The NDNA recently updated its website. Feedback over the last year provided guidance in the redesign. News and announcements will be found on the home page. An easy to use calendar of events has been added. Members may electronically submit info to be posted to the calendar. Once it is edited for length and necessary contact info it will be added to the calendar. Much like many community bulletin board websites now use.

An easy to use calendar of events has been added. Members may electronically submit info to be posted to the calendar. Once it is edited for length and necessary contact info it will be added to the calendar. Much like many community bulletin board websites now use.

Members can search the professional literature from their home? Also, check out the updated NDNA web site can search the professional literature from your home? Also, check out the updated NDNA web site.

Check out our new website! www.ndna.org

As this issue of the Prairie Rose goes to press it will be the beginning of a new year. January is a time for celebrating the New Year and making New Year’s resolutions. Resolutions are personal goals that come in all shapes and sizes. This year, I would like to challenge you to do something a little more difficult—resolve to promote your profession and become a more active participant in NDNA.

First, stay informed about nursing. Know what your professional association is doing for you. Check out the ANA web site http://www.nursingworld.org see what ANA is doing for you. Did you know that as a member of NDNA you have access to CENHAL, a nursing database where you can search the professional literature from your home? Also, check out the updated NDNA web site http://www.ndna.org. Maybe your resolution is as simple as visiting NDNA web site and commenting on a discussion thread.

Second, could you offer your services to NDNA as an expert? Consider becoming a CNE-Net reviewer. This would involve reviewing applications for nursing contact hours.

Third, would you like to write an article for the Prairie Rose? This is an opportunity to be published, to share your wisdom with others.

Fourth, does your district or region need committee members or officer? Every nurse has a talent that can benefit the profession. Maybe your resolution is as simple as attending one district/ state activity this year.

Fifth, make it a point to take a new graduate nurse under your wing. Support and encouragement from an experienced colleague can make the difference in professional development and workplace satisfaction.

If you are thinking of making any resolutions related to your own wellness, check out the Center for American Nurses Web site http://www.centerforamericannurses.org. As a member of NDNA you are also a member of the Center. If you do not know how to access the members’ only section call the NDNA office. I encourage you to

(Continued to page 3)

The “Ideal” Nurse Work Environment Project

Page 13

The Ideal Nurse Work Environment Project

Prairie Rose goes to press on a discussion thread.

It is our hope this website becomes the place to check for issues related to nursing in North Dakota.

I would like to challenge you to do something a little more difficult—resolve to promote your profession and become a more active participant in NDNA.

Check out our new website! www.ndna.org

As this issue of the Prairie Rose goes to press it will be the beginning of a new year. January is a time for celebrating the New Year and making New Year’s resolutions. Resolutions are personal goals that come in all shapes and sizes. This year, I would like to challenge you to do something a little more difficult—resolve to promote your profession and become a more active participant in NDNA.

First, stay informed about nursing. Know what your professional association is doing for you. Check out the ANA web site http://www.nursingworld.org see what ANA is doing for you. Did you know that as a member of NDNA you have access to CENHAL, a nursing database where you can search the professional literature from your home? Also, check out the updated NDNA web site http://www.ndna.org. Maybe your resolution is as simple as visiting NDNA web site and commenting on a discussion thread.

Second, could you offer your services to NDNA as an expert? Consider becoming a CNE-Net reviewer. This would involve reviewing applications for nursing contact hours.

Third, would you like to write an article for the Prairie Rose? This is an opportunity to be published, to share your wisdom with others.

Fourth, does your district or region need committee members or officer? Every nurse has a talent that can benefit the profession. Maybe your resolution is as simple as attending one district/ state activity this year.

Fifth, make it a point to take a new graduate nurse under your wing. Support and encouragement from an experienced colleague can make the difference in professional development and workplace satisfaction.

If you are thinking of making any resolutions related to your own wellness, check out the Center for American Nurses Web site http://www.centerforamericannurses.org. As a member of NDNA you are also a member of the Center. If you do not know how to access the members’ only section call the NDNA office. I encourage you to

(Continued to page 3)
Submitted by Wanda Rose, President NDNA.

In early November, I had the opportunity to travel to Silver Spring, MD with Jane Roggensack, RN, MSN immediate past-president to attend meetings of the Center for American Nurses and the ANA Constituent Assembly. This was my first time attending the Constituent Assembly as your president. It was quite an event to visit with nursing leaders from across the nation. During the meeting each constituent member association (CMA) had an opportunity to share what was happening in their state. Like us, many are struggling with membership numbers. Yet, state nursing associations remain the recognized voice of nursing and healthcare reform. What this means is others contact the nursing associations when seeking input on topics related to healthcare. Nurses need to add their voice to the state associations as numbers along with well thought out initiatives are critical to advancing the profession.

We heard from President Rebecca Patton, stating, “It’s about airlines, it’s about dialogue and it’s about progress.” She continued by affirming “we need to take the instructions seriously that airline attendants give before takeoff. Place the oxygen on yourself first, and then place the oxygen on others.” These instructions are a reminder that we need to take care of ourselves first before we can take care of anyone else. She went on to describe the need for state nurses to care for themselves and to be careful of drug costs, and achieving healthcare access for all Americans. To learn more about “Nursing’s Agenda for Health Care Reform” visit members only at http://www.nursingworld.org. ANA is also taking a leadership role in patient safety by supporting safe staffing legislation.

We heard an update on the National Database of Nursing Quality Indicators (NDNQI). The indicators explore and identify linkages between nursing care and patient outcomes. ANA investment in the database continues and ANA continues to develop ancillary contracts to enrich the NDNQI program. For more information on NDNQI visit the NDNQI web site http://www.nursingquality.org.

Other topics discussed include adding a President–Elect position. Members discussed the pros and cons. The pros included continuity of leadership. The con included time commitment. Another topic was membership categories. Should individuals have a choice of direct membership to ANA only, direct membership to the constituent member association (CMA) only or a joint membership to ANA/CMA? Discussion to include LPNs as members of ANA was also initiated. Another issue was to add a “new graduate position” to the Board of Directors. These issues will be discussed again during the House of Delegates assembly in June.

I came away from those meetings impressed with ANAs role in efforts to improve patient safety, the workplace environment, and to promote health care reform. Nurses are encouraged to contact me with thoughts and opinions on these and other issues important to nurses in ND.

Wanda Rose at wrose@mhos.org

The Prairie Rose Official Publication of North Dakota Nurses Association
531 Airport Road, Suite D, Bismarck, ND 58504-6107
Telephone: (701) 223-1385
CNX-Net: (701) 223-7105
Office Hours: 8:30–4:30 (cst)

EDITOR: Becky Graner

OFFICERS

PRESIDENT
Wanda Rose
NDNA District #6
Bismarck, ND
wrose@mhos.org

VICE PRESIDENT
Jane Roggensack
NDNA District #4
Fargo, ND
jroggen@meritcare.com

SECRETARY/TREASURER
Mary Ann Rose
NDNA District #6
Bismarck, ND
greenlady10@bis.midco.net

BOARD OF DIRECTORS

Chair Government Relations
Joe Myers
NDNA District #3
Grand Forks, ND
university.ofmtaxx.org

SR Region Representative
Robert Young
NDNA District #4
Fargo, ND
ryyoung@meritcare.com

SR Region Representative
Mary Ann Rose
NDNA District #6
Bismarck, ND
greenlady10@bis.midco.net

SW Region Representative
Karen Macdonald
NDNA District #6
Bismarck, ND
kmac@btinet.net

Nursing Education Council
Marylin Schwartzbauer
NDNA District #4
Bismarck, ND
marylin@mhos.org

Nursing Research Council
Evelyn Quigley
NDNA District #4
Fargo, ND
evquigley@meritcare.com

NDNA STAFF

Interim Executive Director
Franklin Adams
franklin@ndna.org

Administrator
Kathy Seidel
kseidel@primecare.org

Administrative Secretary
Jennifer Hardison
jenhardison@ndna.org

Offices

Bismarck, ND
Fargo, ND

Published quarterly: February, May, August and November.
Copy due four weeks prior to month of publication.

Advertising Rates Contact—Arthur L. Davis Agency, 517 Washington Street, P.O. Box 216, Cedar Falls, Iowa 50613, 800-626-4001. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Articles appearing in this publication express the opinions of the authors, they do not necessarily reflect the views of the editors, staff, board or membership of NDNA, or those of the national or district associations. Acceptance of advertising does not imply endorsement of approval by NDNA of the items advertised, the advertisers, or the claims made. NDNA and the Arthur L. Davis Publishing Agency reserve the right to reject advertising without giving reasons. The NDNA and the Arthur L. Davis Publishing Agency, Inc. shall not be liable for any consequences resulting from purchase or use of advertisers’ products from the advertisers’ opinions, expressed or reported, or the claims made herein.

Writing for Publication in the Prairie Rose

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

Articles submitted for continuing education need a purpose, objectives, and a post-test. You may request the necessary contact hour forms from Becky at becky@ndna.org.

Articles are peer reviewed and edited by the staff and RN members of NDNA.

Nurses are strongly encouraged to contribute to the profession by publishing evidence based articles. If you have an idea, but don’t know how or where to start, contact the office of NDNA: 701-223-1385.

The Prairie Rose is one communication vehicle for nurses in North Dakota. Raise your voice.
take advantage of this membership benefit. At the site, you will find resources you need to be an empowered nurse self-advocate. A new feature is *Ask Amanda, RN*, a collaborative online forum to provide resources for nurses faced with challenges in their work environments. In addition, you will find a wonderful section on personal wellness and financial literacy which provides information in planning your career and assists one to age health—“fully.”

If you are not a member of NDNA maybe your resolution is to join ANA/NDNA. Membership can be completed online at [http://nursingworld.org/memapp/](http://nursingworld.org/memapp/)

My resolution as your president is to be open to the possibilities and opportunities this New Year will bring and to listen carefully to what nurses have to say. We are the owners of our profession! There are certain to be surprises and unforeseen opportunities during the year. However, I have learned that nurses working together are creative and have a passion to make the world a better place. All of you energize me and I wish for you the very best in 2008.

Wanda Rose PhD, RN, BC
The sad irony of reorganizations

Communities of Practice (CoPs) are a powerful enabler of productivity and innovation. Voluntary, non-mandated relationships are created by people engaged in similar work. Staff form these relationships to get things done, not at what they do. From these self-created networks, new practices and knowledge emerge and often develop into the core competencies of the organization. These skills develop not through training or performance reviews, but because people find each other and form good relationships. In those relationships, just as with elementary particles, potential manifest and new capabilities are born.

Reorganizations always create a host of unintended consequences because leaders either ignore or are blind to these and other networks. Even sub-atomic particles do not exist alone. One physicist described neutrons, electrons, etc. as “...a set of relationships that reach outward to other things.” Although physicists still name them as separate, these particles aren’t ever visible until they’re in relationship with other particles.

Everything in the Universe is composed of these “bundles of potentiality” that only manifest their potential in relationship.

We live in a culture that does not acknowledge this scientific fact. We believe wholeheartedly in the individual and build organizations based on this erroneous idea. We create org charts of separate boxes, with lines connecting the boxes that indicate reporting relationships and alleged channels of communication. But our newly drawn organizations are as fictitious as building blocks are to physicists. The only form of organization used on this planet is the network—webs of interconnected, interdependent relationships. This is true for human organizations as well. Whatever boxes we stuff staff into, people always reach out to those who will give them information, be their allies, offer support or cheer them up. Those lines and boxes are imaginary. The real organization is always a dense network of relationships.

The scientific search for the basic building blocks of life has revealed a startling fact: there are none. The deeper that physicists peer into the nature of reality, the only thing they find is relationships. Even sub-atomic particles do not exist alone. Why do we imagine our work flows, job descriptions and project deadlines, work as if they were separate? It’s a failing that organizations are a consequence of not seeing the networks that staff weave together. How are you taking advantage of the capabilities that develop from good relationships? Have you experienced times when people came together and surprised you with new competencies that didn’t exist before they came together?

A simple means to support and develop relationships is to create time to think together as staff. Time to think together has disappeared in most organizations. This loss has devastated relationships and led to increasing distrust and disengagement. Yet when a regular forum exists where staff can share their work challenges, everything improves. People learn from each other, find support, create solutions, and gradually discover and use a whole new set of relationships. This is no surprise. We’re all “bundles of potentiality” that only manifest in relationship.

What even money can’t buy

Since we’re not machines, who are we? In my own work in many different cultures, I’ve discovered that we’re a wonderful species. There are common human yearnings: We want to be together; we want to contribute to our community; we want children to be healthy and have better lives. These desires are inherent, they do not require external motivators. But sadly, in this time of fractured relationships and human horrors, it’s difficult to see these traits. However, these positive traits are absolutely necessary if we’re to work well together. If we fail to them, or provoke other behaviors with external rewards, we’ll continue to struggle to motivate employees, worker disengagement (now at historic highs) will continue to escalate, and we’ll become more cynical and disgusted with each other.

These basic human qualities are evident every time there’s a disaster. While official agencies and government struggle to get their act together, neighbors and strangers rush in to provide assistance and comfort. In moments of tragedy and loss, human kindness is our normal response. We may not even know how to find out one another. Is it possible that such powerful relationships are available at work? (I had a client who, after experiencing the Oklahoma City bombing, asked: “Why are we at our best in the worst of times, and at our worst in the best of conditions?”)

Human kindness manifests only in relationship. Archbishop Tutu says: “We can be human only together.” If we’re to evoke kindness, intelligence, accountability and learning in our organizations, we need to promote healthy relationships. So much of what we do as leaders, even actions that are well-intentioned, work to disrupt relationships. Here’s a story I’ve seen played out many times. A boss decides to reward individual staff for their contributions by giving generous bonuses or pay raises. Yet the employees reject these because they’re aware of how individual rewards will impact their relationships with colleagues. I’ve even seen this play out to the extent that employees who really needed the money. The most startling example I witnessed was in England, where a leader decided to reward outstanding ideas with up to $250,000 bonuses. Few months later he asked his employees how they would have used the money. Most of them had asked him to disband the program because it was interfering with their relationships. When he recovered from his shock, he asked them what they wanted instead of the money. They asked for simple things—a thank you, a night at the pub, a box of chocolates.

The leader’s work: Reweaving relationships

I picture you reading this shaking your head in disbelief, or quickly noting how this could never apply to you. You are not alone. I’ve seen this response often enough to realize that employees are far more sensitive to their relationships at work than leaders are. In survey after survey of what people value about their jobs, good relationships with colleagues are always one of the top three motivations. (Pay and money are far down the list. Other top motivators are the ability to learn, and the ability to contribute.)

As leaders, it’s important to notice where you reward individual performance, or use competition to drive results, or remain blind to or interfere with the networks that staff weave together. How are you taking advantage of the capabilities that develop from good relationships? Have you experienced times when people came together and surprised you with new competencies that didn’t exist before they came together?

The leader’s work: Reweaving relationships is to create time to think together as staff. Time to think together has disappeared in most organizations. This loss has devastated relationships and led to increasing distrust and disengagement. Yet when a regular forum exists where staff can share their work challenges, people always reach out to those who will give them information, be their allies, offer support or cheer them up. Those lines and boxes are imaginary. The real organization is always a dense network of relationships.
The Leadership Team of the NDNA Nursing Research Council had its organizational meeting on December 6, 2007 via telephone conference and began to set direction for the Council’s 2008 work. We would like to introduce you to the Council Leadership Team and encourage you to contact us to give input to the Council work as well as to request updates on progress toward goal achievement. The members and the positions they represent and their term of Office are as follows:

Nurse Administrator Position—Evelyn Quigley, ev.quigley@meritcare.com Term: 2006-08

Staff Nurse Position—Dawn Fredrich, godzhws@min.midco.net Term: 2007-09

Nurse Educator Position—Cindy Anderson, cindyanderson@mail.und.nodak.edu Term: 2007-09

APRN Position—Karen Rohr, krohr@mohs.org Term: 2006–2008

Evelyn is serving her second term on the Council and Karen Rohr will be completing her first term in 2008. Cindy and Dawn are both starting their first term on the Council.

Officers were appointed and are as follows:

Chairperson: Evelyn Quigley will fulfill this position and will also then represent the Council on the NDNA Board of Directors in 2008

Secretary: Cindy Anderson will fulfill this position.

Karen Rohr and Dawn Fredrich will be focusing on Membership to the Council which includes updating the Nursing Research Council list and coordinating with the NDNA Office to welcome new members to the Council.

We want to thank Paulette Estvold and Jane Giedt for their leadership to the Council. Both completed two terms of service. Paulette served as Secretary and Jane as Chair during her first term. We invite their continued support and counsel.

The Leadership Team has scheduled its next telephone conference call on January 17 at 8:00AM. Let us know if there is anything you would want us to discuss or incorporate into the goals for the next year. We will continue to publish articles in the Prairie Rose and would invite Council members to volunteer articles to be published. The next publication will occur April 1, 2008. Other goals that we will develop more completely are: Research nursing fatigue, working with the Government Relations Committee on Needle Safety, assisting the NDNA Board of Directors in the reorganization structure of NDNA and increasing membership participation.

Season Holiday wishes to you all. We look forward to working with you in 2008.

Power Nap: Why Sleeping On The Job Boosts Safety

Hospital Employee Health (11/07)

Hospitals across the country, especially VA hospitals, are implementing a new program designed to combat the effects of fatigue on medical workers. Studies show fatigue can impair the performance of nurses in the middle of long shifts, with the effects of being awake for 17 straight hours equal to drinking two alcoholic beverages. The Institute of Medicine recommended limitations on shift length, but VA hospitals have taken a different approach, encouraging healthcare workers to sleep for short periods of time during extended shifts or overnight shifts. The Strategic Nap Program stemmed from a test showed the benefits of taking short naps in the middle of a long, overnight shift. A group of medical professionals who took a 40-minute nap performed better at the end of their shift, showing faster reaction times than those who did not take a nap. Sleep experts say naps should be between 15 minutes and 40 minutes long to avoid grogginess, and these napping programs should become part of an overall safety culture at healthcare facilities. Hospitals implementing the program do not need to bring in any additional staff because the naps take place during scheduled breaks, and most hospitals already have areas suitable and available for staff naps. The pilot program run in the VA Palo Alto Health Care System showed employees working the overnight shift were more likely to take part in the voluntary program. Although officials acknowledge it will be difficult to change preexisting attitudes, with a recent survey showing that over 25 percent of nurses suffer from insomnia, facilities and managers helping workers to organize their schedules will see hikes in productivity and improvements in safety. The Strategic Nap Program could cause the medical community to rethink the ways in which they combat fatigue.

Jo Ann K. Webb, RN, MHA
Senior Director, Federal Relations and Policy
American Organization of Nurse Executives
jwebb@aha.org
202 626-2321

✱ NDNA Nursing Research Council ✱
**6th Annual Northwest Region North Dakota Collaborative Educational Conference**

**“To Die with Dignity: Comfort Care at the End-of-Life”**

April 4, 2008
8:00am – 4:00 pm
Holiday Inn, Minot

Co-Sponsored by:
Northwest Region, NDNA
Omicron Tau, STTI Honor Society of Nursing
Roughrider Chapter, AACN

**Presenters**

**Roberta Young, BSN, RN**
Patient Care Manager, Oncology and Palliative Care Units; MeritCare Health System, Fargo, ND

**Sherry Leslie, BSN, RN**
Retired Hospice Coordinator for Trinity Hospitals; Minot, ND

**Sue Thomas BSW, LSW**
Aftercare Coordinator, Thomas Family Funeral Home; Minot, ND

**Carol Mohagen, BSW, LSW**
Social Worker, Trinity Hospitals Home Health and Hospice; Minot, ND

**Rhoda Owens, MSN, RN**
Home Health/Hospice Coordinator; Trinity Hospitals, Minot, ND

**Jerilyn Alexander, BSN, RN**
Staff Nurse in Intensive Care Unit, NorthStar Criticair Flight Nurse; Trinity Health, Minot, ND

**Jeffrey Verhey, MD**
Home Health/Hospice Medical Director, ICU Medical Director; Trinity Health, Minot, ND

---

**Agenda**

7:30am–8:00am  
Registration

8:00am–8:15am  
Introduction

8:15am–9:45am  
“Palliative Care: The Art, The Science, The Stories”
  
Roberta Young, BSN, RN

9:45am–10:00am  
Break

10:00am–12:00pm  
“Pain and Symptom Management at End-of-Life”
  
Sherry Leslie, BSN, RN

12:00pm–1:00pm  
Lunch and Vendors

1:00pm–1:45pm  
“Lighting the Way”
  
Sue Thomas BSW, LSW
  Carol Mohagen BSW, LSW

1:45pm–2:30pm  
“Hospice Care: Why and When is it Necessary?”
  
Rhoda Owens MSN, RN

2:30pm–2:45pm  
Break

2:45pm–3:45pm  
“Transition from Cure to Comfort”
  
Jeffrey Verhey MD
  Jerilyn Alexander BSN, RN

3:45pm–4:00pm  
Evaluations

---

The purpose of this conference is to familiarize participants with evidence-based quality end-of-life care measures to meet the physical, psychological, spiritual and bereavement needs of patients and their families.

Application for contact hours has been made to CNE-Net, the education division of the North Dakota Nurses Association, an accredited approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Please call Mary Smith at 701-858-3251 for more information about contact hours. Application has been made for 6.25 contact hours.

**Conference Objectives:**

1. Discuss the concept, art, and philosophy of Palliative Care.
2. Identify best practices for pain and symptom management for use during end-of-life patient care.
3. Discuss the Hospice concept, philosophy, and benefits.
4. Identify the grief road blocks of listening, grieving at one's own pace and feeling the emotional roller coaster.
5. Discuss concerns that arise from both a physician and a nursing perspective when making end-of-life decisions in the ICU.
EDUCATIONAL ACTIVITIES CORNER

Educational Activities approved by CNE-Net Oct. to Dec. 2007

A1.938  Upper Plains Cardiopulmonary Rehabilitation Association (UPCRA) 2007 Fall Meeting  UPCA  5.25
A1.939  Improving Parkinson's Care: The TULIPS Model  Struthers Parkinson Center  1.00
A1.940  Managing Diabetes During Challenging Gimes: Diabetes 2007  Mount Rushmore Chapter Diabetes Educators  8.25
A1.941  Recognizing the Specialty of Medical Surgical Nursing  Genesis Health System  7.50
A1.942  Changes in Lifestyle: One Step At A Time  Rho Xi Nursing Honor Society  1.00
A1.943  The Nuts & Bolts of Clinical Pharmacology  Mount Marty College of Nursing Program  5.75
A1.945  Victim-Centered Care for the Sexual Assault Patient  Avera Center for Public Policy  5.75
A1.946  Retina Update  Dakota Eye Institute-Dakota Surgery/Laser Center  3.00
A1.947  Nuclear Medicine & Cardiac Imaging Overview  Center for Diagnostic Imaging
A2.50  Bioemergencies Core Concepts  BORDERs Alert & Ready  2.00
A1.948  Leadership Training-The New Path to Leadership  Northland Healthcare Alliance
A1.949  Avera Nursing Leadership Development Series. Session 2: Navigating with Wisdom and Heart  Avera Health  5.0
A2.51  Nuclear & Radiological Emergencies Core Concepts  BORDERs Alert & Ready  1.05
A2.52  Basic Parish Nurse Preparation Course  Department of Nursing, Dakota Wesleyan University
A1.950  Health Care Literacy  Minnesota West Community & Technical College

CNE-Net regrets there is not always enough lead-time for nurses to be informed of all the CE activities through this newspaper.

APPROVED PROVIDERS OF CONTINUING EDUCATION

The following is a list of CE activities offered by CNE-Net.

Call 701-223-7105 for more information.

<table>
<thead>
<tr>
<th>#</th>
<th>FACILITY</th>
<th>CITY</th>
<th>STATE</th>
<th>EXPIRES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR 43</td>
<td>Sanford School of Medicine</td>
<td>Sioux Falls</td>
<td>SD</td>
<td>05-17-10</td>
</tr>
<tr>
<td>AR 45</td>
<td>West River Regional Medical Center</td>
<td>Hettinger</td>
<td>ND</td>
<td>06-08-10</td>
</tr>
<tr>
<td>AR 46</td>
<td>St. Alexius Medical Center</td>
<td>Bismarck</td>
<td>ND</td>
<td>06-13-10</td>
</tr>
<tr>
<td>AR 47</td>
<td>Memorial Hospital-Sweetwater</td>
<td>Rock Springs</td>
<td>WY</td>
<td>08-01-09</td>
</tr>
<tr>
<td>AR 48</td>
<td>Medcenter One Health Systems</td>
<td>Bismarck</td>
<td>ND</td>
<td>08-20-10</td>
</tr>
<tr>
<td>AR 50</td>
<td>Rapid City Regional Hospital</td>
<td>Rapid City</td>
<td>SD</td>
<td>12-02-10</td>
</tr>
<tr>
<td>AR 51</td>
<td>Avera McKennan Hospital</td>
<td>Sioux Falls</td>
<td>SD</td>
<td>pending</td>
</tr>
<tr>
<td>AR 52</td>
<td>ND Dept of Health-Preventive Health</td>
<td>Bismarck</td>
<td>ND</td>
<td>01-24-09</td>
</tr>
<tr>
<td>AR 53</td>
<td>Evangelical Lutheran Good Samaritan</td>
<td>Sioux Falls</td>
<td>SD</td>
<td>01-12-09</td>
</tr>
<tr>
<td>AR 54</td>
<td>St. John’s Hospital</td>
<td>Jackson</td>
<td>WY</td>
<td>04-21-09</td>
</tr>
<tr>
<td>AR 56</td>
<td>Avera Education &amp; Staffing Solutions</td>
<td>Yankton</td>
<td>SD</td>
<td>03-31-09</td>
</tr>
<tr>
<td>AR 58</td>
<td>Center for Learning &amp; Innovation (Sioux Valley)</td>
<td>Sioux Falls</td>
<td>SD</td>
<td>06-29-09</td>
</tr>
<tr>
<td>AR 59</td>
<td>SD Nurses Association</td>
<td>Sioux Falls</td>
<td>SD</td>
<td>07-31-09</td>
</tr>
<tr>
<td>AR 61</td>
<td>Altru Health Systems</td>
<td>Grand Forks</td>
<td>ND</td>
<td>06-07-08</td>
</tr>
<tr>
<td>AR 63</td>
<td>Ivinson Memorial Hospital</td>
<td>Laramie</td>
<td>WY</td>
<td>06-12-10</td>
</tr>
<tr>
<td>AR 64</td>
<td>MeritCare Health System</td>
<td>Fargo</td>
<td>ND</td>
<td>10-17-10</td>
</tr>
<tr>
<td>AR 65</td>
<td>Health Education Development System</td>
<td>Fort Meade</td>
<td>SD</td>
<td>05-19-09</td>
</tr>
<tr>
<td>AR 66</td>
<td>Heart Hospital of SD</td>
<td>Sioux Falls</td>
<td>SD</td>
<td>10-18-09</td>
</tr>
<tr>
<td>AR 68</td>
<td>Avera St. Luke’s Hospital</td>
<td>Aberdeen</td>
<td>SD</td>
<td>02-02-10</td>
</tr>
<tr>
<td>AR 69</td>
<td>Trinity Health</td>
<td>Minot</td>
<td>ND</td>
<td>01-19-10</td>
</tr>
<tr>
<td>AR 71</td>
<td>ND Long Term Care Association</td>
<td>Bismarck</td>
<td>ND</td>
<td>04-07-09</td>
</tr>
<tr>
<td>AR 72</td>
<td>Virginia Regional Medical Center</td>
<td>Virginia</td>
<td>MN</td>
<td>5-15-10</td>
</tr>
<tr>
<td>AR 73</td>
<td>Southwest Health Care</td>
<td>Bowman</td>
<td>ND</td>
<td>03-04-10</td>
</tr>
<tr>
<td>AR 74</td>
<td>Innovis Health</td>
<td>Fargo</td>
<td>ND</td>
<td>10-22-10</td>
</tr>
<tr>
<td>AR 75</td>
<td>Presentation Medical Center</td>
<td>Rolla</td>
<td>ND</td>
<td>12-01-10</td>
</tr>
<tr>
<td>AR 76</td>
<td>Minnesota State Community College</td>
<td>Moorhead</td>
<td>MN</td>
<td>01-04-08</td>
</tr>
<tr>
<td>AR 77</td>
<td>Hospice of the Red River Valley</td>
<td>Fargo</td>
<td>ND</td>
<td>02-01-08</td>
</tr>
<tr>
<td>AR 78</td>
<td>Sakakawea Medical Center</td>
<td>Hazen</td>
<td>ND</td>
<td>06-20-08</td>
</tr>
<tr>
<td>AR 79</td>
<td>State of Wyoming, Dept of Health</td>
<td>Cheyenne</td>
<td>WY</td>
<td>05-19-09</td>
</tr>
<tr>
<td>AR 80</td>
<td>NE Workforce Training Lake Region College</td>
<td>Devils Lake</td>
<td>ND</td>
<td>06-09-09</td>
</tr>
</tbody>
</table>

Call 701-223-7105 for more information.

Activity Title                                     Contact Hours

12th Annual Pharmacology Seminar Oct. 10 & 11, 2008 Bismarck              TBA
NDNA Annual Business Meeting Oct. 17, 2008
ONGOING CE ACTIVITIES

RN Refresher Course  240
LPN Refresher Course  192
LPN IV Therapy Course  48
Medication Administration  52.8
Fistula Management

Fistulas

“A fistula is an abnormal passage between the lumen of a hollow viscous organ and another hollow organ or the skin.” (Pontieri-Lewis, 2005, p. 68). The Enterocutaneous Fistula is an abnormal connection between the intestine and skin (Colwell et al., 2004).

Etiology

Enterocutaneous Fistulas can occur for a number of reasons. Fistulas can occur postoperatively from a breakdown at an intestinal anastomosis, from excessive tension on the anastomosis or a foreign body close to the suture line. Other factors involving emergent and or urgent surgical procedures such as an unprepped bowel, underresucitation, or previously radiated tissue can cause fistula development (Kozell & Martins, 2003). Predisposing factors to the development of an ECF are malignant tissue, Crohn’s disease, small bowel obstruction, infection, steroid therapy, metabolic and endocrine disorders, and a compromised body close to the suture line. Other factors involving emergent and or urgent surgical procedures such as an unprepped bowel, underresucitation, or previously radiated tissue can cause fistula development (Kozell & Martins, 2003).

Excess fluid through the wound is often the first sign there is a fistula. Low output is directly related to the large bowel while high output is directly related to the small bowel (Colwell & Knaggs, 2003). In describing output from a fistula; output can be watery–originating from the gastric area. Bile output is from the gastric, biliary and duodenum. Yellow/orange output color indicates origin from the small bowel. Colorless output is from the Pancreas. Brown/fecal output is from the large bowel (Kozell & Martins, 2003). Patients commonly develop fever, localized erythema, induration, and progressive local discomfort. Electrolyte imbalance, such as low potassium, and alterations in mental status are frequently present.

Type of Fistulas

An Enterocolonic Fistula occurs from the intestine to the colon. An Enterocutaneous Fistula occurs from the intestine to the skin. An Enterovesical Fistula occurs from the intestine to the bladder. An Enterovaginal Fistula occurs from the intestine to the vagina. A Vesicocutaneous Fistula occurs from the bladder to the skin. A Vesicovaginal Fistula occurs from the bladder to the vagina (Pontieri-Lewis, 2005). Photo of the Gastrointestinal system from www.healthline.com.

Medical Management and Treatment

The goal of medical management is to hopefully close the fistula spontaneously. It can take approximately 4 to 7 weeks with conservative management to close a fistula. Approximately 60%-70% of fistulas will close spontaneously (Colwell et al., 2004). Measures to medically manage the fistula include: hospitalization, maintaining fluid and electrolyte balance, providing bowel rest and nutritional support and initiating medical treatment. Treatment includes ensuring skin protection and containing the fistula effluent (Pontieri-Lewis, 2005).

There are four phases listed in the management of Enterocutaneous Fistulas (Colwell et al, 2004). The phases are stabilization, investigation, conservative treatment and surgery.

(Continued to page 9)
Fistula Management (continued from page 8)

Stabilization
Stabilization is the maintenance of fluid and electrolyte balance. The Gastrointestinal tract excretes five to nine liters of sodium and potassium, chloride and bicarbonate daily. The excretion of these electrolytes can result in hypovolemia, inadequate tissue perfusion, renal failure, sepsis, hemorrhage and evisceration. The medical conditions require immediate surgical intervention. Local and systemic sepsis must be treated with appropriate antibiotics. The patient is placed on ‘nothing by mouth’ which minimizes intestinal output, to rest the gut (Kozell & Martins, 2003).

Investigation
Investigation is the assessment of the anatomical features of the fistula. The fistula is assessed by radiography, called a fistulogram, to determine the origin of the fistula, the length of tract, the continuity of the bowel and other manifestations such as abscess or distal obstruction. The test is usually done between days 7 to 10, when the fistula tract has matured post operatively. Computed tomography, cystoscopy, intravenous pyelogram and ultrasound can be used to identify impediments to fistula closure (Pontieri-Lewis, 2005).

Diagnostic Studies
A fistulogram is a radiographic study that will assist in determining the site of the fistula in the gastrointestinal tract and the skin. A soft catheter is inserted into the fistula and then a contrast dye is instilled. This will also determine patency of the gastrointestinal tract distal to the fistula. Other tests such as barium enema maybe performed, and upper Gastrointestinal x-rays with small bowel follow-through (Pontieri-Lewis, 2005).

Conservative Treatment
Conservative treatment of fistula management includes nutritional support, effluent containment, promoting the patients physical and psychological wellbeing and appropriate use of the patient's dollars (Kozell & Martins, 2003). Nutritional support can be either in the form of oral, enteral, or parenteral nutrition dependent upon a patient's tolerance, the ability to ingest sufficient quantities, the fistula tract location and the bowel mucosa's absorptive capacity. Acceptable protein requirements are 1.5 to 1.75g/kg in a 24 hour period and 45 calories a kg per 24 hours for caloric needs (Kozell & Martins, 2003). High output fistulas or small proximal bowel fistulas can have drainage more than 1000/ml a day. The affected patients are at risk for dehydration and electrolyte imbalance. They are good candidates for total parenteral nutrition (Pontieri-Lewis, 2005). Patients are encouraged to maintain bowel rest and keeping the patient nothing by mouth for at least 4 to 8 weeks (Pontieri-Lewis, 2005).

Surgery
Fistulas can be operated on in the presence of bowel necrosis or abscess. To become a surgical candidate, the patient's condition must be optimized. The patient should be sepsis free for 6 to 8 weeks, have a positive nitrogen balance and the abdominal wall and surrounding tissue should be soft and supple (Kozell & Martins, 2003). Closure of type 2 complex fistula is a surgical closure. The fistulas are usually closed between 10 to 13 weeks. The surgical approach will be either resection or diversion of the fecal stream proximal to the fistula, creating an ostomy or end to end or side to side anastomosis (Kozell & Martins, 2003).

Further Management—Pharmaceutical
Pharmaceutical agents can assist in decreasing of fistula output. Octreotide (Sandostatin) inhibits the release of gastrin and other gastrointestinal hormones thus decreasing the intestinal volume (Pontieri-Lewis, 2005). Fibrin glue can be used to seal a fistula tract, in a low-output fistula. The glue is composed of fibrinogen and thrombin which forms a gel when mixed together. The gel is then endoscopically injected into the fistula tract to create a seal (Pontieri-Lewis, 2005).

Containment of the Fistula Output/Application of Pouches
Pouches with solid skin barriers that are available in various sizes, shapes, materials and are drainable (Colwell et al., 2004). The skin barrier provides an adhesive seal and provides skin protection. The skin barrier can be either integrated into the pouch or separately attached to the pouch. Expected length of wear time of skin barriers is usually 3–7 days. If the appliance begins to lift.

Nursing Management and Treatment
Nursing management of a fistula encompasses many goals including treating sepsis, initiating nutritional support, maintaining fluid and electrolyte balance, providing patient education and perifistular skin protection/fluid containment. It is crucial that health professionals who work as a team to create a plan of care to integrate medical management and nursing management techniques with the collaboration of a wound ostomy continence nurse (Pontieri-Lewis, 2005). It is important to implement a cost-effective system, promote patient comfort, optimize physical function and control odor (Colwell et al., 2004). There are 4 areas to consider providing the most appropriate care to the nursing management and containment of a fistula. The 4 areas are to either manage the fistula with a dressing, pouch, suction or a combination of dressings. The deciding factors to determine the management of the fistula are: if the volume of output is more than 100ml/24hr, if odor is a problem and if the fistula opening is less than 3 inches and if an access cap is needed (Bryant & Nix, 2007). The fistula opening is measured by length and width in centimeters. If the fistula volume is more than 100 ml/24 hours then a pouching system is appropriate. If the volume is less than 100 ml/24 hours then dressings and skin protection is suggested. If an access cap is needed for volume more than 100 ml/24 hours, then a wound management system or a 2 piece pouching system is appropriate. This is also appropriate for a fistula that is odorless. When the fistula opening is less than 3 inches, pouches are appropriate that are small. For example, a pediatric pouch, small wound management system, fecal incontinence collector, a female urinary incontinence pouch, retracted penis pouch, or a 1 or 2 piece ostomy pouch with urinary or fecal spout is appropriate. If the fistula opening is larger than 3 inches, appropriate pouches include a 2 piece ostomy pouch with urinary or fecal spouts, a medium or large wound management system, a open-end drainable pouch or customized pouching system (Bryant & Nix, 2007).

February, March, April 2008—Prairie Rose—Page 9
and leak, fistula effluent will cause excoriation and discomfort to the patient. If applying a pouch, effluent should be emptied regularly from the pouch and the output should be noted and documented. Frequent emptying will extend the length of time of the pouch wear. A high output pouch might be emptied on the hour of connected to a secondary container allowing continuous gravity drainage (Cobb & Knaggs, 2003).

**Peristomal Skin Protection**

Effluent from a fistula is corrosive, especially in the small bowel or from pancreatic drainage. Effluent is corrosive to the peristomal skin, the skin that is around the fistula (Bryant & Nix, 2007). Measures must be taken, to care for the peristomal skin and select a suitable appliance to collect the effluent. Each patient is individual and care must be taken, to select the appliance most appropriate for the patient (Cobb & Knaggs, 2003). In addition to applying the appropriate appliance, patient assessment is crucial to identifying any skin folds, or irregular skin surfaces to select the most appropriate skin barriers for skin protection. Patients should be assessed in a supine or semi-scowlers position. The assessment will indicate what type of appliance is needed, such as a flexible or convex appliance and if filling agents are needed such as paste or strips to fill in irregular surfaces or if adhesives are needed (Bryant & Nix, 2007). Skin sealants or adhesives enhance adherence of a pouching system and help provide a barrier on the skin if there is leakage (Bryant & Nix, 2007).

If at all possible, alcohol based barriers should be avoided on broken skin, as this can cause stinging and discomfort to the patient (Burch, 2003).

Skin barrier powders create a dry surface when the patient’s skin is denuded from effluent and skin barrier powders absorb moisture. Adhesives can help seal in the powder once it is applied, to create a dry surface for the a pouch skin barrier to adhere to (Bryant & Nix, 2007). Within 3 to 4 hours of contact with fistula output, the patient’s skin can excoriate which can lead to increased pain and reduced adhesion of the appliance (Burch, 2003). Wet skin can be dried by a variety of methods. Using a cloth, can be painful and may cause trauma to the skin. Leaving the wound open to air, is not an option, due to the high output of a fistula. The use of a cool hair dryer, is an affective alternative, but not a research proven method (Burch, 2003).

There are a number of products to protect the peristomal skin. When changing a combination of skin barriers to prevent skin contact with the fistula output.

### Controlling Odor

Odor can be controlled with pouching the fistula to contain the effluent. Most pouches are odor proof, though many urinary pouches are not odor proof. Dressings do not control odor unless you are applying a charcoal impregnated dressing over the gauze dressing (Bryant & Nix, 2007). To control odor, dispose of soiled linens and dressings from the room as soon as possible, try to prevent splashing effluent on the patient/linens when emptying a pouch, cleanse the tail of pouches after emptying, and use deodorants appropriately. External deodorants are available in room sprays, liquids or powders or tablets that can be added into a pouch. Room sprays should be odor eliminators not just mask odors (Bryant & Nix, 2007).

### Time Management

When caring for a fistula, there are considerations involving time management. Clinicians must be aware that dressing and pouch changes can take hours, and more than one staff member may be needed to assist. Measures must be taken to provide rest for an hour to allow the appliance to seal before becoming mobile (Burch, 2003). Suction catheters are appropriate when a fistula has high output. A catheter is inserted into an ostomy pouch to contain the effluent. If a pouch with an end adaptor is used then the suction catheter can be threaded through the adaptor into the pouch. Extra care must be taken to keep the catheter from coming into contact with the fistula or base of the wound. This can be achieved by placing a piece of gauze or nonadherent dressing at the base of the fistula or wound bed, (Burch, 2003).

Suction catheters can be attached to low, intermittent suction. This will help contain the high volume of output if the effluent is liquid. Thick drainage will occlude the catheter. Continued measures must be taken to protect the skin, as leakage can still occur (Bryant & Nix, 2007). Negative pressure wound therapy (NPWT) had been effective in containing effluent and aiding in wound healing. The use of NPWT is for explored entero-cutaneous fistulas (Bryant & Nix, 2007).

### References


**Photo of pouching system, with barrier strips, from http://Hollister.com.**

**Arrows indicate fistula formation at the abdomen. Photo from http://surgicaltutor.org.**

**Fistula Management**

(continued from page 9)
Submitted by Karen Macdonald

The Nursing Scholarship program was started in 1982 through the efforts of Betty Maher, then Executive Administrator of the North Dakota Nurses Association and Richard Timmins, Executive Administrator of the North Dakota Community Foundation. The fund was established with $3000, of which $1165 was the permanent endowment, and $1835 to be invested and the income used for nursing education endeavors. The nursing scholarship funds reached $57,612.13 as of November 30, 2004. Participation in the North Dakota Community Foundation allows the funds to be invested within the structure of a statewide public non-profit tax-exempt corporation, designed to receive and distribute charitable funds. A volunteer Board of Directors carries on the work of the Foundation and directs investments of approximately 25 million dollars. From 1980 through 2004, foundation funds had an average growth of 7.8%. Work of the foundation is supported by a 1% fee on the monies. Four percent of the monies are granted each year for legitimate education purposes. The remainder of the funds is included in the corpus of the endowment.

A review of the contributions to the Nursing Scholarship funds shows that the majority of the contributions were from individual nurses who give in honor of a loved one who may or may not have been a nurse. Other contributors include groups such as the UND Medical Foundation, local service clubs, as well as district nurses organizations.

Scholarships have been given to 45 aspiring nursing students who have all attended North Dakota's baccalaureate nursing programs. The scholarships are awarded in early fall of each year and applications can be obtained from the financial aid officers of the individual nursing programs. It can be used for any legitimate educational purpose.

The North Dakota Nurses Association has adopted The Nightingale Tribute to be used to honor deceased nurses. That tribute is found in this issue of The Prairie Rose and will be distributed to all funeral home directors in North Dakota. The Association has further directed that whenever possible, a member of the Board of Directors will offer to provide the tribute during the funeral service of a deceased member of the North Dakota Nurses Association. Part of the information that will be given to the funeral directors will be information about the North Dakota Nurses Scholarship Fund. Contributions to the fund in the name of a deceased nurse are an excellent way of honoring that nurse by providing funds for aspiring nurses to complete their education.

Would you like to help grow the body of the Scholarship Fund to ensure additional monies are available for scholarships? Can we grow the fund to $100,000 or more? The additional scholarships that can be made would enable more students to realize their dream of becoming registered nurses. Donations to the fund are tax deductible and recognition of the donations will be made in future issues of The Prairie Rose.

Checks should be made payable to “North Dakota Community Foundation Nurse Scholarship Fund” or “NDCF Nurse Scholarship Fund.” You may send your donation directly to the North Dakota Community Foundation at PO Box 387, Bismarck, ND 58502-0387.

Clip and save for future use

Donation to the North Dakota Community Foundation Nurse Scholarship Fund

In honor or memory of __________________________
Amount __________________________
Donor __________________________
Please send acknowledgement to __________________________
Mail to North Dakota Community Foundation, PO Box 397, Bismarck, ND 58503-0387
ENROLLMENT FORM POST-TEST EVALUATION FORM

Program Title: Fistula Care
Program Number: P2.41
Date: Please return by April 30, 2008

I. ENROLLMENT FORM
Name: _________________________________________________________________
Last Name First Name Middle Initial
Address: _______________ City / State / Zip: ______________________________
Telephone: ___________ *Email: _____________________ Fax: _______________
State of Licensure: ____________________License #: _______________________
NDNA membership # _____________*Will email certificate of completion if you provide your email address.

II. POST-TEST Choose the one correct answer.
1. A fistula is an abnormal connection between one hollow viscous organ and another hollow organ or skin. T / F
2. Fistulas can occur for a number of reasons, such as tension or breakdown at the intestinal anastamosis. T / F
3. An Enterocutaneous fistula is a abnormal connection between the bladder to the skin. T / F
4. Some of the signs of fistula development are fever, increased fluid output at the wound site, and localized erythema. T / F
5. Medical management of a fistula only involves pharmaceutical management. T / F
6. The four phases of Enterocutaneous fistula management is stabilization, maintenance, conservative treatment and surgery. T / F
7. The goals of nursing management include protecting the perifistular skin and fluid containment. T / F
8. Perifistular skin is the skin around the wound only. T / F
9. If the volume of output is less than 100 ml/24 hours then the fistula should be pouched. T / F
10. If the fistula opening is less than 3 inches, a large wound drainage collector is appropriate. T / F
11. Care must be taken to protect the perifistula skin as the fistula drainage is odorous. T / F
12. When the perifistular skin is exposed to fistula drainage, the skin can excoriate in 1 hour. T / F
13. It is important to be sensitive to the needs of the patient as there are psychological issues and pain management. T / F
14. Appliance leakage can be due to an increase in patient mobility and irregular skin folds at the fistula site. T / F
15. Frequent dressing changes can be uncomfortable and stressful to the patient. T / F

III. EVALUATION
Use the following rating scale for the questions below:

4=Excellent 3=Average 2=Fair 1=Poor N=Not Applicable

TO WHAT EXTENT HAVE YOU ACHIEVED EACH OBJECTIVE?

1. A. Define the etiology of fistulas. 4 3 2 1 N
   B. Review the classification of fistulas. 4 3 2 1 N
   C. Review medical management and treatment. 4 3 2 1 N
   D. Describe nursing management and treatment. 4 3 2 1 N

2. To what extent did the objectives relate to the overall purpose/goal of the activity? 4 3 2 1 N
   This study was developed to describe the Enterocutaneous fistula (ECF) and its management and treatment.

3. To what extent were the teaching/learning resources appropriate and used effectively? 4 3 2 1 N
   A Fistulogram is a radiographic study that assesses the site of the fistula in the gastrointestinal tract and skin

4. How would you rate your knowledge of this content before reading this article? 4 3 2 1 N
   High output fistulas occur at the small bowel.

5. How would you rate your knowledge of this content after reading this article? 4 3 2 1 N
   Fibrin glue can be applied to seal a fistula tract that occurs in a high output fistula.

6. How long did it take you to complete this activity?____________ Minutes

7. Please print your name as you would like it to appear on your certificate of successful completion:
__________________________________________________________________

8. COMMENTS FOR IMPROVEMENTS OR FUTURE CONTINUING EDUCATION:
The "Ideal" Nurse Work Environment Project

The "Ideal" Nurse Work Environment Project was a cooperative venture of the North Dakota Nurses Association, North Dakota Healthcare Association, and UND Center for Rural Health funded by the Center for American Nurses from 2005-2007. The work of the group was to develop and disseminate information to hospital-based chief nurse executives and administrators for the purpose of building support for "ideal" nurse work environment concepts. The project was modified to include all nurses in information dissemination.

The project is in alignment with the Center for American Nurse's mission of serving individual, non-union nurses workplace concerns. The Center's stated primary purposes are: (1) collaborating with others to develop policies that positively impact the work environment (2) providing education to the nursing community on workplace issues (3) supporting nurses in personal and professional growth and development in the workplace, and (4) promoting leadership in the workplace environment. The "Ideal" Nurse Work Environment Project encompasses four of the Center's strategic workforce advocacy areas—Patient Safety—Appropriate Staffing—Workplace Rights—Workplace Health and Safety.

The North Dakota Nurses Association worked with representatives from the North Dakota Healthcare Association and UND Center for Rural Health in collaboratively reviewing ANCC Magnet Criteria and Designation and Texas Nurse Friendly Hospital Criteria and Nurse Friendly Hospital Designation to identify the key components in each model for improving the nursing work environment. The desired outcome was to identify a model whose components are most congruent with the operational and geographic realities of practice settings in North Dakota. Information about these key components was modified for use with "target audiences." Target audiences were hospital-based chief nurse executives and administrators. Later, the audience was enlarged to include all nurses. Information was disseminated in a variety of forms, including PowerPoint presentations, newsletter articles, and personal contacts.

Members of the Ideal Nurse Work Environment Work Group were: NDNA Representatives, Barb Ding and Becky Graner; ND Healthcare Association Representatives, Karen Haskins and Trina Schilling; UND Center for Rural Health Representatives, Mary Amundson and Dr. Patricia Moulton. The Work Group was staffed by Sharon Moos, NDNA Past Executive Director. Project follow-up was completed by Becky Graner, Interim Executive Administrator, NDNA.

The PowerPoint is being published in this edition of the Prairie Rose as a method of sharing the content of the "Ideal" Nurse Work Environment Project. The presentation is for individual review. Comments may be directed to NDNA at 701-223-1385 or email Becky Graner at becky@ndna.org.
ND Health Professions: Nursing Supply
- **National** data reveal average 8 RNs/1000 people.
- In ND:
  - 9 counties have over 10 RNs/1000 people in 2003 compared to 14 counties in 2002.
  - 25 counties have less than 8 RNs/1000 people.
- 4 of which have less than 3.4 RNs/1000 people.
- [http://medicine.nodak.edu/crh](http://medicine.nodak.edu/crh)

ND Health Professions: Nursing Demand
- Turnover rates refer to number of resignations and terminations relative to budgeted positions.
  - State wide RN turnover rates increased from 14.7% in 2002 to 17.6% in 2003.
  - Highest turnover found in semi-rural areas.
  - LPN turnover rates increased from 16.5% in 2002 to 20.1% in 2003.
  - Highest rates in rural areas.
- [http://medicine.nodak.edu/crh](http://medicine.nodak.edu/crh)

ND Health Professions: Nursing Supply
- Data collection 2005:
  - Employment compensation:
    - Annual RN salary national: $48,240
    - Annual LPN salary national: $31,490
  - Annual LPN salary state: $22,912
  - Rural RN wages 17% lower than urban RN
- [http://medicine.nodak.edu/crh](http://medicine.nodak.edu/crh)

ND Health Professions: Nursing Demand
- RN turnover rate increased to 20% in 2005 from 18% in 2004 and 15% in 2003.
- National average is 21%
- LPN turnover rate increased to 21% from 20% in 2004 and 17% in 2003.
- [http://medicine.nodak.edu/crh](http://medicine.nodak.edu/crh)

理想的护士工作环境

### ND Nursing Needs Study Five Year Facility Survey Results
- **Impact of needs study – Is the study used?**
  - 54% report
  - 57% have not used results
  - 23% have distributed and discussed
  - 18% have increased recruitment and retention activities
  - 32% report have not seen results
  - [http://medicine.nodak.edu/crh](http://medicine.nodak.edu/crh)

### Ideal Nurse Work Environment
- **Characteristics of a Healthy Environment**
  - #1 indicator is a healthy organizational culture.
  - What is a healthy culture?
    - The mix of knowledge, skills, behaviors, physical environment that supports creativity and growth while maintaining financial responsibility and optimal outcomes for patients.
    - To determine view of organization's culture one needs a process and framework from which to work.

### Embracing the principles
- Organizations may engage in a formal process such as the Magnet/Texas Nurse Friendly or
- One could engage in an organizational value clarification by identifying the essential elements for the ideal nursing practice environment that best fit the individual situation.

### Based on Ideal Nurse Work Environment project objective:
“Create awareness and build support for development of ideal nurse work environments in ND hospitals”
- The original task force recommended the Texas Nurse Friendly model as a guideline for organizations to utilize when tailoring their facility to meet their unique needs.
- The focus of the committee is to assist organizations to design, implement, and maintain an ideal nursing practice environment to support the advancement of nursing practice and the improvement of patient outcomes.

### Nurse Friendly Hospital Criteria
- **Texas Nurse Association model as guide**
  - Control of nursing practice
  - Safety of the work environment
  - System to address patient care concerns
  - Nurse orientation

### Ideal Environment
- **Principle 1**
  - Nursing practice control
  - The practice of nursing is governed by nurses.
  - Consistently identified as essential to satisfaction
  - Nurses are accountable for their own practice

### Principle 2
- Safety
- Environment safe for patients and staff
- Nurses have voice on safety committee
- Safety standards exceed OSHA standards
- Resource: Center for American Nurses, Transforming Nursing

### Principle 3
- Patient care improvement
- Nurses embrace code of ethics
- Nurses engage in process improvement to reduce healthcare errors

### Principle 4
- Orientation
- New employee orientation
- Mentorship opportunities beyond orientation for new staff
- Growing the next generation of leaders

### Principle 5
- Nurse leader
  - Chief Nursing Officer full member of administrative team
  - Prepared educationally for position
  - Supported by organization/ colleagues in ongoing education efforts

### Principle 6
- Professional growth/development
- Opportunities to develop enhance nursing practice
- Opportunities to develop professional skills
- Technology support to access web-based education opportunities

### Principle 7
- Fair compensation
- Competitive wages
- Performance review
- Coaching for reaching professional potential
- Staff part of budget process
- Mentorship in budget preparation
- Staff participates in monthly financial review of unit operations

(Continued to page 15)
• Principle 8
  - Recognition
  - Appreciation and gratitude for service
  - Honoring exceptional service

• Principle 9
  - Balanced lifestyle
  - Address issues of fatigue, overtime, family responsibility, scheduling, etc.
  - Address issues that increase stress
  - Debriefing after adverse events
  - Reflective practices
  - Employee wellness programs

• Principle 10
  - Bully management
  - Communication skills
  - Relationship/respect
  - Zero tolerance for abusive behavior
  - Resource: Center for American Nurses: Bullying in the Workplace: Reversing a Culture brochure
  - www.centerforamericanurses.org
  - Catalog information: CENTER 17

• Principle 11
  - Management accountability
  - Create environment of trust, respect, and open communication
  - Leadership training
  - Resource:

Sources for further exploration


• This work was made possible by a grant from the Center for American Nurses Growth, Innovation and Advocacy Program (GIA Program)