wounds to skin tears, pressure and leg ulcers, and MASD (moisture associated skin damage). Assessment, risk factors and treatment–including many new products–were discussed.

**Tricia Reddy**, MSN, ANP-BC, RN from the Massachusetts College of Pharmacy & Health Sciences shared an important **HIV AIDS Update**, looking at the latest approaches, medical protocols and nursing considerations for treating patients with HIV-AIDS. Some elements discussed were: lab tests and vaccines recommended during an initial evaluation; new antiretrovirals and their side effects; common opportunistic infections and prophylaxis recommendations; risk reduction strategies, and lingering myths about the disease.

**It's Not Your Grandmother's Diabetes** was an informative and entertaining look at this pervasive disease offered by **Mary Jo Dudley**, RN. BSN, CDE. In the past decade a great deal has been learned about how insulin really works in the body; how food / carbs and even stress affect blood sugar levels–all of which has led to more Type 2 diabetes prevention; new medications, and better methods for helping patients manage their diabetes. For information and resources, see Mary Jo's website: www.ideabetes.com

*Opening session of the day.*

*Pain Management Panel.*

*Tricia Reddy*

*Bridget Mudge*

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*Mary Jo Dudley*

*Marilyn Daley*

*Jean Proehl*

*Tom Szopa*

# NURSING NEWS

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## VISION STATEMENT

To be the premier resource for professional practice and advocacy for nurses in New Hampshire.
Adopted: 11/15/99

## MISSION STATEMENT

The New Hampshire Nurses' Association, as a constituent member of the American Nurses Association, exists to promote the practice of professional nursing, advance the development of professional nurses, and improve health standards and availability of health care services for all people of New Hampshire.
Adopted: 10/16/97

## PHILOSOPHY

Membership and participation in the professional organization affords each nurse the opportunity to make a unique and significant contribution to the profession of nursing. The membership of the New Hampshire Nurses' Association, individually and collectively, has an obligation to address issues related to the development and maintenance of high standards of nursing practice, education and research. We participate in the proceedings of the American Nurses Association (ANA) and support and promote ANA Standards and its Code of Ethics.

We believe that the profession of nursing is responsible for ensuring quality nursing practice and that continuing education in nursing is essential to the advancement of the profession and the practice of nursing.

We believe that nurses function independently and collaboratively with other professionals to enhance and promote the health status of individuals, families and communities. We have an obligation to initiate legislative strategies to improve the quality of health and the delivery of health care services while promoting quality practice environments that advocate for the economic and general welfare of nurses.

Adopted: 5/80
Revised: 1991
Revised: 12/4/97

## LETTER FROM THE PRESIDENT

# Fixing the Health Care System

***Louise Smith Cushing***

*NHNA has received inquires about why we have not published anything on proposals for health care reform in Nursing News. The simple answer is that things change from hour to hour on this in DC ….never mind quarterly. So don't be surprised if proposals for "fixing health care" look quite different by the time this publication is released.*

***Louise Smith Cushing***

"Nurses Have the Power" is the name of a recently released video by the American Nurses Association (ANA) which urges all nurses to advocate for a healthcare system that is patient-centered, comprehensive, affordable, accessible, and delivers the quality of care all people in America deserve. To me, this seems reasonable and very much similar to embracing the ANA Code of Ethics close to 40 years ago which focused on the principles of human dignity, respect, and compassion. Even if we are satisfied with our own health care, do we as nurses have a responsibility to make sure the system works for everyone? There are significant moral and ethical questions at the heart of complicated legislative battles over health care, such as the concept of health care as a basic human right, not a privilege.

It is not that simple, is it? Most of us would like to understand the details of what we are advocating for. If the US Congress is having difficulty deciphering all the recommendations and the implications for American citizens, then how can the nursing workforce with all of their multiple responsibilities, do so? Let me share with you some of what I have learned after reading multiple articles, watching bipartisan debates, and studying ANA's publications on the health care reform issue.

Our health care system is definitely in trouble. Fewer and fewer Americans have health insurance and therefore cannot afford good medical care. Nearly 46 million Americans have no insurance and 25 million more are underinsured. One in six Americans under 65 has no insurance. More than 80% of the uninsured are in working families. One major reason for this crisis is that many employers, especially small businesses, have stopped offering insurance to employees because of high costs. A recent national survey estimated that 12.6 million non-elderly adults who tried to purchase health insurance were discriminated against because of a pre-existing condition in the prior three year period, or dropped from coverage when they became seriously ill. The sad personal stories are endless. I think one of the worst I had heard occurred a few years ago in a Boston hospital, where a women with an acute abdomen went to the ER–was not seen due to lack of health insurance–and subsequently died.

There is little debate that health care reform is necessary–President Obama, Republican and Democratic members of Congress, the American Medical Association, the American Nurses' Association and America's Health Insurance Plans, which represents the insurance industry, have all agreed the system needs to be changed, although they disagree on how to do it.

The fundamental principles of the President's plan can be found at **www.HealthReform.gov**

1. **Reduce costs**–Rising health care costs are crushing the budgets of governments, businesses, individuals, and families, and must be brought under control.
2. **Guarantee choice**–Every American must have the freedom to choose their plan and doctor–including the choice of a public insurance option.
3. **Ensure quality care for all**–All Americans must have quality and affordable health care.

At the center of the President's plan is the creation of a government-sponsored health insurance program as an option for all Americans, similar to Medicare now available for those over age 65. It does allow individuals to keep the insurance they have. The plan seeks to prohibit insurance discrimination against people with pre-existing conditions, and create incentives for people to use preventive services and wellness plans.

Key provisions of **House bill, H.R. 3200, America's Affordable Health Choices Act, 2009** were summarized and published online by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor–addressing:

- **Coverage and choice.** The bill is intended to protect current coverage and preserve choice of doctors, hospital and health plans.

- **Affordability**–to ensure that all American have affordable health coverage with new and/or revised policies such as expanding Medicaid and improving Medicare.

***President's Message continued on page 3***

*President's Message continued from page 2*

- **Shared responsibility**–among individuals, employers and government to ensure that all Americans have affordable coverage of essential health benefits.
- **Prevention and wellness**–is included in several measures of the bill such as creation of community-based programs to deliver prevention and wellness services.
- **Workforce investment**–through proposed expansion of the health care workforce in several ways, including more scholarships and loans for individuals in key professions and areas of shortage.
- **Controlling costs**–in numerous ways, such as investing in health care through stronger prevention and wellness measures, increasing access to primary care, and reforms to Medicaid and Medicare.

There has been a great deal of concern voiced about how we will pay for this. The President has said that he's already identified ways to pay for the vast majority of up-front costs such as cutting waste, fraud and abuse in Medicare and Medicaid, ending big subsidies to insurance companies, and increasing efficiency. He has also proposed reducing tax deductions for high-income Americans.

Some opposed to these proposals don't like the idea of having a government-sponsored health insurance program for all Americans. One concern is that employers would opt for the government-run insurance over private insurance because the former would most likely be cheaper–but of lower quality. They also believe that the President's plan is costly and will make health insurance more expensive, not less. For more details on this position, see House Minority leader John Boehner's website: **http://republicanleader.house.gov**

The American Nurse's Association has kept its members well-informed about what and how our professional organization is influencing health care change. ANA's Health System Reform Agenda was published in February, 2008 and remains focused on the four most critical elements of health care reform from the perspective of the nursing profession. These include **access to care**, the **quality** of health care, the **cost** of health care, and the health care **workforce**. Many of ANA's publications and communications to its members throughout 2009 have included updates on the issues surrounding health care and the organization's involvement. I recently downloaded a 10-page paper from the ANA website titled *"H.R. 3200: Facts to Help Dispel House Health Care Reform Bill Myths"*, which I found very informative. You can sign up for N-Stat updates and/or find a variety of information at **www.RNaction.org** and **www.RNaction.org/toolkit**, including their *"Top Ten Reasons to Support Health Care"*.

The Government Affairs Commission of NHNA met recently to begin drafting our position paper on Health Care for the Citizens of New Hampshire. We support the same four most critical elements of a health care solution as ANA. The draft includes NHNA's commitment to a health care solution which will support the patient, family, community and nurses providing care in the state of New Hampshire. Key reasons for this commitment are the need to:

1. Ensure non-discrimination related to pre-existing conditions; severity of illness, gender and/or age
2. Recognize the importance of advance practice registered nurses;
3. End exorbitant out-of-pocket expenses, deductible or co-pays;
4. Provide funding for increasing the quality of the nursing workforce;
5. Increase focus on and access to preventative care;
6. Ensure quality health care across the lifespan;
7. Recognize the need for tort reform in health care.

In preparing our final position paper, we will be detailing each of these points relative to access, cost, quality and workforce. We are also investigating existing health insurance laws in our State. **We plan to present the paper at our annual meeting October 22nd for final approval by the membership. MEMBERS: Please plan to attend to voice your concerns for 'fixing' the health care system.**

[Note: this year's meeting will follow our Fall conference at 4:45 rather than opening the day. See centerfold and our website for registration details.]

# Safe Staffing–A Year's Progress

A year has passed with a coalition of organizations working to promote safe staffing. Progress has been slow but important. At the September, 2009 meeting of the New Hampshire Organization of Nurse Leaders, a report on the state of safe staffing among the state's acute care facilities was presented.

The New Hampshire Nurses Association began the discussion of safe staffing in summer 2008 and drafted legislation to mandate safe staffing committees in acute care institutions. NHNA members and concerned nurses had indicated to the NHNA Government Affairs that staffing had become a major issue in some facilities. NHNA recognized that staffing ratios, similar to the effort in California, and discussed in Massachusetts, was not an appropriate solution for New Hampshire. After examining best practices and legislation passed by other states, using the core principles provided by the American Nurses Association, the Government Affairs Commission proposed legislation to mandate staffing committees which include equal representation of staff nurses to determine staffing guidelines.

Soon after the legislation was drafted and before being signed by the sponsor, NHNA was contacted by the New Hampshire Hospital Association (NHHA) and its affiliate organization, the New Hampshire Organization of Nurse Leaders (NHONL). They proposed voluntary compliance with safe staffing committees and staffing guidelines, voicing concerns with any legislative proposal. In an effort to seek a collaborative and constructive solution, NHNA temporarily withdrew the legislation and agreed to work with NHHA, NHONL and the human resource directors' organization (NHHHRA) to promote consensus for voluntary compliance. The joint work group or coalition was established: NHNA, NHHA, NHONL and HHRA.

The first activity was to determine safe staffing principles. Documents from other states were reviewed and language adapted to meet the needs of New Hampshire nurses, and core principles were ratified (see insert).

The second activity was to assess current practice of each facility related to those core principles–so a survey instrument was developed by the steering committee and distributed electronically by NHHA in July 2009. Follow-up emails and letters to Chief Nursing Officers and Chief Executive Officers stressed the need to complete and return the survey. Responses would indicate any need for further education in safe staffing and core principles.

The results of the survey provided much fodder for discussion at the NHONL September 1st meeting. Representatives from NHNA were also in attendance. In brief, 21 of the 32 organizations receiving surveys responded (65% return rate). Of the 21 that returned surveys, 4 had staffing committees all chaired by nursing directors. None of the 4 committees adhered to all of the core principles. Three of the four were composed with at least 50% of the members being direct care staff and met monthly. The remaining 17 facilities reviewed their staffing plans yearly.

Fifteen of the 21 responding facilities used national standards to develop their plans. *ANA and other specialty organizations such as the perianesthesia nurses (ASPAN) and operating room nurses (AORN) publish staffing standards.* Thirteen of the 21 respondents believed that their staff understood how the staffing plan was developed. The overwhelmingly majority (90%, 18/21) of those replying to the survey based their staffing on numbers of patients admitted. Seventy percent also used nurse experience. Only half of the staffing guidelines were based on acuity; technology was listed as a consideration by 4 of the respondents.

The discussion at the September NHONL meeting centered on improving compliance with the core staffing principles. A 'toolkit' of resources for Safe Staffing Committees is to be developed.

## CORE PRINCIPLES OF SAFE STAFFING COMMITTEES

**Staffing committees should:**

- Have not more than 13 members
- Have at least 50% staff/direct care RNs
- Have a mechanism to ensure representation of shifts
- Have a designated term of service for members
- Be provided time and resources to develop plans
- Incorporate periodic quality evaluation tools
- Have minutes that are accessible to staff
- Be lead by the chief nurse executive
- Provision of safe patient care and adequate nurse staffing

**Plans should consider:**

- Individual and aggregate patient needs and requirements for nursing care
- Specialized qualifications and competencies of nurses and support staff
- Availability and requirements for specialized equipment and technology
- The geographic environment of the facility
- Patient safety as paramount when planning nurse work hours
- Nationally recognized evidence-based standards and guidelines

## SURVEY QUESTIONS POSED

- Does your hospital have a standing committee that develops nurse staffing guidelines for your organization?
- Who chairs the nurse staffing committee?
- How many members are on the nurse staffing committee?
- Is committee membership composed of at least 50% direct care nurses?
- Which areas of nursing practice are represented on the nurse staffing committee?
- Are nurse members of the nurse staffing committee provided with support to attend meetings?
- How do staff nurses become members of the nurse staffing committee?
- How long do the members of the nurse staffing committee remain on the committee?
- How frequently does the committee meet?
- Which of the following characteristics describe your current nurse staffing guidelines?
- Acuity / admits / discharges / nurse experience / ancillary support / technology
- How often are your nurse staffing guidelines reviewed?
- Do you use national standards to determine your nurse staffing plan?
- Overall all do the RNs who provide direct care understand how your hospital's nurse staffing plan was developed?
- How do you evaluate the effectiveness of your hospital's nurse staffing plan?

# Research Recap & Reflections

***Susan Fetzer, RN***

**Geriatric Research**
The CDC has reported U.S. life expectancy is now at almost 78 years for a child born in 2007, an increase of three months from 2006. Researchers said declining death rates for almost all leading causes of death helped push the number upward. In a related topic, a study by the Agency for Healthcare Research and Quality found hospitalization rates for osteoporosis-related fractures and other injuries have increased by 55% since 1995. The aging population is one reason for the increase, but officials said lack of exercise and deficiencies in calcium and vitamin D also may have played a role. According to a CDC study found more than 47,000 elderly patients are seen in hospital emergency rooms each year after a fall involving a walker or cane.

Researchers said nearly 9 of 10 cases reviewed involved walkers rather than canes. The CDC said health care professionals should take more time to better fit patients with walking aids and teach safe use. Overall though, a review of studies found that mental health and emotional happiness generally improve with age—except for among those with dementia-related diseases—and that older adults tend to have better emotional control and are less negative.
***Reflection:*** *Our grandchildren will live longer and be happier if they can use a walker correctly!*

**Isn't Technology Marvelous?**
King Pharmaceuticals obtained FDA clearance for Embeda, which is extended-release morphine for pain. To prevent abuse, Embeda contains a chemical designed to counteract the morphine if the capsule is crushed, chewed or dissolved. However, there is no concrete evidence that the drug truly is tamper-resistant, the company said.
***Reflection:*** *Those who may need this drug, might not be able to swallow it.*

A shoemaker and technology company have teamed up to develop shoes with a built-in GPS device that can be used to track Alzheimer's disease patients to within 30 feet, anywhere on the planet. One adviser to the project said about 60% of Alzheimer's patients will experience at least one "critical wandering incident".
***Reflection:*** *The shoe monitor replaces the EKG monitor!*

**Golden Rules**
The best way to reduce the risk of heart disease and other chronic illness is to follow the old adage of don't smoke, eat a healthy diet, lose weight and exercise, a new study found. Data showed people who followed those four golden rules had a 93% lower risk of diabetes, 81% lower risk of a heart attack and half the risk of stroke compared with people who didn't follow any of the recommendations. Even following just one of the rules cut the risk of disease, researchers said.
***Reflection:*** *Those "old wives" really knew what they were talking about.*

**Hand Hygiene meets technology**
A hand hygiene compliance program that uses infrared and RFID technology is being tested by staff at Jackson Memorial Hospital inMiami to see if the technology can reduce hospital-acquired infections. The program captures and time-stamps hand-washings using sensors in soap-dispensing units that read staff ID badges.
***Reflection:*** *It may be a problem for some health care providers who don't wear a badge.*

**Happy Visitors**
The Animal-Assisted Therapy program at Edward Hospital in Naperville, Ill., has 84 dogs and handlers that have made more than 100,000 patient visits to help reduce pain. A study found that patients who are visited by a dog require half the pain medication than patients who aren't.
***Reflection:*** *And these visitors are probably cleaner and HIPPA is not an issue.*

**SOS**
The nation is readying for a new wave of swine flu this fall, but more than half of the schools in the U.S. will be coping without a full-time registered nurse on staff, according to the National Association of School Nurses. A USA TODAY analysis of U.S. Census data found each school nurse cares for about 971 students, but in 13 states the ratio is more than 2,000 to 1. That exceeds the CDC recommendation that schools have one nurse for every 750 students.
***Reflection:*** *All nurses should be prepared to help out this flu season, if our School Nurse colleagues sound the call!*

# An Extended Family: The International Council of Nurses

***Notes from the ICN 24th Quadrennial Congress***
***Durban, South Africa June 29, 2009***

I am sitting in the company of 5,600 nurses from all across the world. In this enormous arena we are gathered awaiting the opening ceremony of the International Council of Nurses. The International Council meets in this manner every four years. This is the first time it is meeting in on the African continent. Nurses of all color, shape, size and manner of dress are pouring into the arena. Jubilant flags abound. Around me are languages that bear no resemblance to the familiar. I am nestled in a back bleacher surrounded by nurses from South Africa, our host country. As I look at the vast expanse of people I feel the exponential power of our collective curiosity electrifying the air. It is like a reunion. We are all connected but have not yet really met. The meeting was about to be birthed. Something magical, something mystical is transpiring. It starts as a solitary Zulu chant coming from the far right of the bleacher. It is being answered by another voice from the far left. Back and forth the volley continues, infectiously spreading to all the nurses that surround me. The chant produces a groundswell of vibration. Nurses spill from the bleachers and add dance to the chant. Such beauty …such power. A kind South African nurse leans over to my struggling American ear and begins to make understandable the African tongue. "What we are chanting is *…'We are coming home… We are home… Praise to all the nations of the world… We are home'…"* My heart opens wide. My eyes well up at the unfolding revelation that these nurses are indeed my brothers and my sisters.

And this is how my week with the International Council of Nurses started. The rest of the week was trying to figure out how to be in 2-3 places at once. Many sessions had 3-4 topics packed into one session and there could be 10 such sessions running simultaneously. I sprinted like a gazelle throughout most of the day (next time I will definitely pack sneakers!). I became humbled and troubled by much of what I learned. In North America we have 10% of the global burden of disease yet have 37% of all the world's health workers. Half of the world's financial expenditure for health is spent in North America. Contrast these statistics to what is occurring in Sub Saharan Africa. These countries collectively have 24% of the world's burden of disease but only 3% of healthcare workers and only 1 percent of the world's finances for health.

In parts of South Africa there is one nurse for 80 patients. In Uganda, it can be one nurse for 90 patients. I heard stories of nurses who, already stretched beyond belief, stretched even further to use their own money to buy medicine on the black market in order to help relieve the inconsolable suffering of their patients. As I was standing in the lunch line, I asked the nurse behind me where she was from. She had come to South Africa from Zimbabwe. Her family left that country after their tribal chief made clear that he desired the then pre-adolescent nurse and her 2 sisters to add to his collection of wives. I asked what kind of nursing she did and proudly she reported that she

***ICN conference site.***

"operated in the theatre". (It took my brain a few moments to get that I was talking with an OR nurse.) She spends a good portion of her day searching throughout the hospital for supplies. When she has gathered enough, the surgery begins. She confides that by the time the scavenging is good enough to go, she is already exhausted. This is her daily routine. I look at her in amazement and appreciation. She urges us to get into another food line. She has dutifully assessed that at this station, they will be out of food by the time we get to the head of the line. I heed the prodding of my newly met resource nurse and am grateful to have her as preceptor.

I learned about nursing in Islamic countries. A Director of Nursing from Saudi Arabia shared a telling comment made by one of her Muslim nursing students: "I read about nursing from the West, but I think about nursing from the East". In Islam, health is seen as a blessing from Allah. Disease and curing are predestined as God's will. That is why prayer is seen as an integral part of nursing in the Islamic world. Surgeries are delayed until prayer by the patient is completed. A nursing action is to support the ability to pray. When establishing vascular access, an Islamic nurse is found prefacing, "in the name of Allah may the insertion of this IV bring healing." I left that session wondering what the practice of American nursing would look like if spirituality was so seamlessly woven into our daily patient care.

I discovered that my understanding of gender violence was at best superficial. During this nursing congress I encountered the lived stories of abuse. The details made me shudder. What does one do when a gun-bearing rapist holds your infant son in the air while systemically raping you… all the while threatening to kill your child if you dare utter a sound? As I heard story after story I mourned the fallen and bore witness to those that survived. It became clear to me that our profession is not immune to martyrdom. That night I prayed earnestly for my African brothers and sisters.

I had the opportunity to hear the recent past president from Botswana, his Excellency Festus G. Mogae, speak on the challenges of healthcare. In 2001 the rate of HIV transmission from mother to child in Botswana was 40%. The president listened to health experts and set up clinics. *He built them but they would not come.* Rather than give up in frustration he rededicated himself to understanding the fear. His insight from the experience was that sometimes you do the wrong thing trying to do something better. He

***Jim Biernat at ICN.***

decided to transform these HIV clinics to antenatal clinics. Blood is routinely drawn and privately the question is asked if the mother would like to know her HIV status. In the early stages only 50% consented and only 50% of these wanted to hear the results. Over time the proportion began to favorably shift. Now, 98% of the mothers in Botswana go for antenatal care. By 2009 the transmission rate from mother to child decreased to 4%. From 40% to 4% in just 8 years. That is an astounding accomplishment that warrants focused study. The gained wisdom from this study could be leveraged for the benefit of mothers across the globe. His Excellency Mogae is spending his retirement days trying to convince other presidents in Africa to devote 15% of their GDP to healthcare. By his assessment, this is necessary for the continent to stave the migration of healthcare workers to the West. In order to adequately address current inadequacies, Sub Saharan Africa needs 700,000 additional healthcare workers. I did not fully appreciate the extent that Africa serves as a training ground for healthcare workers that leave to work in the West. Forty five percent of the doctors and 25% of the nurses in Ghana leave to work in the West. That is a phenomenal drain of resources. Is it time for us in the West to ethically give back in some creative way that can be equitable?

While in Africa, I had lunch with Becky Patton, our ANA president. She too was deeply moved by this congress. She shared with me that the professional nurses association of South Africa, during apartheid, would not allow black nurses to be part of the association. To this day I cannot get my head around how nurses dedicated to healing could inflict such injury. They have since transformed into DENOSA- the Democratic Nursing Organization of South Africa. DENOSA is the embodiment of hope: Black and white now coming together as one. It was the fledgling DENOSA that hosted this Congress. It is the spirit of DENOSA that continuously cries out to all nurses wherever we may be, *"Praise to all the nations of the world… We are going home… We are home…"*

Jim Biernat, RN, MA

# Healthcare in China: Where East Meets West

***Sandra McBournie RN, BS, M. Ed.***

***Sandra McBournie***

In May of 2009, NHTI was privileged to sponsor a "study abroad tour" in China–it's first study tour that focused specifically on healthcare. Our group traveled for fifteen days in China, visiting three cities, two hospitals and many attractions. Sometimes half-way around the Earth felt like out of this world, as we discovered differences in culture, customs, and humanness that not only kept the trip exciting, but prompted the adoption of the term "planet China" which was affectionately used throughout the trip.

Before our 'space ship' took off, participants attended a pre-trip lecture by licensed acupuncturist and Chinese Medicine Herbalist, Kasia Weglarz, LicAc., of the *Plymouth Center for Acupuncture.* This provided a basic introduction of the principles of Chinese medicine including theories of yin and yang and the introduction of Qi , the invisible universal life force that flows in channels through the human body. The talk set the stage for what was to be an eye opening and sometimes awe striking experience.

The first eye opening experience came at approximately 3:00 a.m. on the first night in Shanghai. Thanks to Greenwich Mean Time, we were 12 hours off our normal schedule. If we all knew that the guest house at Tongji University in Shanghai, where we were staying, was buzzing with jet lagged travelers we could have joined each other for tea and discussed some of what we were in awe of thus far. Experiences such as waiting an hour on the tarmac in the airplane while a team of Chinese men covered in full hazmat gear from head to toe screened the temperature of each passenger; or our first "Chinese style" dinner, where we sat around a large dining table with a lazy Susan in the center spinning around unidentifiable meat and vegetables, waiting to be shared and eaten "family style".

Chopsticks were our only utensil option and warm beer, soda, tea or water were the beverage choices at every meal. We each served ourselves onto dessert sized plates… and the lazy Susan kept spinning. An inquiry with our Chinese guide, Yu Xiao, a retired Professor from Tongji University, still working part-time as an international student liaison, to identify different foods was often responded to with the Chinese name only, but was *always* accompanied by an explanation as to why it was good for you. These explanations proved to be an appropriate precursor to our next lecture by Traditional Chinese Medicine practitioner, Dr. Zhang.

Dr. Zhang, who titled her lecture *Healthy Living with Chinese Food and Herbs*, practiced at a Shanghai hospital and clinic and was a third generation (and first female) traditional Chinese medicine doctor in her family. It should be noted that in China traditional (historically used) medicine is Traditional Chinese Medicine [TCM] and their alternative medicine, or what the Chinese refer to as Western medicine, is the allopathy currently widely practiced in the U.S.. Quite the opposite of how most Americans refer to it. *But then of course, things are different in on other planets!* Dr. Zhang enhanced our basic knowledge of yin/yang theories by explaining exactly how this theory is used in identifying abnormalities in the body and what role tea, herbs, and food each play in restoring balance to the body. It became evident that a large part of her role is the prevention of imbalances that cause illness, which can be done by understanding one's unique body make up and providing diet recommendations.

***Employees from Tiantan Puhua Hospital in Beijing, China pose for the camera with NHTI's Healthcare in China: Where East Meets West participants. Sandra (center) with NHTI study tour group in China.***

Our lecture was followed by a visit to Tongji University Hospital's TCM clinic. Here we were welcomed with open arms and doors. Our group was able to not only see acupuncture treatment in progress on stroke victims with hemiplegia, and university athletes with joint injuries, but two were fortunate enough to experience it firsthand and received treatments for joint injuries. And, yes, they both reported some relief. *Maybe the medicine practiced on this planet is onto something?*

In a large room I will call the physical therapy department, (for lack of a more accurate comparison in our healthcare system), we witnessed electronic muscle stimulation, Tuina—a form of Chinese massage, and spinal traction in use. Again, members in our group were able to participate in treatments and all of our questions were kindly and patiently answered. From there we toured the beautiful campus, viewing ponds filled with lily pads and koi, and perfectly situated sitting pagodas; and were treated to another hearty traditional Chinese meal (and more unidentifiable, but sometimes tasty, sometimes scary food) on our little plates. *And so, the planet and lazy Susan kept spinning…*

After a week in Shanghai we took in the sites in the city of Xian and boarded an overnight train to Beijing. We were privileged to visit the Beijing Tiantan Puhua Hospital. This small (approximately 40 bed) hospital was oddly situated in a neighborhood accessed only by traveling down an alleyway with a quintessential "old China" feel, as evidenced by an elderly man stooping over his stir-fry pans of rice, and street vendors selling freshly cooked food from their single story stucco homes with clay tile roofs. We then turned the corner to find a modest hospital entrance on the outside (noting the rows of Mercedes and BMW's parked out front—oh the disparities of this planet) and a grand warm welcome on the inside by a group of smiling nurses, including the charge nurse and director of nurses. Most were attired like 1950's US nurses with crisp, shiny whites from head to toe. *Yes, nurses still wear caps on planet China.* They were eager to meet, mingle, and answer any questions, and shortly these two groups from opposite sides of the Earth (or is that universe?) found common bonds and interests. After all, we are all caregivers.

We toured their nurses' station, complete with patient charts, and computers with electronic medical records and physician order entry capability. We visited patient rooms, each equipped with private bathroom, shower, microwave, toaster oven, refrigerator, sleep sofa, coffee table, chair, closet and, of course, hospital bed. We noticed similarities to U.S. hospitals in the medication room, clean and dirty utility rooms, and even the way the code cart in their intensive care unit was organized was familiar. Inquiring about the standard of care when caring for a patient in need of the emergency cart contents, we learned that they have a tendency of following doctor's orders in lieu of adhering to nursing protocols. This answer was repeated when similar scenarios were posed. Overall, nursing autonomy appeared to be superseded by following doctor's orders and personalized, individualized care; obvious once the 1:1 nurse patient ratio for *all* cases was conveyed. They were amazed when we mentioned our common 5:1 nurse patient ratio on the medical surgical floors in the U.S.

Western names noted on the name plates outside patient rooms (no HIPPAA here) prompted a question about the patient population. After a presentation by the marketing director of the hospital, we learned that the majority of the patients admitted are international and come to the facility for stem cell treatment. Beijing Tiantan Puhua Hospital, is primarily a neuroscience hospital, created from a joint venture between Pacific Medical Group (comprised of a group of medical doctors from California) and a Beijing affiliate. This type of "joint venture" has become quite common in China in recent years, and has contributed to their growing economy.

Our visit ended with hugs, kisses, pictures and email exchanges with this wonderful group of people. Our 'interplanetary' hosts had become our friends and colleagues. Overall the trip was a once in a lifetime opportunity to witness this ancient culture in action, explore TCM principles in use at their native source and network with like-minded individuals from across the globe (or is that universe?).

For more information about Tiantan Puhua Hospital visit http://www.puhuachina.com/. For more on Traditional Chinese Medicine and a complete presentation of the trip you are welcome to attend **Herbal Therapy and Chinese Medicine: *A Pharmacy and Nursing Perspective*** with presenters and China trip participants Steve Ottariano, BS Pharm, and Sandra McBournie, RN, BS, MEd on October 21, 2009 from 5:00-8:30 p.m. at NHTI. 3.0 contact hours will be awarded. To register or for more information on the Center for Nursing Professional Development, please visit http://www.nhti.edu/businesstraining/nursing/index.html

# Taiwan—My Second Nursing Home

***Sue Fetzer, RN, PhD***
***Assoc. Professor, UNH Dept. of Nursing***

Ten years ago I was invited to Taiwan to present a series of critical care in-service lectures. As I will try anything once, flying half-way across the globe was a challenge as it is a 26 hour plane trip when you consider the 12 hour time difference. Since that first trip, I have been going back nearly every year for up to two months at a time. For Spring 2010 I am planning a three month sabbatical to Taiwan. I thoroughly enjoy my Taiwanese nursing colleagues, and learn as much or more from them as they do from me.

Taiwan is an island the size of Vermont and New Hampshire put together, and stretched out north to south. Northern Taiwan has snow in the mountains during the winter months, while southern Taiwan has is tropical rain forest. Down the middle of the island is a severe mountain range which, like our own Rockies, is mostly uninhabitable. The monsoon (our term is hurricane) this past July put the mountainous region of Taiwan in the news due to the landslides and subsequent deaths. In this relatively small island, with its mountain range, are 23 million people. (For comparison, New Hampshire and Vermont combined have less than two million!) The population lives on the flatter periphery of the island; cities are masses of tall high rise apartments and public transportation. Private transportation is mainly by motor scooter. At any time of day or night, stopped for red lights are a virtual mass of scooters, with one, two and even a family of four aboard.

Most know Taiwan by its former name, Formosa, when it was occupied by Japan. After 50 years of Japanese rule, it was given to China, and still remains a Republic of China [ROC] yet Taiwan elects its own President. It is an unusual love-hate relationship between the two countries. Taiwan is also infamous for diagnosing the first case of SARS, and its health care response. Some of my nurse colleagues were stationed at the entrance to the hospital in 12 hour shifts, doing temperature screening of every person who entered during the crisis. Even today, when you visit a nursing unit, some nurses continue to wear surgical masks continuously during their 8 hour shift.

I practice at the National Cheng Kung University (NCKU) and Hospital in Tainan, the oldest city in Taiwan. Tainan is located in the south, and has a moderate climate. Summer months are unbearable—hot and humid with rain every day. Winter is similar to October weather in New Hampshire. NCKU is the third largest medical school in the country, and on the same campus with the 1,200 bed hospital. There are 36 hospitals in Taiwan, most are over 1,000 beds. Staff nursing in Taiwan is similar to any Western facility. Nurses chart on computer, give IV medications via pump, use tympanic thermometers and track down physicians for the correct order. At NCKU all the orders are written in English, not the common tongue of Mandarin, and most health care providers are bi or tri-lingual, speaking English, Mandarin Chinese and Taiwanese, the native language.

Differences include wearing white uniforms (with optional cap), full time employment (35 hours/week) and lack of nursing assistants. It is a cultural norm that families provide personal care to the patient when they are hospitalized, including feeding, bathing and ambulating. The exception is the critical care units, with a family dorm facility right outside the ICU door! Traditional Eastern medicine is practiced alongside and with Western therapies. Most hospitals have two pharmacies, one Western and one Eastern.

My activities in Taiwan are different during each visit. I consult with nursing faculty assisting with research and manuscript development. In Taiwan, university faculty must publish their research in international English journals to obtain future research funding and tenure. I provide guest lectures to undergraduate and graduate students, and hold doctoral student seminars. I do rounds in the hospital and consult with head nurses.

Someone once told me that the people of Taiwan don't collect "things", they collect friends. Taiwanese nurses have honed networking to a fine art! There are over 170,000 nurses in Taiwan, yet it is a small community. This past Spring I conducted a workshop for the Sigma Theta Tau chapter in Taichung, a city in the center of the island. The President of the chapter drove me back to the high speed railroad terminal. In our discussion we discovered that she had taken a class, many years ago, from my New Hampshire colleague, Dr. Rosemary Wang, who had coordinated my first visit to Taiwan. It is truly a small world in nursing. I am looking forward to my visit next spring!

***President of Fooyin University, Kaohsiung, Taiwan after the author's presentation to the nursing department.***

***National Cheng Kung University complex in Tainan, the oldest city in Taiwan.***

***Nursing Faculty with National Cheng Kung University, Tainan, Taiwan ROC—with President of the Medical Center.***

# Travelogue: Jeddah, Saudi Arabia

*by Lisa Thomka, PhD, RN*

Last Fall I had the pleasure to share time and rich dialogue with Sandy Lovering, DNSc, RN, Chief of Nursing Affairs at King Faisal Specialty Hospital and Research Center (KFSHRC), Jeddah, Saudi Arabia. Sandy was visiting Dartmouth-Hitchcock Medical Center to share her research on Islamic Nursing and the Crescent of Care. As we sat on my porch we spoke of common concerns in Nursing such as the need to engage in evidence-based practice, the role of leaders in achieving quality patient outcomes, the concept of shared governance to support decision-making at the bedside, and the journey to Magnet, among other things.

For me, it was a time to hear about a world that certainly had not ever been a part of my experience. Sandy, a Canadian native, spoke of some of the differences between nursing in North America vs. Saudi Arabia. For example, nurses in Saudi Arabia collaborate with patients through a deeper sense of spirituality and connectedness. They are very much guided by their religion in how they practice and engage their patients and their families, and some nurses wear the traditional cover per their cultural requirements.

I learned about operational differences such as nurses at KFSHRC are paid on the new moon and the full moon rather than on an every other week basis. The vast majority of nurses are ex-patriots, or non-natives, because Nursing is not thought of as a high social status role for Saudis. But that is changing. I found all of this to be intriguing and the conversation made me long to learn more. And in true leadership form, Sandy strongly encouraged me to submit an abstract to speak at their 4th International Nursing Conference to be held in Jeddah in April 2009 so that I could visit their world. That's how I came to be in Jeddah, in the Kingdom of Saudi Arabia with the opportunity to experience the most fascinating landscapes, culture, and people that one could ever hope to encounter.

Since my husband would be traveling with me, we did some homework in preparation for our journey to Jeddah. We read about Saudi culture, its customs, and its history. We wanted to be thoughtful and polite visitors as well as good 'ambassadors' for the United States. We flew on Saudi Airlines which follows Islamic law, so there was no alcohol on board, and there were rooms available for the structured prayer times throughout the flight. After an uneventful flight, we arrived in Jeddah on time. Once we completed the entry process into the Kingdom we were met by a representative from the hospital who ensured that we would be taken to our housing accommodations for our eight day stay. We opted to stay in the compound where the hospital employees live rather than at a hotel. It was relaxed and comfortable and afforded us easy access to our hosts.

Language was never a problem as every sign and product is in Arabic and English, even the Chuck E. Cheese and McDonald's signs. Everyone who we met spoke English and was gracious and welcoming. Their monetary currency is directly tied to the American dollar so that $1.00 nearly always equals 3.7 riyals. We learned that a Pepsi from a vending machine has cost 1 riyal for many years. Gas was quite reasonable at 12 cents per liter or about 50 cents per gallon.

Since women do not drive in Saudi Arabia, all transportation for them is provided by the hospital. This includes transport to and from work and for shopping excursions, etc. My husband was kept busy throughout our time there playing golf, seeing the sites, driving along the Red Sea, enjoying morning coffee at Starbucks and photographing much of this beautiful city. While he was out enjoying the city I was facilitating a series of workshops at the hospital and making rounds to meet my new clinical colleagues. The hospital is a beautiful and thoroughly modern facility. It's a tertiary care hospital providing a full range of services to the community. Like many hospitals here in the US, they are already planning on expanding their facilities and services.

As I rounded on the various units and services the one thing that really struck me was the incredible cultural diversity within the Nursing workforce. I met nurses from South Africa, Canada, the Philippines, Sweden, Jordan, Egypt, New Zealand, and Denmark. It was the most incredible mix of talented and committed nursing professionals that I had ever had the pleasure to meet in one place. Many of these same nurses brought their diverse cultural backgrounds, thoughts, ideas and beliefs to the workshops. During those sessions, the more we shared ideas and problems and experiences at King Faisal Specialty Hospital, the more I realized that, in many respects, we're not so different after all. Clinicians there struggle with the same issues of communication across shifts, between members of the team, and across levels of care. They must meet regulatory requirements and are also constantly challenged with the need to improve quality and safety on behalf of patient care. We spoke about the need to engage in reflective practice and the struggle that nurses everywhere have to avoid engaging in our own 'victim' behavior.

We engaged each other in the conversation about the need to pay close attention to our Nursing Code of Ethics, also a challenge to US nurses. The multi generational workforce, especially in Nursing, is as much a challenge there as it is here. Shared governance was also a topic of interest as KFSHRC nurses are moving quickly along their journey to Magnet. Implementing shared governance in a hospital in a Muslim country gave us a lot of fuel for discussion.

We laughed a lot! The more we shared our experiences in Nursing and healthcare, the more we discovered our sameness. The more we 'looked in the mirror' together the more we laughed and developed some patience with our collective humanness. And as we acknowledged that humanness we gave ourselves permission to openly discuss our challenges more fully and to collectively move forward with a shared commitment at problem resolution and accomplishment. It was all so thoroughly rewarding that I left being inspired to be a better nurse.

During the long flight home I had time to fully reflect on my time spent with this marvelous group of colleagues and healthcare professionals who want the same things for their patients and their families that we do, and who struggle with providing that care just like we do. It was an amazing experience and one that I wish that more nurses could come to know. I look forward to some day being invited to return to share such valuable time and space with my new friends and colleagues in the Kingdom of Saudi Arabia.


*Entering Jeddah.*


*ER entrance.*

*Lisa and hospital CEO.*

*Rounds with new colleagues.*

*New friends!*

*American influence everywhere!*

# Kenya 2009—Medical Mission Trip

*Mertie L. Potter, DNP, APRN, BC*

The following is a brief report of the medical mission team of which I had the privilege of being a member. We journeyed to Kenya from June 14 through July 1, 2009. Although the needs can be overwhelming at times, a wise person shared with me on my first medical mission trip in 1999 that "Doing something is better than doing nothing."

The team was made up of ordinary people willing to go and willing to help. Sixteen of us were prepared to go. Only 12 were able to go. Four were unable to go due to one of the following: illness, house fire, or work-related emergency (bad things happen to medical teams, too.) One of those who went is an asylumee in the U.S. and went to visit his refugee mother who has cancer. Another of our team was a local student from Daystar University (refugee) who was imprisoned and tortured for 3 years before having a grenade thrown at him. By the way, the 2 men were from warring tribes and were roommates for the entire trip.

**Kenya Facts:**
**Source: UNICEF: The State of the World's Children Report 2009**
**Population:** 37,538,000 (2007)
**National language:** English, Kiswahili
**Per capita income:** US $680/year (2007)
**Life expectancy:** 53 (2007)
Percent of population using improved drinking water sources: 57% (2006)
Percent of population using adequate sanitation facilities: 42% (2006)
Under 5 Mortality Rate: 121/1,000 live births (2007)

Kenya is world-known for its wildlife. Kenya faces difficulties with overcrowding and overuse of farming regions. It has emerged as a financial center for Eastern Africa. Although corruption and uncertain governmental procedures have injured its reputation to some degree, Kenya remains the region's hub for financial transactions. Nearly 75 percent of the population work in agriculture, producing tea and coffee for export and corn and wheat for local consumption.

The purpose of the medical mission trip was to:

- Provide dental & eyeglass clinics
- Partner with nationals in HIV/AIDS education
- Support global missions of a Concord local church

Clinic Sites:

- Machakos
- Dagoretti
- Karen

Approximately 1000 individuals were seen in the following: HIV/AIDS educational sessions, dental clinics, and eyeglass clinics–partnering with the help of local facilities to provide translators, information, and HIV/AIDS testing.

Since our seasoned mission dentist was unable to come, we had decided not to do dental clinics this time. However, compassion overcame one of our new team members, a dental surgeon. He borrowed equipment and began doing dental clinics. His nurse-wife's hands became the dental chair headrest.

Additional visits were made to the following places:

- Daystar University Graduation–Athi River Campus. One of our translators graduated that day. One of our team members and other translators were graduates of Daystar University. Our team leader was the former director of Daystar U.S. and made many of our connections possible through his many years of partnering with Daystar University in Kenya.
- Daystar University Nursing Program–Nairobi– met with the nursing director and faculty.
- Aga Khan University–met with director and psychiatric-mental health program coordinator.
- Mathari Hospital–visited the public psychiatric facility. They only have 2 psychotropic medications.
- Chiromo Lane Medical Centre–private psychiatric hospital. They have many psychotropic medications.
- Industrial Area Prison–made visit there with Christian Law Association (CLA) lawyers, Attorneys from CLA of Kenya are the only attorneys representing many of the indigent who are imprisoned there and at numerous other facilities in Kenya.
- Christian Law Association (CLA) of Kenya–Interestingly, the director of CLA told my husband, the director of Christian Legal Society (CLS) of the U. S., that she was failing in school for 2 years. A medical mission team came and gave her eyeglasses. She said it changed her life.
- Masaai Tribe–Although we were prepared to refer to "ethnic groups," many were proud of their tribes and referred to them as such. Two interesting Masaai Tribal customs are:

  1. Mixing of cow's blood with milk–a drink of sustenance that still is used in some areas. They say it tastes sweet. No, we didn't try it!
  2. The males dress very colorfully and perform a custom of jumping. Tradition says the higher they jump, the more attractive they are.

Common expressions:

- Jambo–hello
- Mazunga–1 white face
- Wazungas–2 or more white faces–We "wazungas" made some babies cry, because they had never seen a "mazunga!"
- Asante sana–thank you very much
- Karibou–welcome
- Karibou tena–come again

Special thanks to NHNPA for providing a scholarship to help with my expenses for this very meaningful medical mission trip. As many of us know, it is we who go who seem to be more blessed than those we go to serve.

Gratefully,
Mertie

New Hampshire Nurses' Association

# CRITICAL CARE CERTIFICATION REVIEW

**Nov. 7-8** *hosted by*
**Concord Hospital**
**Concord, NH**

**DOWNLOAD THE COMPLETE REGISTRATION BROCHURE AT**
**wwwNHNurses.org**
***or call 603-225-3783***
***to have one sent to you***

This continuing nursing education activity has been submitted (for approval of 14 contact hours) to ANA-MAINE, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

## CRITICAL CARE REVIEW:

**8:00 A.M TO 4:30 P.M.**

**DAY 1**

**Test taking tips**
**Hematology/immune Issues**
**Cardiovascular Issues**
**Endocrine Issues**
**Gastrointestinal Issues**
**Professional Caring & Ethical Practice part 1**

**DAY 2**

**Neurological Issues**
**Renal Issues**
**Pulmonary Issues**
**Multisystem Issues**
**Professional Caring & Ethical Practice part 2**

## PRESENTER: Shirley Jackson MS, RN, CCRN, CCNS

Ms. Jackson is a Clinical Nurse Specialist in Critical Care with Elliot Hospital and also teaches paramedics through New England EMS Institute. She acts as regional faculty for both Basic and Advanced Cardiac Life Support. Prior to her 20 years at Elliot, Shirley worked as Clinical Instructor of Surgical Critical Care at Johns Hopkins; Surgical ICU Charge Nurse at St. Elizabeth's in Boston, and Critical Care Instructor at Lowell General. Shirley earned her BSN at UNH; her MSN at Boston University, and a post graduate certificate in Educational Technology Integration through Penn State. NHNA is excited to have her teaching this information packed weekend session!

**$100** NHNA MEMBERS

**REGISTER NOW!**
**Class size limited.**
***This 2-day session is a $300 value!***
***1-day option available***

**$125** NON MEMBERS

NHNA NEW HAMPSHIRE NURSES ASSOCIATION

**ATTENTION: NHNA MEMBERS**
*and 'NOT YET' MEMBERS...*

# Last Call for Nominations

## Take an active role in shaping your Association!

**Run for NHNA Board office or one of our Commissions / Committees!**

**2010 ELECTION BALLOT - Deadline Nov. 1, 2009**

See **www.NHNurses.org** (or call our office) for the INTENT to SERVE application form and list of vacancies.

### *NHNA BOARD of DIRECTORS:*

The Board, as elected by the membership, establishes policies and procedures for the transaction of business, coordination of Association activities and operation. It assumes responsibility for fiscal solvency of the organization. Composition of the Board: four officers - President, President Elect, Secretary and Treasurer: three Directors at Large, plus four Chairs of the **Commissions below**.

### *GOVERNMENTAL AFFAIRS:*

- Serves as the "voice of nursing" when it comes to the NH legislative and health policy arena.
- Conducts an annual Town Hall Forum to allow public review of proposed legislation on healthcare and nursing practice to focus legislative efforts.
- Conducts annual Health Policy Days to educate nurses and nursing students on the legislative process in NH - and how best to be heard.

### *ORGANIZATIONAL & MEMBERSHIP AFFAIRS:*

- Responsible for the management and operations of the Association.
- Works to build membership.
- Increases member services.
- Organizes annual CE conferences and plans special events to promote nursing through its' Event Planning subcommittee.

### *CONTINUING EDUCATION:*

- Administers the peer review process and grants ANCC approval for CE activities submitted by providers.
- Acts as consultant / resource to NHNA members on matters of accreditation, credentialing & standards.
- Enhances the professional development of NH nurses by ensuring the quality of CE activities.

### *NURSING PRACTICE:*

Develops programs & activities related to:

- Educational and delivery systems for practice
- Economics of practice and health care
- Rights and responsibilities of nurses
- Promotion of both ANA Standards & Code for nurses
- Development of 'white papers' and policy statements


# new frontiers in nursing

*What would Florence do?*

**October 22, 2009** 8:00-4:30 *Grappone Conference Center, Concord, NH*

***SPECIAL KEYNOTE SPEAKER:*** **Dr. William H. Thomas, MD - Caring for our Aging Population**

Dr. Thomas is an internationally recognized authority on geriatric medicine and long term care reform. He is founder of **The Eden Alternative**, a now international non-profit dedicated to creating more life-enhancing eldercare options - including his **Green House** model, now being replicated in all 50 states. Dr. Thomas will address how our aging society impacts healthcare in general and nursing in particular. *Whether or not you ever intended to be a 'geriatric' nurse - at some point in your career you will now be dealing with this growing population!* He predicts that nurses will be working within new models of care - shifting from emphasis on acute care to more management of chronic conditions; from a technology focus to a systems approach involving more community based resources. [Something to which Florence would certainly relate!]

***CONCURRENT SESSIONS: SELECT A or B C or D E or F***

**A.**

**Ready for the Aging Boom? - *Providing Quality Care for Persons with Dementia*** **Jo Ann Jordan, M.Ed., BS, RN - Regional Dementia Specialist, Genesis Healthcare**

Estimates say 19 million "baby boomers" will develop Alzheimer's or a related dementia. Medication provides limited treatment in slowing down memory loss. Care giving strategies aimed at understanding behaviors, decreasing anxiety, limiting "excess disability", strategic stimulation, communication techniques and understanding the losses which occur through the stages of dementia are the key in providing quality of life and care for this growing population.

**B.**

**Reflective Nursing - *Taking a Look in the Mirror***
**Lisa Thomka, PhD, RN, CNS - Director of Nursing Retention & Magnet Coordinator - DHMC**

Strengthening the culture of nursing requires reflective and transformational leadership. Looking in the mirror provides the discipline of nursing a marvelous opportunity to capitalize on our strengths and to identify and begin to address the barriers to a healthier professional culture.

**C.**

**Healing with Advocacy, *a Palliative Approach to Care-Planning***
**Linda Hotchkiss APRN, MS, BC-PC Clinical Ops.Officer Rockingham VNA & Hospice; Dir. Palliative Care, Exeter Hospital**

When patients hear the words "weeks to months to live" nurses must become patient and family advocates. The central focus of critical palliative care planning is to identify what the patient wants, needs, and/or wishes for to reduce suffering at end of life. Through active listening, teaching and realistic conversations, we as health care providers can empower a patient and family with the most precious gift, the dignity that comes from being in control of their life and its journey.

**D.**

**DOLLAR$ and $EN$E of Healthcare – *Why Nurses Should Care***
**Kevin Kilday, Sr. VP of Finance; CFO – Catholic Medical Center**

Healthcare costs continue to rise. Millions of Americans have no health insurance. Washington politicians debate the how-to's of reforming the healthcare system. What drives escalating costs, is there hope that the reforms in Washington will decrease them, and why should I as an RN care about all this? This dynamic presentation will discuss how the finances of the system work; what might be coming with future reforms, and what our role should be in making changes.

**E.**

**Aging with Developmental Disabilities**
**Joan Hahn, PhD, APRN, BC, CDDN - Associate Professor, UNH**

Persons with developmental disabilities who are aging are increasing in numbers - and are often facing unique challenges compared to the general elder population. This session will discuss issues encountered by older adults with lifelong disabilities and roles that nurses can play to promote healthy aging and transitions in later years.

**F.**

**Care of Patients with Morbid Obesity: Maureen Quigley, APRN**
**Clinical Program Director - DHMC Bariatric Surgery Program**

In 1893, Florence Nightingale noted that a "longing for health was a common experience for everyone everywhere." Bariatric surgery offers the potential for return to health for obese individuals. Implications of morbid obesity, current surgical options and nursing considerations in the care of patients with morbid obesity will be discussed.

**CLOSING PLENARY SESSION (3:15-4:30)**

**RN to BSN in 10 Years**
**Janet Haebler, MSN, RN - Associate Director of State Govt. Affairs - ANA**

Nursing education has been hotly debated for over 40 years. But fast forward from 1965 to 2008 when over 600 delegates at the ANA House of Delegates adopted a resolution requesting that ANA support initiatives requiring registered nurses (RNs) to obtain a baccalaureate degree in nursing within ten years after initial licensure. Why now? What does it mean for nurses currently licensed? What steps are needed to advance this initiative?

**ANNUAL MEMBERSHIP MEETING - 4:45**

NHNA members are encouraged to attend this important business meeting even if you are unable to come for the conference itself. **PLEASE USE THE FORM BELOW TO REGISTER** or RSVP to 225-3783 so we can ensure that a quorum will be present. Thank you.

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

**With thanks to:** Arthur L. Davis Publishing Agency, Inc. ALDPub.com | NursingALD.com **&** **Lunch sponsor:** The Campaign for Nursing's Future – Johnson & Johnson

**Directions from I-93 North or South:**
**Exit 15 West - right at first light onto Commercial St.**
**1/4 mile to Constitution Ave. - Courtyard Marriott**

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| [ ] Non-member | $115 | $140 |
| [ ] Retired RN | $ 75 | $ 90 |
| [ ] Nursing Student | $ 50 | $ 65 |

* Member number _____

CHECK CONCURRENT WORKSHOP PREFERENCES:
[ ]A or [ ]B [ ]C or [ ]D [ ]E or [ ]F

[ ] ATTENDING ANNUAL MEMBER MEETING ONLY

# Letter to the Editor

## ARNP to APRN

The New Hampshire law, which went into effect July 21 accomplished two major changes for advanced practice nursing: the legal title of Advanced Registered Nurse Practitioner (ARNP) changed to Advanced Practice Registered Nurse (APRN) and the abolition of the Joint Health Council. This provides advanced practice nurses in NH with truly independent practice!

New Hampshire has a proven record of leadership in advanced practice nursing. Having attained legal authority to practice in 1975 with supervision, prescriptive authority with collaboration in 1983, and independent practice in 1993, demonstrates the ongoing commitment of advanced practice nurses to grow and improve health care services and choices to the public. The abolition of the Joint Health Council, also a provision of the new law, allows truly independent practice for APRNs in NH.

Why is title change important? Currently there are at least 20 different titles for advanced practice nursing in the US. Many are performing in the same or similar roles.

*A Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education* (July, 2008) was completed through the work of the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee. In all, 72 nursing organizations contributed toward this work. One of the recommendations of the consensus model is consistency in title of APRN.

The Board of Nursing looks for your ideas, continued collaboration and support as we move forward. We thank all who participated in the passage of this legislation.

Patricia Orzano RN MA
Assistant Director, Nursing Education
New Hampshire Board of Nursing

# NH Advanced Practice Nurses See Major Victory in 2009!

## *Joint Health Council Repeal and New APRN Designation*

***by Lisah K. Carpenter, Executive Director, NH Nurse Practitioner Association***

In 1991, nurse practitioners in NH achieved independent practice and prescriptive authority–with a catch–the Joint Health Council (JHC). In theory, the JHC was created to help nurse practitioners transition into independent prescriptive authority; in practice, it was often a vehicle of restriction, via the drug formulary that it was charged to maintain. Over the years, the NH Nurse Practitioner Association went back repeatedly to the Legislature to fix inequities that arose from this system. Efforts to repeal the law were vigorously opposed by the medical community. NHNPA turned its attention to educating policymakers about advanced practice nursing, and supported nurses who ran for public office.

Finally, this year, the stars aligned and with barely a blip of debate SB 66 was adopted, repealing this outdated section of the Nurse Practice Act. Policymakers understood the role of nurse practitioners, their education and competency, and the redundancies built into the system that did not exist twenty years earlier, making prescribing a much safer practice. Nurse practitioners had come of age in NH.

Today, if you go to the BON or NHNPA websites seeking information regarding the JHC, you will note that the links have disappeared. Quite simply, the JHC and drug formulary no longer exist. In their place remains what has always been there: well-educated professional clinicians, who provide safe, effective care, who prescribe within their scopes of practice, and who seek collaboration and consultation from their peers, as needed.

The JHC was the last bastion of non-nursing oversight of nurse practitioner practice in NH, and it is with no small amount of joy that we celebrate its demise. Having said that, it should be noted that the JHC served an important role in the history of nurse practitioner practice, allowing nurse practitioners in NH to make the leap to independent prescriptive practice authority. The men and women who served on the JHC over the years, particularly the nurses and nurse practitioners, deserve our utmost respect. Time and time again, they held the line on independent practice authority, never allowing the JHC to overstep the limited scope of its authority.

The second piece of SB 66 changed the designation of nurse practitioner from Advanced Registered Nurse Practitioner (ARNP) to Advanced Practice Registered Nurse (APRN). The reasoning behind the BON's request for this change arose from the national adoption of the Consensus Model for APRN Regulation (see article by Patricia Orzano in this publication). Nationally, more and more states are moving to standardize the language around licensing of APRNs, and it made sense for NH to take steps in this direction.

Although intended as a simple change in title, the amended language has raised numerous questions within the APRN community in NH. NHNPA is working with the BON to develop a Q&A document that we hope will provide adequate clarification. As soon as that document becomes available, it will be posted on the BON website, disseminated to the NHNPA listserv, and linked via the NHNPA website. As a threshold matter:

- All nurse practitioners, certified nurse anesthetists, and certified nurse midwives practicing in NH must use APRN as their licensing credential.
- In addition, APRNs in NH are encouraged to hold themselves out as nurse practitioners, certified nurse anesthetists and certified nurse midwives, and to utilize the additional credentials afforded them by their accrediting body, i.e., FNP, PNP, etc., to further identify their areas of expertise.
- All references to ARNP should be changed as soon as reasonably possible, i.e., prescription pads, business cards, letterhead, signage, new employment contacts, yellow page advertisements, etc.–where necessary, it is acceptable to cross out the old designation by hand and write in APRN.

As we move forward to develop the Q&A document, questions with respect to the new APRN designation may be sent to either:

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# In My Opinion

## Prohibit Dual Licensure

*Sue Fetzer, RN*

*Sue Fetzer*

The US Constitution has stood the test of time, albeit with 27 amendments. The New Hampshire Nurse Practice Act (NPA) is not quite as old as the US Constitution, but you would think that after over 100 years, the NPA would be clear on most issues related to nursing practice. It was crafted by our 'foremothers' (I am not trying to be sexist, but there were no male nurses in 1906) to protect the practice of nurses educated in schools of nursing from those who would just claim they had nursing experience. It protects the public from just anyone who would call themselves a nurse. The NPA has been amended. Two years ago the brightest minds in the state with extensive nursing backgrounds championed a revised and reorganized New Hampshire Nurse Practice Act and the issue never came up. Until now, the issue prompted, in part, by the economy, or so they say.

The issue is unique to newly graduated nurses, but affects all practicing nurses and employers of nurses. The issue is dual licensure, as a nursing assistant and a registered nurse. First, some background. In nursing school, once a student has successfully completed a Fundamentals of Nursing course, they are eligible to apply and obtain a license as an LNA. Many nursing students opt for the LNA license for a variety of reasons. They can work as an LNA during school break and summer vacation to earn money for tuition. They can work as an LNA to practice fundamental skills. They can work as an LNA to demonstrate to a future employer of RNs their work ethic and potential employability. Employers reap the benefits of LNAs who are in nursing school. The LNA nursing student is interested in the profession, asks appropriate questions and is usually eager to learn.

Once graduated from a nursing program, the NCLEX exam (State Boards) can be scheduled almost immediately, and the graduate is usually notified in 3-4 days whether they have passed and have an active RN license. And here is the issue… there is no rule, law or guideline which requires the newly licensed RN to give up the LNA license. I would never have given a thought to working as an LNA when I graduated from nursing school and just achieved my RN license. But that was then, and this is now, and here is where the problem economy enters the equation.

Despite the ongoing shortage of nurses, in New Hampshire, the nursing shortage exists in specific pockets. Emergency room, ICU and OR nurses are always in demand; but these specialties require experience, and rarely take on a new graduate. Long term care has vacancies, but salaries in this specialty, due to reimbursement problems, have not kept up with acute care employers and are not attractive to new graduates. Nurses who have facility seniority in a part time status are increasing their hours for economic reasons. Many nurses have put off retirement, for economic reasons. The questionable impact of Health Care Reform on acute care facilities' margin (revenues minus expenses) has many employers looking carefully at staffing hours and positions. In New Hampshire, few full time positions have been advertised this summer and nearly all require experience.

So what is the newly licensed graduate nurse to do? New Hampshire produced over 400 new graduates in 2009. I would suspect that nearly all of these graduates wanted, desired, or needed full time RN positions. Many of our best and brightest left New Hampshire for states like North Carolina, Oregon, Colorado and Texas where new graduates are being given "sign-on bonuses" for full time positions. No such bonuses in New Hampshire—in this economy it is an employer's market. Most NH employers can be selective and not feel rushed into hiring decisions. New graduate orientation programs have been put off or cancelled altogether in cost saving measures. As a result, the newly licensed RN's—unable or unwilling to relocate, unable or unwilling to accept less than full time employment, unable or unwilling to practice in their second or third choice specialty—fall back to their "second" license, that of LNA. They simply resumed their LNA job, while they continued "looking for an RN job", hoping things would change. A Registered Nurse mind in an LNA body! In New Hampshire, it's legal!

While I am certainly sympathetic with the plight of a new graduate RN who wants to use his or her credential and cannot find the "right" job, in my opinion, dual licensure as an LNA and RN must be prohibited. The New Hampshire Nurse Practice Act must be amended!

Consider the following dual licensure scenarios:

> New RN graduate is working as an LNA in your facility, on your unit. The facility would like to hire the LNA into a RN position, but there are no vacancies, and they are unwilling to upgrade the LNA position to an RN position. In fact, what would stop a facility from downgrading RN positions to LNA positions and hiring additional new graduates with LNA and RN licenses? The New Hampshire Nurse Practice Act would not stop them.
>
> You are working with an LNA (RN) as a member of your care team for the day. What activities do you delegate to the LNA? Can you delegate activities that you might not normally delegate because you know the LNA has a RN license? Or do you need to abide by the LNA job description? Does your employer have an LNA job description?
>
> The LNA (RN) has been working in your facility as an LNA for 8 months. A RN position comes available. The LNA has not practiced in the role of RN, and needs a new graduate preceptor. You are selected. How comfortable do you feel assisting the LNA in making a role transition? How difficult will it be for the LNA to begin to "think and act" like a registered nurse?

The practice of nursing assistants and registered nurses in today's health care systems must be clearly delineated, both in mind and in spirit. Allowing dual licensure creates confusion for the licensee and nurse colleagues. Allowing dual licensure is not in the best interest of practicing nurses and ultimately, health care consumers. I urge the Board of Nursing to amend the Nurse Practice Act. Once a nursing license is obtained, the nursing assistant license should expire.

## Nursing Budget: Friend or Foe

*Marie T. Sullivan, RN, MSN, CRRN*

Budgets! To many the word conjures up late nights of number crunching, reducing staff levels and plain fear. It is often an arduous task and one that is anticipated with dread every year. However, it is important that every nurse and nurse manager understand that they are an integral part of the budget process.

When I first entered the realm of nursing leadership, the manager was given the task of providing and ensuring quality clinical care. Money and budgets were secondary to the tasks at hand. Twenty years later, the role of the nurse leader has evolved. Quality of care is still of utmost importance but it must be intertwined with a strong operational budget.

Health care today is highly regulated by governmental agencies, managed care plans, accreditation agencies and numerous professional boards. As we look and examine quality of care indicators, we do so in the framework of a plan. As nurses, we are all familiar with patient plans of care. We develop them with three things in mind: the problem, the standards of care to address the problem and the outcome. Likewise, we can transfer these concepts into the budgetary process.

First and foremost, a budget is a plan that is formalized and quantified. It represents management's expectations for the year based on standards set forth by the organization. It compares revenues and expenses in order to determine expected outcomes. In essence we have established a hypothesis since we are giving our best educated guess based on past and future performance. Without proper budgeting, the facility is at financial risk. No one wants quality of care to be jeopardized because of inadequate planning.

The nurse manager understands the needs of the unit or department and is the best person to set forth the standards necessary to address the plan. Budgeting allows the nurse to make choices which will ultimately allow the manager to provide the best care possible within the hospitals financial means. This allows us to analyze the resources needed to care for our patients instead of wasting staff and equipment.

Once we have our basic plan, we must look at the standards that address the plan or the interventions necessary to resolve our problem. There are numerous areas which must be taken into consideration including the types of patients the unit receives, physician preference regarding patient care equipment, technology, patient supplies, safety requirements, average length of stay, average age of the patients and human resources. Budgeting will have a direct effect on the amount of clinical care necessary and the way in which it is provided. As we forecast the year ahead, it is imperative to take into account the need for RN's, LPN's, LNA's, one to one sitters, and any ancillary personnel. As an executive in a rehabilitation hospital, knowledge of the number of therapists available to patients also becomes an integral part of the budgetary process.

The outcome will enhance communication, increase coordination between departments, decrease duplication amongst divisions, increase efficiencies, measure financial performance, and appropriately anticipate problems and opportunities with adequate response time.

With this in mind, what are the budgeting skills that all nurse managers need? Dana in the article "Essential business skills for nurses" has summarized the following proficiencies that are necessary for every nurse leader.

1. Basic financial terminology
2. Proficiency in reading and understanding organizational budget reports
3. Development of a basic unit budget and recognize the different line items
4. Ability to monitor and analyze budget variances in order to develop strategies to address them
5. Establishment of strong working relationships with the finance department
6. Active member of the committee that deals with productivity, material supplies, and human resources

Once we have an adequate understanding of the process we can clearly see that a well developed budget will enhance and direct the care that is essential for each patient. There will be no surprises and all capital and operations will be accounted for.

Budgets can become our friend.

***Reference:***

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Marie T. Sullivan is the Vice President of Patient Care Services at Northeast Rehabilitation Hospital in Salem NH.

# Spotlight on CCE (Commiss

**NHNA extends heartfelt thanks to all of its volunteers for their hard work and commitment to the Association and the nursing profession. Over the next several issues of Nursing News, we intend to highlight the members of each Commission and Board of Directors …beginning with CCE.**

*The purpose of this Commission is to administer the peer review approval process for continuing education activities submitted by a wide range of providers who want to offer CNE contact hours. As such, they are responsible for ensuring quality nursing education for the advancement of professional nursing practice here in NH. They are required to operate within complex Standards and Criteria for Continuing Education in Nursing put forth by the American Nurses' Credentialing Center's Commission on Accreditation. The group meets monthly but most of their work goes on between sessions as they review detailed applications for individual CE activities or for full Providership status; communicate with these applicants on any revisions necessary to meet approval standards; and handle a myriad of requisite documentation and evaluation reports.*

Each Commission member was asked to share why they became involved with NHNA–and CCE specifically, and also how they benefit from their active participation.

*Aleta Billadeau*

**Aleta Billadeau, RN, BSN, MSN and Commission Chair** has been in nursing for 26 years since graduating from Brigham Young University, Provo, UT; her MSN is from St. Joseph's College of Maine. She works for Concord Hospital as Nursing Supervisor/Educator-—House supervisor, instructor for Orientation/ ACLS/Basic Dysrhythmia/Reiki and is a member of various hospital committees.

"I feel that the nursing profession has given me many opportunities and is such an exciting and rewarding career that I wanted to serve in some way to help support the nurses in New Hampshire. I feel that volunteering time in some way, somewhere, is an important activity to include in my life, so I'm happy to find a place I can be useful to nurses. I'm involved with the continuing education programs where I work, so CCE was a natural fit. It has actually helped me understand the ANCC criteria much better than I might have it I wasn't on the commission, so that has also helped me at work. This year I'm the chair of the commission, and the ANCC has made some changes to the criteria, so our commission is responsible to make all of our processes for approving CE activities and Providers for CE in line with the new criteria."

"To be on the CCE, a nurse needs to be involved with education for awhile and to have some experience running continuing education programs. I was doing this at CH, so when someone leaving the commission suggested I consider volunteering, I did. That was in 2006, so I'm in my second two year term. Being active with NHNA helps me keep a pulse on the things that are going on in the state that are related to Nursing. NHNA monitors the state house for bills or changes in local government that may affect the profession, or our health, and lobbies for the benefit of nurses. Also NHNA offers great conferences at local venues for nurses in the state to attend to maintain continuing education requirements. I believe that part of being a professional includes being a member of your professional organization, even if you can't be a volunteer at this time, the organization needs support of all the nurses to be their voice. Nobody else is going to look out for nurses, and the nursing profession, if nurses don't do it!"

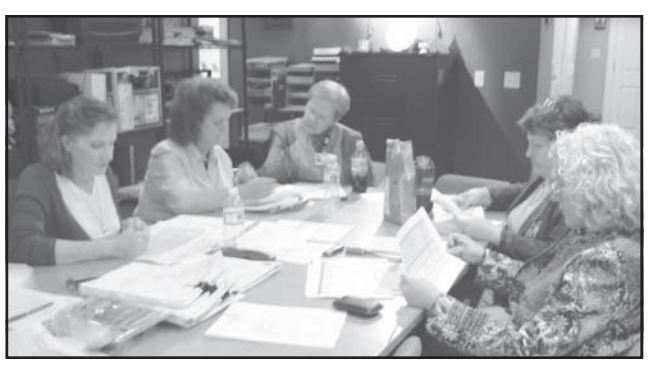
*Aleta spends any spare time with her husband and sons; volunteering at church; gardening; reading; sewing, and also enjoys digital photography.*

*Judith Evans*

**Judith Evans, BSN, MSN, EdD** obtained her first nursing degree from the University of Rochester, in NY. She works as both Director and faculty with the new nursing program at Franklin Pierce University.

"I have practiced as a nurse for over 40 years, and since my early days have valued professional connections, and commitment to my professional organization. Our professional organization provides us with a collective voice to influence the future, and support America's health initiatives. I worked with NYSNA in the 1960s and have continued with the state chapter wherever I have practiced. This is my second time on the NHNA CCE Commission. I believe in the value of continuing education for nurses, and feel I can contribute to supporting quality education for nurses through this commission. I spent a lot of time reading the seemingly never ending policies that support continuing education, as well as reviewing what other states and other commissions do. Being active with NHNA, I feel that I am part of vibrant voice for nursing in New Hampshire."

*Judy's favorite pastimes are sitting on the porch in the summer, next to the fire place in the winter, reading a good book.*



*Debra Hastings*

**Debra Hastings, PhD, RN, CNOR** earned her first nursing degree through UNH 35 years ago, and later, her PhD in Nursing from Duquesne University in Pittsburgh, PA. She is currently Director, Continuing Nursing Education for DHMC.

"I believe that membership/ involvement in one's professional organization is a responsibility of each member of the discipline. The work we do as members of the CCE Commission mirrors the work I do in my position at DHMC. As the lead nurse planner of continuing nursing education (CNE) at DHMC, I am involved in the needs assessment, planning, implementation, and evaluation of all accredited CNE activities provided to nurses through our Nursing Continuing Education Council (NCEC). Sharing my expertise as a member of CCE, is one way I can give back to my professional organization. The knowledge and skills required for my position as a nurse planner of an Accredited Provider of CNE are similar to the requirements for membership on the Commission. I am currently Board Certified in Nursing Professional Development (NPD) through the American Nurses Credentialing Center (ANCC)."

"Collaboration and discussion with others on the Commission as well as dialogue with nurse colleagues throughout the state helps me stay informed on current issues, updates, and changes related to CNE on both a statewide and national level."

*In any free time, Deb enjoys traveling. "The British Isles, especially London—and a few places in the Caribbean are my favorite destination points."*

*Marilyn Ireland*

**Marilyn Ireland, MS, RN, BC** obtained her Nursing Diploma from Yarmouth Regional Hospital School of Nursing, Nova Scotia 30 years ago and later her Master of Science in Nursing from UNH. Marilyn is Director Education / Organizational Development at Wentworth-Douglass Hospital in Dover–and past Chair of the CCE.

"Being involved in the Commission on Continuing Education has been very helpful to me as an adjunct to my role in staff development. I have been kept well-informed of the latest criteria and expectations for nursing professional development from the ANCC and am able to efficiently put them into practice in the work setting. The opportunity to network with colleagues in similar positions has been invaluable. The CCE was a natural fit with my background and experience in staff development. My job requires me to plan nursing professional development education activates and to maintain and revise the providership for my organization. My work and Commission roles are synergistic in continuing development of my expertise in nursing professional development."

"It is very fulfilling to have the opportunity to be directly linked with nursing thought leaders from throughout the state and from various practice and academic settings. I count it as a privilege to be able to serve the nurses of NH in the capacity of CCE representative, and to represent my employer organization within NHNA. Other benefits include the usual discounted attendance at continuing education events, organizational literature, etc.

*Marilyn enjoys spending time with her husband, friends, and two dogs at their lake house in Laconia. "Especially when the sun is shining brightly and the days are warm. Boating, golfing, and being in warm places has become a life ambition!"*

*Kris Irwin*

**Kris Irwin MSN, RN, BC** has been in nursing 20 years after graduating from Salem State College; Salem, MA. She went on to earn her MSN with a focus on Nursing Education. Kris works as Manager, Nursing Practice and Education at Elliot Hospital, and joined the CCE this year.

*CCE continued on page 15*

# ION ON CONTINUING EDUCATION)

***CCE continued from page 14***

"Being involved with NHNA fosters my professional growth; it allows me to interact with nurses from throughout the state, and have direct involvement with the present and future state of nursing. When asked if I was interested; I immediately said "yes!" I am passionate about nursing, fostering nurses as teachers, and providing opportunities for continuing education and professional development. I have been involved in nursing education since 2001 and have been certified in Nursing Professional Development since 2002–so CCE was a good fit. I had successfully completed two applications for providership, and therefore had some experience with that processes.

*When not working or volunteering for NHNA, Kris enjoys spending time with my husband and three sons and loves to read.*

***Sandra McBournie***

**Sandra McBournie, RN, BS, M.Ed.,** graduated from the University of Lowell as a nurse 19 years ago. She is currently employed as Professor of Nursing and Program Coordinator for the Center for Nursing Professional Development at NHTI in Concord.

As to why Sandra belongs to NHNA and the CE Commission, she says: "As an advocate for nurses and of the nursing profession, it is important to support nursing and its role in the state of NH. CCE is my area of expertise and it is comprised of wonderful nurses committed to nursing professional development and the mission of NHNA. The benefit of active involvement with NHNA for me would be professional fulfillment, excellent connections with nursing colleagues and friends, and the ability to stay connected."

*Her 'favorite things' include skiing, hiking, biking, travel and family.*

***Rae Mello-Andrews***

**Rae Mello-Andrews, CEN, RN, BSN, MS,** obtained her first nursing degree 21 years ago through NHTI. She works for LRG Healthcare as a Clinical Educator.

"I believe that nurses need to be heard from on various topics involving both our profession and our daily lives. We all should be a part of at least one organization to show that we are professionals. I joined CCE this year when a colleague left her position and I was asked to replace her. I've enjoyed my eight years nursing education and wanted to expand my knowledge. With the Commission I get a lot of colleague interaction which helps me in my role as a clinical educator and I am more aware of the issues that all nurses are encountering every day."

*Rae is also a Paramedic at Gilford Fire Rescue, and President of Lakes Region Rotary Club. With any actual 'free time', she enjoys knitting and reading.*

***Pat Moysenko***

**Pat Moysenko, MSN, RN-BC, CDE** is another new addition to CCE this year. Her first nursing degree came from U-Mass, Lowell, 37 years ago. She works as Clinical Program Coordinator for St Joseph Hospital in Nashua.

"I am recently licensed to practice nursing in NH and I'm looking to become professionally active in NH. Membership in NHNA is a great way to become professionally involved. CCE was a good fit since I have a long standing interest in promoting effective continuing education for nurses – and have been involved in assessing educational needs and planning and implementing Nursing CE programs for many years. I am also certified in Professional Development. I believe that active participation in continuing education contributes to the provision of effective evidence based patient care. The benefit of being part of NHNA and CCE for me would be professional networking and support, and more awareness of the healthcare issues in the state of N.H."

*When asked about her 'favorite things', Pat replied: "That's easy—GRANDCHILDREN!! They're better than dark chocolate & red wine together!"*

***Brenda Shurtleff***

**Brenda Shurtleff, RN, MSN, CWOCN** has been in nursing for 29 years, since graduating from Mount Saint Mary College in Newburgh, NY. She is currently Director of Clinical Education, House Support and Wound Ostomy Clinic at St. Joseph Hospital in Nashua.

"I became involved in NHNA because of shared vision. I am committed to maintain standards of nursing practice; strengthen the quality and integrity of continuing nursing education, and improve overall health outcome in my community. Influencing these objectives is the rapid evolution of technology and scientific knowledge, increased diversity and consumerism as well as social, economic, legislative and regulatory factors. Branches within the NHNA advocate, defend and provide leadership in each of these challenges. I agreed to participate on the CCE for several reasons. Having years of experience in nursing education I have an in-depth understanding of the application and approval process for becoming an approved provider, and thus feel I am competent to mentor others. My participation also keeps me abreast on the ANCC Commission on Accreditation (COA) criteria, and thus keeping my organization proactive."

"As the standing Co-Chair of the Professional Development Council, I have been administratively responsible for implementing the annual educational needs assessment, prioritizing educational needs, and facilitating the development of the educational calendar. Over the last 20 years, I have personally developed, implemented and evaluated numerous programs and have authored the application document for approval as a provider of continuing education. As part of CCE, my connections with other members of the group have provided valuable information on their philosophies and practices. Southern NH Medical Center is a magnet hospital and it is important that we provide leadership in our professional organizations."

*"In my spare time I enjoy gardening, ikebana (designing Japanese flower arrangements), and traveling (my goal is to visit every national park). Not much 'spare time' since I spend most every weekend working on my family's farm (milking cows and driving tractors)! "*

***Jo-Ann Vatcher***

**Jo-Ann Vatcher, RN, MS** has been in nursing for 35 years since graduating from the University of Pennsylvania, and is now Director of Education for Frisbie Memorial Hospital in Rochester.

"As a professional nurse, I have an obligation to be involved in/aware of what is going on in the profession. NHNA membership is one way in which I can fulfill that obligation. As I write them, those words seem a bit trite but I do believe them. I was a member of, and for a time, Chair of the CCE many years ago (and I don't know exactly when!). Having been off the Commission for sometime, I felt it was time to get involved again–partly to get a better handle on what was going on at the national level with the ANCC."

As to the professional benefit of active participation, Jo says: "Particularly in the current climate where hospitals and other healthcare organizations have to make cuts in resources (money and human!) the opportunity to network and interact with other professional nurses is essential. I particularly value the opportunity to interact with other nurses who practice in hospital-based nursing education and staff development."

*And her favorite things? "All things (well most-things) Red Sox; reading and spending time with the family."*

***Anne Ward***

**Anne R. Ward, RN, MS** earned her first nursing degree 32 years ago from Columbus College (now University), Columbus, GA. Her MS (with emphasis in Maternal-Child Nursing) is from the University of Hawaii, Manoa. Anne is now employed by Cheshire Medical Center / Dartmouth Hitchcock Keene as Staff Development Educator–and joined CCE this year.

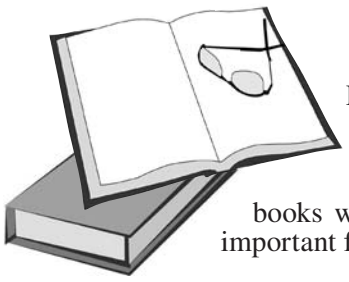
A woman of very concise language, Anne responded that she feels involvement with NHNA is an important professional obligation; that CCE was the right fit because "Coordination of Continuing Education is what I do for my employer", and as to benefit of belonging: "I regard my participation on the Commission as a learning experience and a forum for networking with peers."

*When asked about spare time activities–she gave what many of the group may actually have wanted to say: "Is there really such a thing as spare time?!"*

***Kathy Knight***

We also want to acknowledge the recent departure from CCE of a long time Commission member and former Co-Chair, **Kathy Knight, MS, RN, CAGS** from St. Joseph Hospital in Nashua. The group already misses her CE expertise, willingness to lend a hand whenever needed, and her warm personality. Keep in touch, Kathy!

# On the Bookshelf



Ed Note: *On the Bookshelf* is a new column which will offer reviews of books written by, related to, or important for, nurses.

***Reviewer**: Alex Armitage, BSc (Hons), MSc., RN recently graduated from the Direct Entry Master's Program at the University of New Hampshire, and is a per diem ICU nurse at Southern New Hampshire Medical Center.*

**River City: A Nurse's Year in Vietnam**
Patricia L. Walsh, TOA Press, LLC., Boulder CO
Published February 1, 2009, Paperback, 308 pages

River City describes Patricia Walsh's 1967-1968 Vietnam experience. Patricia Walsh volunteered to go to Vietnam and work as a civilian nurse anesthetist with the United States Agency for International Development in Danang, Vietnam. This moving book starts with her arrival into an area of Vietnam so remote and poor that it was unimaginable to someone so young and inexperienced. Immediately the book's imagery draws the reader in through sight, smell and sound. The reader progresses with Walsh from naiveté, though the ordeals of war, to a profound and deep understanding of the complexity of relationships and the tenacity and strength that materialize through living with unimaginable hardship. Facilities were primitive, with dirt operating-room floors and no electricity much of the time. Medical supplies went primarily to the black market resulting extreme supply shortages, forcing the civilian medical team to beg from military hospitals and airbases in the area. The situation was so desperate they had to peel skin from cadavers to use as burn dressings or napalm patients.

Hardened by necessity and limited material goods she was conditioned to understand sacrifices and make very tough decisions in an effort to make the most of what they had. Not everyone who volunteered could deal with these realities and those who did found meaning in their own manner. In one poignant scene Walsh chronicles passing over a woman who is bleeding profusely and urgently waiting for surgery, in favor of another who had a better chance of survival: "more salvageable" were the words she used to describe the patient chosen for surgery. As she writes of this account she highlights her devastatingly hard choice by juxtaposing the visiting surgeon's extreme negative reaction to this triage choice. Her focus was outcome-based when prioritizing patient care. From an American armchair we can relate to the surgeon's concerns—we have enough resources to make very different ethical decisions—but she draws us in and through her eyes we are led to experience pragmatism in resource allocation for this impoverished setting. This book is a tribute to the creativity and strength of character required to evaluate and treat too many patients with too few resources, where no matter what choices are made someone will not be treated.

The story moves along swiftly, embracing the reader. With clarity of thought and expression, Walsh captures both the horror and the grace of humanity in these unspeakable conditions without lapsing into sentimentality. Patricia Walsh's Vietnam is one of caring nurses and doctors who served the local civilians, women and children caught in the crossfire of a war over which they had no control. When asked how she could go there, Walsh replied, "How could I not?"

Even for those of us who do not typically trend towards this genre of writing, this book is an interesting and valuable read. Her tenure in Vietnam left her with more than just permanent physical injury. Walsh shares the lessons she learned from this profound experience and how they affected and molded the rest of her life. One is left with a renewed sense of appreciation for our abundant life, and our access to medical resources.

River City chronicles the dedication, self-sacrifice, trials and triumphs of practicing medicine in times of war. This book is a wonderful tribute to nursing. It gives a glimpse into what the human spirit can endure and overcome. It underscores the value of seeing each person as human regardless of race, color or creed. It is a testament that doing something, however imperfect, is infinitely better than doing nothing at all. River City is well worth reading.

# Forensic Nurse Wins Excellence Award

***Pictured Above, Left to Right—Anne Marie Manning and SANE Director Heather Farr***

The NHCADSV (NH Coalition Against Domestic & Sexual Violence) is pleased to announce that Anne Marie Manning has been chosen as the first recipient of the Jennifer Pierce-Weeks Award of Excellence. This honor is named for the founder of the SANE program in New Hampshire. It is given to a Sexual Assault Nurse Examiner (SANE) who exemplifies an outstanding commitment to quality, compassionate, patient-centered care for sexual assault victims.

Anne completed the very first NH SANE training offered through the Attorney General's office in 1996. Since that time Anne has performed nearly 80 examinations of sexually assaulted patients, has served on the SANE Advisory board, and continues to dedicate many long hours of her service as a SANE nurse. She has earned both the Adolescent/Adult and Pediatric SANE certifications through the International Association of Forensic Nurses. She is a respected and knowledgeable resource for both her peers and law enforcement. Anne's dedication to the SANE program and to her patients has had a profound impact on many lives. In all of her work, Anne exhibits a commitment to nursing excellence in the compassionate, patient-centered care she provides to victims of sexual assault.

Anne was presented her award at the Attorney General's Statewide Conference on Domestic and Sexual Violence and Stalking on May 14th.

# In Memory of Our Colleagues

## Variety of Careers

**Pauline L. (Kenney) Locke**, 77, May 22, 2009, at home surrounded by her family after a long battle with idiopathic pulmonary fibrosis. Born in Laconia, she was a graduate of the Laconia Hospital School of Nursing. As a registered nurse, she worked in medical and surgical nursing at Lakes Region General Hospital, in geriatric nursing at McKerley's Harris Hill Nursing Home in Penacook, as an assistant fundamentals instructor at Laconia Hospital School of Nursing and as an office nurse for Dr. Nathan Brody.

## College Health Nurse

**Janet Talbot (Whipple) Morrison**, 78, died May 30, 2009. A native of Goffstown, she attended nursing school in Vermont but later licensed in New Hampshire. Her nursing career was spent at New England College in Henniker where she practiced in the college health services. After retiring she was a volunteer visiting nurse, and help found the Henniker food pantry.

## Psychiatric Nurse

**Kathleen (Rokowski) Pelillo**, 65, died June 3, 2009. Born in Connecticut, she moved to New Hampshire to attend the New Hampshire Hospital School of Nursing. After graduation she worked as a psychiatric nurse at the Hospital for 37 years, retiring in 2004.

## Practiced in Long Term Care

*Constance Simonson*

**Constance Ray (Nicolini) Simonson**, 79, of Nashua, passed June 14, 2009. After graduating from the Carney Hospital School of Nursing in 1951 she practiced at Massachusetts General Hospital and Boston City Hospital. Moving to Nashua in 1964 and she had been employed as a nurse at the Greenbriar Terrace Nursing Home, Langdon Place and Fairview Nursing Home.

## School Nurse Leader

*Patricia Marsh-Thorell*

**Patricia I. Marsh-Thorell**, 69, died June 21 2009. A New York native she received her nursing diploma in Brooklyn and later a bachelors degree from New England College in Henniker. She practiced as a school nurse for the Timberland and Kearsage school districts before her retirement. Pat served as president of the New Hampshire School Nurses Association and was honored as their School Nurse of the year in 1995.

## Career Cut Short

*Marlene Sheehan*

**Marlene (Fogarty) Sheehan**, age 53, died June 28, 2009 at home following a long courageous battle with cancer. A Massachusetts native, she graduated from Shepard Gill School of Nursing at Mass General in 1977. She most recently worked as a nurse for Nashua Crossing.

## Concord Hospital Graduate

**Ethel G. Woodward**, 68, of Contoocook died July 15, 2009. She was a graduate of the Concord Hospital School of Nursing and received a bachelor's degree from New England College in Henniker. She practiced at Concord Hospital and also in Oakland, California.

## Pioneer ICU Nurse

*Kathleen McFarland*

**Kathleen Murphy McFarland**, 78, of Nashua, NH died July 13, 2009 after a brief illness. Kathleen was born in Inverness, Cape Breton Island, Nova Scotia and graduated as an RN from St. Martha's School of Nursing, Antigonish, NS in 1953. Her career in nursing began in Portland, Maine where she resided for seven years before moving to Nashua and joining the staff at Memorial Hospital, now Southern New Hampshire Medical Center. Kathleen was an integral part of Nashua's first Intensive Care Unit which opened in 1966 at Memorial. She later became a specialized Cardiac Care Nurse and eventually the Director of Nursing. Mrs. McFarland also taught cardiac care at the St. Joseph Hospital School of Nursing.

## Laconia Hospital Graduate

*Linda Shumsky*

**Linda L. Shumsky**, 62, of Nashua, passed away peacefully July 14, 2009. A graduate of the Laconia Hospital School of Nursing, her nursing career included various hospitals in Laconia, NH, Providence, RI and Boston, MA.

## Belated Acknowledgement

*Cathleen Werkowski*

**Cathleen Werkowski, 58**, of Londonderry, NH, died November 29, 2008 in the Parkland Medical Center in Derry, NH. Mrs. Werkowski was born in Hartford, CT and was a resident of Londonderry since the early 1980's. Mrs. Werkowski was a graduate of the NH Technical Institute RN program and worked most recently for Advantage Care Professionals in Londonderry.

# Kudos!

*Marcy Doyle*

Lamprey Health Care named **Marcy Doyle**, RN, MSN, MPH, with the Nashua Area Health Center, as Director of Clinical Quality. Recently, Doyle was recognized for her contribution to community health centers and medically underserved communities as a finalist for the 2009 National Geiger Gibson Emerging Leader Award. She is responsible for overseeing the electronic medical record system, as well as clinical systems analysis and process improvement. Additionally Doyle is leading the NCQA Medical Home Initiative project for Lamprey Health Care.

Ms. Doyle received a Bachelor of Science in microbiology in 1997 from the University of New Hampshire, and also attended the Johns Hopkins University School of Hygiene & Public Health, where she received a master's in health science and policy in 1999. In 2005, Doyle graduated from the accelerated Master of Nursing in Clinical Nurse Leadership program from the University of New Hampshire.

# NH Board of Nursing Ceases Newsletter

The New Hampshire Board of Nursing recently announced that it would cease the print version of its biannual newsletter distributed to every RN, LPN and LNA licensee in the state. Past Board newsletters have included actions taken by the Board against licensees and their infractions. In addition, practice advisories were also published. While the print newsletter was budget neutral as the Board contracted with a vendor for advertising sales, a recent audit report found that the activity had not been approved by the Governor and Council. Margaret Walker, Board Executive Director, noted that since 2007, the Board has been discussing the need to convert from a print to web-based communication tool. The Newsletter materials will be posted on the Board of Nursing website www.nh.gov/nursing

# Wound Care and Bariatric Team Recognized at Cheshire Medical

Over the past few years nursing leadership at Cheshire Medical Center in Keene reviewed data regarding the incidence of hospital-acquired pressure ulcers. In an effort to protect patients from negatively impact patient outcomes **Wound Care Committee** nurses Maureen Bergeron, Jane Bridges, Joan Brown, Kitty Doty, Chaele Ellsworth, Christy Jackson, Anita Lawrence, Rose Morgan, Mary Puls and Thomas Romard studied current practice, set goals and made a number of changes to policies and procedures. In addition, new pressure-relieving mattresses and beds were purchased which help in preventing pressure ulcers. The ongoing evaluation and data collection after implementation has revealed that the interventions have significantly decreased the number of hospital-acquired pressure ulcers experienced. In fact, for the past three months, there have been no occurrences. As a result, the Wound Care group received a Chairman's Award.

The **Bariatric Surgery Team** was also recognized. Over the past year, Dr. Donald Dupuis and Jean Lord, RN, Director of Outpatient Surgical Services, assembled a multidisciplinary Bariatric Surgery Team to develop the processes necessary to implement an Adjustable Laparoscopic Gastric Banding program, with a goal that this program would become a Center of Excellence. The program took its first steps in April 2008, when the team hosted community informational meetings. These presentations featured the program coordinator, a physician, a nutritionist, a behavioral health consultant and patients that had undergone laparoscopic banding surgery. During the first nine months, the program has conducted surgery on about 60 patients. Average age of patients is 45, and average weight loss so far is 26 pounds; many have reduced or eliminated medications for diabetes and cholesterol control.

# "Nurses Know We Need Health Care Reform…"

***Judith Evans, RN, M.Ed.***

Those words were spoken by President Barack Obama at the town hall meeting in Portsmouth, NH on August 11, 2009. And when the president spoke those words, followed by an affirmation of ANA's support of the health care reform platform, there was a resounding cheer that reverberated in the large, packed gymnasium. Two of us from the Franklin Pierce University nursing program were among those fortunate enough to attend this historical event. Living and working in Portsmouth, we were able to take advantage of two coveted tickets that ANA President Becky Patton had arranged to be held City Hall.

Attending this event is one of those life experiences that will not be easily forgotten. I had seen every presidential candidate in person during the last campaign, and attended house parties and rallies as I contemplated my presidential choice. But being at our elected President's Town Hall meeting, listening to his thoughtful analysis of health care issues and possible solutions to address the shortcomings of our current system was truly awe-inspiring.

One of the most enduring memories was trying to hear and understand the loud comments both pro and anti the health care reform platform. The long driveway leading into Portsmouth High School was lined with those who had come to present their views, either for or against. The left side of the driveway was lined with those who supported health care reform, the right side with those who were protesting the proposed changes, both sides many people deep. On the right were people with posters decorated with skulls and crossbones that read "No Death Panels." On the left were posters encouraging "Health Care Reform Now,"

including some held by our colleagues from the Massachusetts Nurses Association (MARN). People and groups on both sides of the driveway yelled loudly to get the attention of ticket holders who walked down the middle of the pavement in the presence of the local police. Both groups were equally passionate about their stance, and both sides yelled as loudly as they could to try to get the attention of ticket holders.

Inside the gymnasium, the atmosphere was much calmer. The President very thoughtfully and clearly discredited the many myths about reform that have been circulating far and wide, including myths about "death panels", complete government takeover of health care, and rationing health care, among others. Listening to his presentation, I was proud to be a nurse and to have so clearly affirmed that our contribution to the health of the nation is critical. There are many important roles for nurses in our health care of the future. The current reform proposal emphasizes health promotion and disease prevention–we know how to do that, and we're good at it. We know how to help clients and their loved ones approach end of life care. We know wasteful spending when we see it. The "take away" message of the day is that there is an essential role for nurses in the future of health care reform, and we must step up to the challenge.

# Wentworth Douglass Nurses in the News

***Nancy Correia***

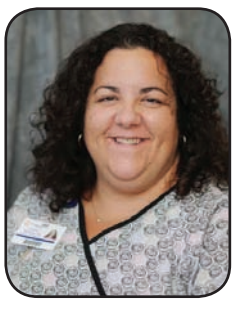
**Nancy Correia**, RN, BSN is the new Nurse Coordinator of the Walk-in Center at Walk-In Urgent Care in Lee, NH. Nancy started at WDH 20 years ago, practiced in the emergency department becoming a charge RN and preceptor, transferred into Cardiac Rehabilitation and recently was promoted to coordinator for Urgent Care.

**Karen Driscoll**, ED Patient Care Coordinator, has recently passed the certification exam for CEN (Certified Emergency Nurse) which is a nationally recognized credential in emergency nursing. The CEN credential represents a commitment of the individual nurse as well as the ED that supports CEN credentialing, to quality state of the art emergency care.

***Brian Flynn***

**Brian Flynn**, RN, CEN has been promoted to the position of Patient Care Coordinator in the Emergency Department. Brian joined the WDH ED staff in June 2007. He has assumed the trauma coordinator role as part of his overall responsibilities.

**Katie (Katherine) Furber**, RN, ED has finished her graduate work at UNH in the Family Nurse Practitioner program and has successfully passed the FNP certification exam. Katie is now eligible to practice as a certified family nurse practitioner.



***Stacey Savage***

**Stacey Savage**, RN, BSN, WDH Emergency Department Clinical Coordinator earned her BSN from the University of Southern Indiana in May. Stacey serves as a newly elected Board Member for NH Emergency Nurses Association and was selected to represent NH ENA at the General Assembly as a voting delegate in Baltimore, MD this October.

***Gail Wasiewski***

**Gail Wasiewski**, RN CEN on has been reappointed as Past President, NH State Emergency Nurses Association in 2009. Gail has served in many positions in NH State ENA including 2 terms of President and Past President. Gail is the EMS and Emergency Management Coordinator for WDH and an Instructor for Trauma Nurse Core Curriculum (TNCC). Gail will represent NH ENA at the General and Scientific Assemblies in Baltimore, MD in October.

***Congratulations to each of these nurses for their accomplishments and commitment to the profession!***

# Welcome New Members

Michelle Adamyk—Hollis, NH
Laurie Anderson—Nashua, NH
Kathy Ball—Nashua, NH
Anne P. Bartoloni—Rochester, NH
Margaret Burns—Bow, NH
Catherine Byrnes—Walpole, NH
Maribeth Gertrude Clark—Rindge, NH
Patricia Clements—Manchester, NH
Susan Coakley—Merrimack, NH
Cynthia Darois—Nashua, NH
Kristina DeBruin—Merrimack, NH
Jane Dillon—Concord, NH
Priscilla Dodge—Pittsburg, NH
Jennifer Anne Dolan—Kearsarge, NH
Kristina Dunn—Loudon, NH
Linda Eaton—Northfield, NH
Denise Fregault—Amherst, NH
Vicki George—Plainfield, NH
Julie Gilston—Greenland, NH
Barbara Goyette—Hudson, NH
Christine Hamill—Chester, NH
Janice Hayes—Gilford, NH
Julia Jason—Franklin, NH
Cathy Johnson—Lyme, NH
Kathryn Johnson—Rindge, NH
Osman Kaynak—Contoocook, NH
Lisa Lang—Londonderry, NH
Dawn LaPorte—Derry, NH
Theresa Levine—Nashua, NH
Rachel MacCormack—Londonderry, NH
Laura Madden—Walpole, NH
Kathleen Martin—Nashua, NH
Cynthia McKenzie—Concord, NH
Ann Moser—Mason, NH
Erin Monahan—Goffstown, NH
Pat Moysenko—Chelmsford, MA
Joanne Nabarowsky—Berlin, NH
Jessica Emmy Nelson—Sandown, NH
Karin O'Donnell—Nashua, NH
Donna Pare—Stratham, NH
Debra Peterson—Nashua, NH
Esmeralda Roxo—Bedford, NH
Patricia B. Savo—Mt Vernon, NH
Mary Scott—Amherst, NH
Tracy Solano—Derry, NH
Stacy Swanson—Milford, NH
Nikki Toli—Goffstown, NH
Christina Tourville—Manchester, NH
Julie Tuttle—Mason, NH
Joanna Vallie—Nashua, NH
Diane Veprauskas—New Ipswich, NH
Cindy Viveiros—Nashua, NH
Jacqueline Figueroa Webb—New London, NH
Tanya Wilkie—Sunapee, NH
Marie York—Pembroke, NH

# VOICE & VISIBILITY

## *Add your voice to Our Voice! Join NHNA Today*

Check One ☑

**MEMBERSHIP**

☐ **NHNA Membership $125/yr or [ ] $10.92/mo** (State only - no ANA benefits or voting rights)

☐ **ANA Membership $171/yr** (Membership in ANA only - no NHNA voting rights or ability to hold office)

**DUAL ANA & NHNA MEMBERSHIP** (Full benefits and privileges of both organizations)

☐ **Full Membership $249/yr or [ ] $21.25/mo** (RNs only - employed full or part time)

☐ **Reduced Membership $124.50/yr** (Nursing Students, New Graduates, or RN's not employed)

☐ **Special Membership $62.25/yr** (Retired or Disabled RN's)

**NHNA ASSOCIATE MEMBERSHIP** (Non-voting status with limited benefits)

☐ **Associate Membership $45.00/yr** (LPN, LNAs, healthcare professionals, and friends of nursing)

☐ **Student Associate Membership $25.00/yr** (Nursing Students who are also a members of NHSNA #_____ )

**NHNA Membership Application** **[ ] New [ ] Renewal Date:____/____/____**

| | | | |
|---|---|---|---|
| Last Name | First Name | Middle Initial | REFERRED BY: |
| RN License Number & State | Credentials (RN, BSN, Etc) | Years in Nursing | Field of Nursing |
| Basic School of Nursing | | Graduation Date | Birth Date |
| Home Address | | | |
| City | State | Zip | Home Phone |
| Employer Name | | Job Title | Department |
| Work Address | | | |
| City | State | Zip | Work Phone |
| Home E-mail Address | Work E-mail Address | | Work Fax |

[ ] **Check enclosed for $_____ payable to the New Hampshire Nurses' Association**
[ ] Authorization for monthly **checking account deduction** of $_____ (Attach first month's payment plus voided check.)
[ ] **Charge to:** ___MasterCard ___ Visa #_____ EXP___/___ Sec Code ____
By signing this Monthly Electronic Payment Authorization, you are authorizing ANA to either charge the credit card indicated or deduct the monthly payment from your checking account as designated above.
[ ] **Automated Annual Renewal:** authorizes the automatic continuation of this Electronic Payment Authorization until cancelled by written notification of termination - thirty (30) days prior to scheduled renewal.
Name on account if different from application:_____Signature_____

**MAIL APPLICATION TO: ANA Customer and Member Billing PO Box 504345 St. Louis, MO 63150-4345**
**Keep a copy for your own records. Call the NHNA office with any questions: 603-225-3783**

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