The Prairie Rose

NDNA
North Dakota Nurses Association

THE OFFICIAL PUBLICATION OF THE NORTH DAKOTA NURSES ASSOCIATION
Circulation 14,000 To All Registered Nurses, LPNs & Student Nurses in North Dakota

Vol. 77 • Number 4 November, December 2008, January 2009

Inside

Geriatric Nursing Excellence Collaborative Educational Conference
Page 5

The Many Dimensions of Stress in Nursing
Page 9

CONTENTS

President's Message

Why do I need to be involved in politics, I am only a nurse?

"Nurses have the authority, leadership and unique knowledge of health issues to influence opinions and ensure the profession's role as a major participant in the policymaking process. (ASPN, 2007).

Wanda Rose

By the time you receive this issue of the *Prairie Rose* the general election may be over. If the election is not over you have a responsibility to vote. Exercising your right to vote is the most important action you can take to become involved in the political process. Voting is your responsibility as a U.S. citizen! Legislation occurring at the local, state, and federal level impacts healthcare services and affects the role and future of nursing.

The potential power of 10,000 nurses in North Dakota is awesome, but this potential won't be realized unless you take the steps to vote.

After the election it is imperative for nurses to become involved in the political process. On January 6, 2009 the North Dakota Legislative Session begins.

Because politics involves every aspect of our professional and personal lives it is important for every nurse to become politically involve. Becoming politically involved provides an opportunity to influence social policy and advocate for the nursing profession and your patients. So, where do you begin if you have never been involved in the political process? Perhaps the most important part of the process is to get to know your legislators, at both the federal level (members of Congress) and at the state level because *most legislators are not experts on health care and nursing*, so your knowledge and experiences are vital to them. It is the personal connection with your legislator that makes the difference in their response. If you have an ongoing relationship, they are much more likely to listen and respond when you call them to support or oppose a particular piece of legislation.

If you do not know your state legislators you can call your county auditor and give them your address and the auditor's office will give you the names of your state representatives and the senator from your district. Or go to http://www.legis.nd.gov/ and click on District Locator under Legislative District.

One of the most effective and easiest methods for nurses to communicate with their elected official is to call their members of Congress and state legislators. To leave a message for your U.S. Senators and Representatives by phone, call the U.S. Capitol Switchboard at 202-224-3121 and ask to be connected to your Senators' or Representatives' offices. To leave a message for your state legislator during the North Dakota Legislative session call ND Legislative Hotline at 1-888-635-3447 or 1-701-328-3373 in Bismarck.

Once connected to your elected official's office or phone bank be sure to identify who you are, your address, and the issue you are calling about. Your message can be as simple as "I would like him/her to vote no or yes on a particular bill or issue" with a brief mention of the reason: "the bill will improve access of health care for children."

During the legislative session it is important for nurses to stay informed about legislative issues that impact nursing. One way is to visit the North Dakota Nurses Association web site at http://ndna.org where legislative information will be posted during the legislative session.

To find Information on the North Dakota Legislature go to http://www.legis.nd.gov/assembly/61-2009/ This site will allow you to access copies and current status of bills introduced and action taken. You can also locate information on each legislator, which includes addresses, phone numbers and e-mail addresses.

At the state level, the clearest connection between public policy and practice is the Nurse Practices Act (NPA). The legislation of the NPA defines what we as nurses can and cannot do. Your ability to practice nursing is protected by the NPA. As a result, legislation and regulations at the state level directly determine educational preparation, licensure requirements, and, for Advanced Practice Nurses, prescriptive practice agreements with collaborating physicians. Thus, most areas of your practice are dependent on public policies. Therefore, nursing involvement in the policy process can effect whether nursing

(Continued to page 2)

Presort Standard
US Postage
PAID
Permit #14
Princeton, MN
55371

ANA Urges a Ban on BPA in Food, Health Care and Children's Products

Silver Spring, MD—The American Nurses Association (ANA) voiced concerns over the safety of the chemical bisphenol A (BPA) to the Food and Drug Administration (FDA) on Tuesday. The FDA invited a panel of experts to comment on the agency's recent report which suggests that trace amounts of BPA are not dangerous. However, the National Toxicology Program (NTP) concluded BPA poses "some concern" to infants and children. BPA is a plastic hardening chemical used in baby bottles and food can liners.

In testimony, ANA urged the FDA to ban the use of BPA in food, health care and children's products. Nancy Hughes, the Director for Occupational and Environmental Health for the ANA commented, "The ANA is a firm advocate of the precautionary approach regarding dangers to the public health. Safer alternatives to BPA are available and currently in use."

For more information on ANA's environmental health policy please visit, http://www.nursingworld.org/MainMenuCategories/OccupationalandEnvironmental/environmentalhealth.aspx

President's Message

(continued from page 1)

practice is crippled or enhanced by such laws and regulations. Nurses are strategically positioned to make significant improvements in the health care provided within North Dakota and this country.

The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy. The North Dakota Nurses Association works to protect the rights of nurses that may be impeded by unfavorable laws.

As a nurse, you must decide whether you want to become politically involved and protect your ability to practice nursing. There is no better time than NOW to become politically involved. Being an active participant in the legislative process is really quite simple and effective. Go out there and let your voice be heard. That is how we collectively improve the lives of our patients and the nursing profession.

ASPN (2007). *Governmental Affairs: A Primer for Political Action*. Retrieved September 19, 2008, from http://www.aspan.org/GovernPrimer.htm

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

EDITOR: Becky Graner

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, 800-626-4081**. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

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 volunteers at 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 at NDNA: 701- 223-1385.

The Prairie Rose is one communication vehicle for nurses in North Dakota.

Raise your voice.

Macdonald Represents ANCC at International Conference on Advanced Nursing Practice

Karen Macdonald, outgoing chair of the ANCC Commission on Certification, attended the 5th International Council of Nurses International Nurse Practitioner/Advanced Practice Nursing Network (INP/APNN) Conference September 17-20 in Toronto, Ontario, Canada. Over 700 nurses from 30 different countries attended the conference which featured scientific programs as well as social events.

International Leadership in education and health policy related to advanced nursing practice featured Ann Baile Hamric from the USA whose newest edition of Advanced Nursing Practice: An Integrative Approach (edited with Judith Spross and Charlene Hanson) was released at the conference. She emphasized that advanced practice is a concept not a role, and that direct practice is central. She indicated that all nurses are specialized in a sense as they pick a practice area, but advanced practice nurses go beyond this with an expanded scope of practice. Her integrative approach emphasizes what advanced practice is (not just junior medicine) but a value added complement to other disciplines in the care of patients.

Stephanie Ferguson, Director of ICN Leadership Change emphasized the nursing core–advised that advanced practice nurses look in a mirror and ask the question: Are you a nurse? She calls for the best plan of care of the patient through collaborative and valued partnerships. She states: If you always think what you always think, you'll always get what you always get."

The three day conference was packed with scientific and practice sessions. One on care of the geriatric patient included the message: "A silver "tusanmi" is coming" with the aging population.

Countries that gave information about the advanced practice development included:

Australia—began with acute care and bush nurses in remote areas, now expanding into urban areas. Role and scope independent on state development, New Zealand has 40 NPs at this time. Prescribing continues to be a problem as one nurse related that if she gave the patient a prescription, he needed to pay full price, but if the patient received the prescription from a physician, the cost was discounted.

Africa/Middle East—WHO has been supportive of the development of APNs in Botswana and Ghana. Bahrain has had NPs since 2003, and Pakistan is developing the role.

Canada—Ministries of Health of the various provinces are very supportive and provide funding. Canada now uses ANCC's Adult and Pediatric examinations for licensure. One nurse practitioner has a solo practice in a remote village of 5000 people, the Ministry pays her salary and the town provides the building. She sees approximately 30 patients a day, but relies heavily on 911 for things she cannot handle.

European—development of the advanced practice role is problematic because of lack of prescribing privileges in UK, but in Ireland this is not a problem. Also nurses often must work part time as APNs and part time as District Nurses because they are not accepted through National Health Insurance.

The conference include a Network meeting of all members of INP/APNN. Membership in the network is open to all who are members of their country association recognized by ICN. Currently there are 1300 members. The next meeting is in two years in Brisbane, Australia.

Melanie Roger, NP, United Kingdon; Karen Macdonald, ANCC Chair, Commission on Certification; Mollie Burley, Lecturer, School of Rural Health, Victoria, Australia

Kelly Beaudrau, Past Chair of NACNS Lucille Auffrey, CEO of Canadian Nurses Association; Karen Macdonald Sandra Bruno, Co-Chair INP/APNN Planning Committee; Alba Dicenso, Professor, McMaster University

Nova Scotia Advanced Practice Nurses, Karen Macdonald, and Joellen Hawkins, Professor Emeritus at Boston College (her father was Dr. Charles Beck who practiced in Harvey ND in the late 40's and 40's)

Medicare & Medicaid Service Changes Impact Nursing

The Centers for Medicare & Medicaid Services (CMS) recently added three (3) new hospital-acquired conditions (HACs) in the final rule for the Medicare acute care inpatient prospective payment system. Hospitals began reporting on these HACs in October of 2007, payment changes begin October 2008.

Listed are the 10 HACs:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
   - Fractures
   - Dislocations
   - Intracranial Injuries
   - Crushing Injuries
   - Burns
   - Electric Shock
6. Manifestations of Poor Glycemic Control
   - Diabetic Ketoacidosis
   - Nonketotic Hyperosmolar Coma
   - Hypoglycemic Coma
   - Secondary Diabetes with Ketoacidosis
   - Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following:
   - Coronary Artery Bypass Graft (CABG)-Mediastinitis
   - Bariatric Surgery
     - ♣ Laparoscopic Gastric Bypass
     - ♣ Gastroenterostomy
     - ♣ Laparoscopic Gastric Restrictive Surgery
   - Orthopedic Procedures
     - ♣ Spine
     - ♣ Neck
     - ♣ Shoulder
     - ♣ Elbow
10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
    - Total Knee Replacement
    - Hip Replacement

So what does this mean to nurses? Section 5001(c) of the Deficit Reduction Act of 2005 requires the identification of conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. For details see the following link http://www.cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage.

Physicians and nurses will need to clearly document the status of the patient upon entry into the health care system. Proof of adherence to evidence based guidelines is essential.

As you can see by the list, every one of the identified hospital acquired conditions falls under the purview of nursing. Whether it is vigilance during surgery to guard against and monitor for breaks in technique or in the provision of routine care, it is the nurse who can make a difference. It is also clear the importance of utilization of evidence based guidelines. The following link http://www.ahrq.gov/qual/nurseshdbk/ will take you to the US Department of Health & Human Services Agency for Healthcare Research and Quality. This site offers a Patient Safety and Quality Evidence-based Handbook for Nurses that can be accessed electronically. Nurses and all those on the team must be aware of evidence based practices. When tasks are delegated to assistive/support staff, they too must adhere to standards of care.

Many HACs are linked to infection control practices. A recent story in the Washington Post reported the incidence of hand washing by health professionals. The article states 25% of health care workers do not regularly disinfect their hands. I initially thought; you have got to be kidding! Then I spent time in several large health care facilities and spoke to others who have had family members hospitalized over the last 3 months. Sadly, it seems many health care workers are not disinfecting nor washing their hands! Or worse yet, they do not wear gloves and even then they do not wash their hands! Proper hand washing is key to preventing infections. Not washing your hands may cost you . . . not only could you become ill, but your patients may suffer as well. And now it may cost you in lost reimbursement for your workplace.

All health care persons need to be aware of practices that place themselves and others at risk. It is inconceivable that health care workers are still not washing their hands, and as evidenced by direct observation of health care workers while at work, they are accessing veins without gloves, waving their hands over prepped IV sites to hurry drying before placing IVs, leaving IV tubing draped on the floor, leaving foley collection bags on the floor, sliding reusable blood pressure cuffs across patient beds, or making "hourly rounds" just to the patient's doorway without stepping in to take a closer look at IV sites, urine output, or any number of other drainage/collection devices. Some of us may feel outraged over the 10 listed hospital acquired conditions that are so closely tied to the practice of nursing. Sadly, it seems we have made some of our own problems.

Collectively, we need to be vigilant, even to those details that at first glance don't seem to make much of a difference. We need to grasp the consequences of cutting corners, superficially completing tasks, and the unacceptable disregarding of evidence that clearly improves practice. We need to know that all members of our team are adhering to the standards of care. It is not good enough if the RN washes his or her hands and the physician and the assistants do not. We need to be outraged and take action when family members tell stories of items dropped on the floor, then picked up and used on the patient. We need to be outraged and take action when a story of excessive blood loss occurs or necessary medication gets pumped to the floor because nurses check IV lines from the doorway. The overall outcome should not have been increased policing and penalty by those that pay for services. Instead the outcome should have been health care watching over itself and insisting healthcare providers adhere to practices that maintain patient safety.

If you have ideas on how to improve these and other issues in the workplace or within the workforce NDNA would love to hear from you. If you give us permission we will publish ideas to the website so others can read and learn. Contact me at becky@ndna.org

Thank you to all who wash your hands! . . . .to the rest, go wash your hands!

"Geriatric Nursing Excellence" Collaborative Educational Conference

Patricia Kappas-Larson

Mark your calendars and plan on attending the 7th Annual Northwest Region North Dakota Collaborative Educational Conference to be held on April 3, 2009 from 7:45am–3:30pm at the Holiday Inn, Minot, ND. This education conference is being co-sponsored by the NW Region, NDNA; Omicron Tau Chapter, Sigma Theta Tau International Honor Society of Nursing and Roughrider Chapter, American Association of Critical Care Nurses.

The purpose of this conference is to provide participants with evidence based information relating to excellence in geriatric nursing practice.

The objectives for the conference are:

- Identify the key health issues that can be modified to improve health outcomes for the elderly patient.
- Discuss one national model with demonstrated success in the delivery of care to frail, vulnerable individuals.
- Differentiate mental health issues in the elderly including depression, dementia and delirium.
- Recognize specific issues concerning medications and the elderly.
- Describe the development of a student staffed adult health maintenance, promotion and wellness center.
- Explore the community resources available for the elderly and vulnerable adult.
- Identify geriatric nursing excellence initiatives to advance the care of older adults through alliances and models of care which promote geriatric nursing expertise.

Keynote speaker for the conference will be Patricia Kappas-Larson APRN-BC, MPH on "A Paradigm Shift: Frailty and the Consequences of Chronic Illness." Pat is the Senior Vice President of Professional Development/Public Affairs for Evercare/Ovations, a division of UnitedHealth Group in Minnetonka, Minnesota. She has galvanized public support for nurse-driven care models while strengthening the voice of nursing in key policy discussions. Pat's leadership has helped open doors for nursing in Congressional forums where national health care decisions are made. Her trailblazing contributions to care delivery have helped reshape health care nationally and internationally.

Pat's innovative work in practice and systems transformation has made an extraordinary impact on the health of people living with long-term conditions, all while generating substantial cost savings for the health care system. She has been instrumental in the design and testing of care models for those with complex needs, including people with end stage renal disease, the frail and elderly. She has also helped redefine the role of nurses within the Medicare program while promoting the need for increase care coordination.

Pat has been the catalyst of public-private partnerships that are improving access, quality of life and health outcomes for thousands of people. She is helping pave the way for the next generation of nursing leaders through curriculum and mentoring relationships. She is a member of leading nursing organizations, including the Hartford National Nursing Home Collaborative Steering Committee, the Health Affairs Committee for the National Conference of Nurse Practitioners, American Geriatric Society, American Society of Aging, National Nursing Centers Consortium, American Association of Nurse Practitioners, American College of Nurse Practitioners, National Organization of Nurse Practitioner Faculties, American Nurses Association, Minnesota American Nurses Association, Sigma Theta Tau International Honor Society of Nursing, and American Organization of Nurse Executives.

Pat has published several manuscripts in professional nursing journals including her most recent one "The Evercare Story: Reshaping the Heath Care Model: Revolutionizing Long-Term Care" in the February 2008 issue of *Journal for Nurse Practitioners*. In this manuscript she describes how one nurse practitioner-developed collaborative practice model and the elements that have contributed to its success in delivering effective care to the growing geriatric and chronically ill population.

Additional speakers scheduled include Deborah Townsend APRN, CNS, MS; Nikki Medalen RN, BSN; Mari Don Sorum; Linda Pettersen RN, PhD; and Bonnie Ler FNP, MSN. Refer to agenda. Additional information on this conference including registration form will be published in the next issue of the *Prairie Rose*. More information can be obtained by calling Mary Smith RN, MS at 701-858-3251 or Rhoda Owens RN, MSN at 701-720-1588. 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 RN, MS at 701-858-3251 for more information about contact hours.

Agenda for "Geriatric Nursing Excellence"
Holiday Inn; Minot, ND
April 3, 2009

7:45am–8:30am	Registration	
8:30am–8:45am	Welcome/Opening Remarks	
8:45am–10:15am	Patricia Kappas-Larson APRN-BC, MPH	"A Paradigm Shift: Frailty and the Consequences of Chronic Illness"
10:15am–10:45am	Break	Refreshments Provided to Conference Participants
10:45am–11:45am	Deborah Townsend APRN, CNS, MS	"Mental Health Issues and the Elderly: Differentiation Between Dementia Depression and Delirium"
11:45am–12:00pm	Linda Pettersen RN, PhD	"Geriatric Nursing Initiatives"
12:00pm–12:45pm	Lunch	Lunch Provided to Conference Participants
12:45pm–1:45pm	Bonnie Ler MSN, FNP	"Special Considerations Relating to Medications and the Elderly"
1:45pm–2:15pm	Break	Refreshments Provided to Conference Participants
2:15pm–2:45pm	MariDon Sorum	"Remaining Home in Later Years: It's Our Right!"
2:45pm–3:15pm	Nikki Medalen RN, BSN	"Development of a Student Staffed Adult Health Maintenance Center"
3:15pm–3:30pm	Evaluations	

Call To Action

Please sign the **Nightingale Declaration for Our Healthy World** at http://www.nightingaledeclaration.net.

Each year, nurses gratefully celebrate International Nurses Week around May 12, the birthday of Florence Nightingale (1820-1910). At this time in human history, however, the world needs much more than celebration.

Nursing shortages in the U.S. and other developed nations are now critical—epidemic, worldwide. The problem is serious, complex and impacting health and well-being across the globe. Nurses and healthcare providers—recognized as the 'arms and legs' of healthcare as well as the 'heart and soul' of healthcare implementation—need your help.

Overcoming this crisis will require exceptional advocacy and leadership. To that end, the **Nightingale Initiative for Global Health (NIGH)** is engaging in transdisciplinary dialogues for partnership. We are collaborating with nurses, midwives, related professionals and healthcare providers and other concerned citizens throughout the world. With focus on connection rather than specialization, NIGH is building a diverse and committed global network for addressing this challenge and implementing our objectives for education, empowerment and support during the upcoming decade.

By accessing the NIGH website at http://www.nightingaledeclaration.net and signing the **Nightingale Declaration for Our Healthy World**, you will join over 17,500 citizens from 86 countries, and over 1,000 organizations in answering this call.

Why this **Declaration**? Signatures representing all 193 Member States of the United Nations will lay the foundation for accomplishing NIGH's proposed adoption of two United Nations Resolutions that will be presented to the 2008 UN General Assembly declaring **2010: International Year of the Nurse and 2011-2020: United Nations Decade for a Healthy World.**

With these proposed UN Resolutions bringing visibility, recognition and value to nurses and healthcare providers, this action not only empowers them, but raises public awareness as to the crucial connection between empowered nurses and healthcare workers and the health of people everywhere.

In 1893, Florence Nightingale wrote: "Health is not only to be well, but to use well every power we have."

Standing alongside Nightingale, each of us has an opportunity—right now—to use our power to make a difference. For the sake of our own health, our children's health and the world's health please join us by taking this first critical step and signing the **Nightingale Declaration for Our Healthy World!**

Nurse Practitioner Receives 2008 AANP State Award for Excellence

Cheryl Rising a family Nurse Practitioner with Medcenter One Heath care systems in Bismarck was recognized for her excellence in NP clinical practice. The award was presented during the National Conference of the American Academy of Nurse Practitioners in Washington, D.C., June 28th.

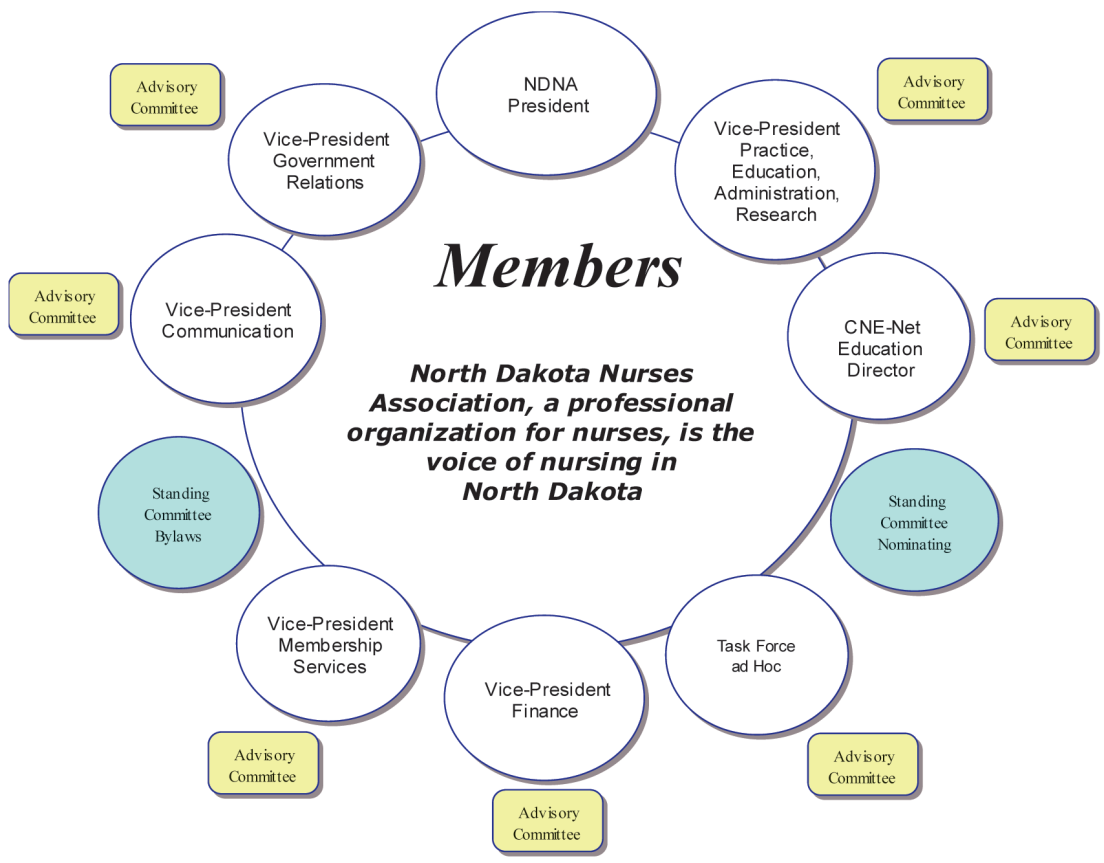
The AANP was founded in 1985 and is the oldest, largest and only full-service national professional organization for nurse practitioners of all specialties. The professional organization represents 95,000 nurse practitioners across the United States advocating the role of nurse practitioners as providers of high-quality, cost-effective and personalized health care.

During the conference Cheryl and other attendees from ND met with the ND legislative delegation on health care issues that impact across the entire state, included were medical home legislation, hospice and home care, long term care, as well as Medicaid patient access issues.

Cheryl has been in nursing for over 30 years. Her work includes acute care, critical care, hospice and long term care in Bismarck and Fargo. Cheryl has been with Medcenter One Health Systems since 2002. She developed the Nurse Practitioner Nursing Home program for Medcenter One which delivers quality care for individuals in these settings.

NDNA Business Meeting

The North Dakota Nurses Association annual meeting was held October 17, 2008 in Bismarck at the Kelly Inn. Members who attended rendered their thoughts and opinions on the proposed structure and bylaw changes. After thoughtful discussion those in attendance voted to accept the structure and the new bylaws. Below is the structure adopted and approved.



The fully executed NDNA bylaws will be available on the NDNA website. Major changes include the deletion of regions, the removal of definition of district structure, and the addition of verbiage that that allows for affiliate membership of other nursing organizations to NDNA.

The composition of the board of directors has been completely re-designed. The goal was to place the membership on center stage and provide leadership that puts into action the purposes and functions of NDNA. There will no longer be an executive board; instead the President and the five (5) VPs will be the full board of directors for NDNA. Each VP will lead an advisory committee made up of any and all interested member of NDNA. Each VP and advisory committee has been charged with specific purposes/functions to put into action. There will be far fewer elected positions instead there will be an emphasis on volunteer participation. Members are welcome to participate in all areas that interest them. During last year's strategic planning the concept of inclusion was brought up time and again. While it is recognized many members have a variety of commitments that limit participation time, the new structure allows for all to be involved as little or as much as they are able. All members are strongly encouraged to provide a working email or to at least check the news section of the NDNA website on a regular basis. It will be through these electronic mediums that most information will be shared with the members.

The following resolutions were passed at the business meeting: NDNA Moves to support

1. Health care reform that ensures quality care for everyone with a choice of doctors & plans without gaps in access or coverage, preventive care as part of any basic benefit plan that promotes health and eliminates economic and racial disparities, controlled costs by providing care that is cost-efficient and medically effective and financing that is fair with responsibility shared by employers, individuals, and government.
2. Initiatives to re-establish a division of public health nursing within the ND State Health Dept. Currently we lack a unified voice in our state on issues of importance to public health nurses. We need representation at Association of State and Territorial Directors of Nursing (ASTDN) to the same level as we have in similar organizations (ASTHO, ASTDD, etc.) Resources from this group can be utilized by local health departments to strengthen public health nursing.
3. Initiated Measure #3 on the ND General Election Ballot. Measure #3 will use only new funds from the 1998 Tobacco settlement for tobacco prevention. It establishes a tobacco prevention and control advisory committee, which includes representation from NDNA, who will develop a comprehensive statewide tobacco prevention and control plan.
4. Legislation that will allow APRNs to be recognized as a primary care provider for Medicaid recipients.
5. Form a task force to plan and implement a NDNA centennial celebration.

A brainstorming session was led by Roberta Young (Fargo) to collect ideas that will increase the membership. One barrier that was identified was the perception that membership dues are too expensive. A member clarified to all and bears repeating is that membership dues translate in to just $0.66/day or $20/month. Well over half the membership fee is sent to ANA each month to maintain constituent member status. Another comment often heard when members ask colleagues to join is "what do I get?" To answer this question, members present felt it is time to clearly state that membership in a professional organization is an opportunity to give back to one's profession. It is the opportunity to grow and strengthen nursing in North Dakota. Membership in NDNA includes full membership in ANA. Additional member benefits besides those provided through ANA membership include: free death and dismemberment insurance, discount in AAA (beginning in 2009), free contact hours (available through NDNA website, Prairie Rose, and through ANA website), discounted registration fees at NDNA provided continuing nursing education conferences, and multiple opportunities for learning and practicing leadership roles. NDNA is presently looking to add other national nursing continuing education providers to the list of member benefits. These additions would increase the scope, number, and variety of education offerings, with the intent to appeal to a diverse audience.

The business meeting ended with a Nightingale Tribute PowerPoint presentation which honored nurses who have passed away over this last year. Members are encouraged to continue to collect and send names and photos if available of nurses (member and nonmember) who have passed away so this tribute can continue every year.

As the process of implementation of the new structure and bylaws continue all members are asked to consider serving in some capacity. And when the nominating committee seeks you out, seriously consider signing a "consent to serve" and take the opportunity to create the future of nursing in North Dakota and with that fulfill a professional tenet to give back to your profession.

The North Dakota Nurses Association is pleased to bring you this continuing nursing education article. Nurses wishing to earn contact hours for **The Many Dimensions of Stress in Nursing** require the following:

1. Read the complete article. It takes approximately 120 minutes to complete.
2. Complete the post-test found at the end of the article.
3. Non-Members: Please return the entire completed enrollment form, post-test, evaluation, and check or money order for $20 payable to NDNA.
4. **NDNA MEMBERS WILL RECEIVE CONTACT HOURS FREE-OF-CHARGE.**
5. Please send to: **NDNA @ 531 Airport Road, Suite D, Bismarck, ND, 58504**
6. Upon receipt of all required materials and completion of the post-test, you will receive a certificate of completion for **2.0** contact hours from CNE-Net.

Please allow approximately four weeks from the time you submit your completed information for your certificate of completion to be processed. *Those wishing to receive their certificate by email will need to supply a functional email address.*

CNE-Net, the education division of the North Dakota Nurses Association, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Accreditation as a provider refers to recognition of educational activities only and does not imply ANCC Commission on Accreditation or CNE-Net approval or endorsement of any product.

This continuing education activity expires **May 2010**.

The Many Dimensions of Stress in Nursing

Author
Becky Graner MS, RN, Certified Holistic Stress Management Instructor

AUTHOR DISCLOSURE STATEMENT

Becky Graner MS, RN has no conflicts of interest to disclose.

Purpose

Examine commonly used terminology related to stress, while viewing the sources and consequences of stress through the lens of adult development theory.

Key terminology: *burnout, bullying, compassion fatigue, hierarchy of needs, grief, adult development.*

Objectives

- Examine the various terminologies related to stress used in nursing.
- Explore the relationship of well known models (Grief/Hierarchy of Needs) to the concept of stress.
- Discover an adult developmental model that illustrates the wide range of human responses when coping with stressors.

Sara has been a nurse for eight (8) years. She has two (2) young children, one requiring daycare, the other in the second grade. Her husband of ten (10) years has just lost his job as the lead foreman at a local factory. He carried the family's health insurance. He does not have a college education and would like to return to school now that he is unemployed. As Sara prepares to leave for work, he tells her he does not want to "baby-sit for awhile;" rather he wants to return to school as soon as possible. Sara typically has a twenty minute commute to work; whenever she drops her daughter off at daycare she needs to add ten minutes to her travel time. Upon arrival at daycare she is told her regular baby sitter is going to need six (6) weeks off for unexpected surgery newly scheduled for Friday. Today (Wednesday), she is already late for her third 12 hour shift and knows tolerance for tardiness is nonexistent. Parking is especially bad today. Upon arrival to her unit, Bernice, a seasoned nurse of twenty (20) years yells at her to stop dawdling and get to report. Bernice mumbles under her breath, but loud enough for all to hear, "darn young nurses are so self-centered; some of us would like to get out of here on time!" As Sara opens the door to the report room, she notices she is working with her least favorite Certified Nursing Assistant, Mary who most shifts is found talking on the phone to her friends. Some one tosses Sara the charge nurse forms to fill out; in her present state of mind and hurry to arrive at work she forgot she is the designated charge nurse this shift. A colleague snickers, "good luck, the family in 410 is already screaming to talk to someone in charge." Sara looks at the forms and notices no one has taken notes on the first 2 patients who have already been reported on. Is it any wonder we melt down?

Nursing literature is replete with descriptions of fatigue/sleep deprivation, burn-out, compassion fatigue, consequences of being bullied and other stress related maladies. Many of the studies reviewed for this article investigated the precipitating factors and the consequences of stress in healthcare workers. What became clear was, no matter how stress is labeled, it is still stress and it produces a mixed response in nurses experiencing it with resulting consequences for patients and organizations.

In this article the author will describe a wide view from which the various terminologies related to stress can be considered and offer an adult development approach that considers the range of human responses for coping with the stressors associated with the work of nursing and life in general.

Human Response

Imagine the flood of biochemicals that is coursing through Sara's body at this point. Walter Cannon's now classic work described the "fight or flight response;" the activation of the sympathetic nervous system that prepares one to deal with threat or danger (Benson, 1975). For our ancestors this response may have provided them with the necessary tools to survive the dangers of primitive living. Today, running or fighting is usually not appropriate as a response, yet our biochemistry continues to respond with the same physiologically reaction when faced with a triggering event. Hans Selye discovered the exact cascade of events triggered during a stress episode (Olpin & Hesson, 2007). Any problem **imagined or real**, initiates the thinking part of the brain (cerebral cortex) to send an alarm to the hypothalamus, which signals the sympathetic nervous system to go to high alert (Davis, Eshelman, & McKay, 2000; Olpin & Hesson, 2007). Physiologically, one's heart and respiratory rate increase, muscles tense, blood pressure increases, and metabolism gears up to feed working muscles. Blood is directed away from hands, feet, and digestive system to major muscle groups. Pupils dilate and hearing sharpens, all to better equip us to fight or run. Unchecked and repeated activation of the sympathetic response can have long-term negative effects. Adrenal glands

(Continued to page 10)

The Many Dimensions of Stress in Nursing

(continued from page 9)

secret corticoids (epinephrine and norepinephrine), which in turn inhibit digestion, reproduction, growth, tissue repair, and immune/inflammatory function (Davis, Robbins-Eshelman, & Mckay, 2000). This human response (fight or flight) has now become one of the leading contributors to poor health (Seaward, 2006). More recent research indicates women respond differently from men; instead of fight of flight women respond with what has been identified as "tend and befriend" (Taylor, Klein, Lewis, Gruenewald, Gurung, & Updegraff, 2000). This behavior perhaps better describes the emotional, behavioral response rather than the physiological response to stress. As with fight or flight, tend and befriend has its strengths when applied in a situationally appropriate manner. All are ways in which humans cope with stress.

Benson (1975) describes the opposing mechanism to the "flight or fight" response and names it the "relaxation response." Once the brain stops sending distress signals to the hypothalamus the sympathetic nervous system comes off high alert and is moderated by the parasympathetic nervous system. Physiologically one's heart and respiratory rate come down or return to normal, blood pressure normalizes, the GI system sees a return flow of blood. The body stops pumping out glucose to feed hard working muscles. Benson advocates learning to consciously initiate the relaxation response to counter the negative influences of chronic stress.

Ways of Categorizing Stress

Joinson (1992) coined the term "compassion fatigue" when describing nurses who may have absorbed the traumatic stress of those they care for in suffering situations. Dr. Charles Figley has studied "traumatized people" since the 1970s. He defines compassion fatigue as "a state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper" (Expert Interview, 2005, p.1). Figley differentiates burnout from compassion fatigue as "burnout is a lack of satisfaction with your job, too much stress, not enough pay" (Expert Interview, 2005, p.1). More recently compassion fatigue has been linked to the concept of secondary traumatic stress, as features resemble those of posttraumatic stress disorder (Cox, 2008). Figley (2004) categories manifestations of compassion fatigue/burnout syndrome into seven (7) major areas: "cognitive, emotional, behavioral, spiritual, personal relationships, physical, somatic, and work performance" (p. 14). Under each category are listed descriptions such as: increased heart rate, increased breathing, sleep disturbances, depression, preoccupation with trauma, apathy, loss of faith, poor work quality, task avoidance, and low morale to name a few (Figley, 2004). A closely related concept, burnout, has also received much attention in the nursing literature. Blamed for high staff turnover rates, poor performance, and increased patient dissatisfaction, burnout is described as a syndrome composed of emotional exhaustion, reduced sense of personal achievement, of being emotionally over extended or a sense of being depleted of energy because of the demands of interacting with patients, families, co-workers, and employers (Milliken, Clements, & Tillman, 2007). Many sources describe measures to counter burnout which often include administrative level management's acknowledgement of the toll nursing work has on the individual and the need to initiate measures to assess and modify the total nursing work environment (Erickson & Grove, 2007; Matheson & Bobay, 2007; Milliken, Clements, & Tillman, 2007; Mimura & Griffiths, 2003; Sabo, 2006; Sherman, 2004; Shirey, 2006a; Shirey, 2006b; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). It is worth noting that in the work environment both the physical and emotional components are key factors in nurses experiencing burnout. Strategies to improve the physical work environment are abundant; however, strategies to improve the nurse's emotional environment are often addressed from the perspective of what management can do rather than what the individual can do.

Psychological harassment and emotional aggression are descriptive of the more commonly used term bullying. Intimidation, incivility, lateral violence anger, agitation, and oppressed group behaviors are words used to described the unhealthy bullying that has long been part of nursing's culture (Erickson & Grove, 2007; Felblinger, 2007; Matheson & Bobay, 2007; Stevens, 2002). A common reason for this negative behavior is closely tied to theories of oppression, a controlling environment, and feelings of lack of control by the nurse in the work place. These and other factors lead to agitation/frustration, anger and aggression (Stevens, 2002). This form of violence escalates when the stressors that precipitate the behavior go unchecked and unrecognized. Longo (2007) lists examples of bullying behaviors as accusations against others, nonverbal body signals such as staring at someone, being ignored, gossip, being yelled at, humiliated, frequently given undesirable assignments, sabotage, information withholding, and physical threats. Consequences of bullying by the perpetrator include escalating feelings of anger and shame. For those being bullied, the range of possible responses has serious consequences on recruitment and retention activities. The organization faces serious financial issues related to sick time, nonproductive work time and an environment prone to increased errors. Being bullied is extremely stressful for the recipient. The bully is also the victim of stress, through less often recognized as they are a casualty of poor coping skills. This self-protective behavior tends to cover up the core issues that promulgated this angry response in the first place.

Fatigue, another concept that negatively impacts patient safety is often defined in terms of the need for adequate sleep/rest between hours worked. When those charged with caring for patients arrive at work already exhausted due to a variety of reasons, they increase the risk for adverse events both for the patient and for themselves (NSO, 2001). Fatigue can be traced to certain lifestyle habits such as poor nutrition and lack of physical fitness. Difficulty falling and staying asleep is considered a national epidemic (Hauri & Linde, 1996; Jacobs, 1998). Research compared a severely fatigued caregiver's performance on a task that requires tracking to someone driving while under the influence of alcohol; in both instances performance is equally diminished (Gaba & Howard, 2002). A tired caregiver is as much a risk to others as to themselves; as in Sara's case a twenty (20) to thirty (30) minute commute after a 12 hour shift puts her and any passenger at increased risk for an automobile crash. In 2006 the American Nurses Association (ANA) published two position statements related to fatigue because of increasing concerns of patient and staff safety: (1) *Assuring Patient Safety: Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued* and (2) *Assuring Patient Safety: The Employers' Role in Promoting Healthy Nursing Work Hours for Registered Nurses in All Roles and Settings.* These position statements call upon nurses and employers to evaluate current practices and institute measures to guard the safety of both the patient and the nurse (ANA, 2006).

Fatigue is also intertwined with the concept of vigilance. Even when well rested, nurses cannot realistically be expected to remain vigilant over an extended amount of time such as the common 12 hours shifts many nurses work. Vigilance is defined as "a state of watchful attention, of maximal physiological and psychological readiness to act and of having the ability to detect and react to danger" (Hirter & Van Nest, 1995, in Meyer & Lavin, 2005). Vigilance has been described as the true essence of nursings' work (Meyer & Lavin, 2005). This state of high alert while seeming at first glance a noble way to describe the work of nursing may instead be compared to the state of alarm described in the stress reaction. It is critical nurses not only recognize but also act on cues from patients. Unfortunately, as described in Selye's General Adaptation Response (Olpin & Hesson, 2007), it is well known the human response to being on high alert is to fatigue over time. Just as the chronic stimulation of the fight or flight response leads to collapse, expectations that nurses must remain on high vigilance without breaks or emotional support can conceivably lead to what has been identified as burnout, compassion fatigue, or even bullying. In our present work/life environment, I propose many nurses are stressed beyond their ability to cope; manifesting

(Continued to page 11)

The Many Dimensions of Stress in Nursing

(continued from page 10)

a plethora of responses unique to the individual based on the person's values, culture, experiences, family, education and beliefs. These responses range from appetite changes, gastrointestinal disturbances, headaches, fatigue, changes in sleep, memory disturbances, anger, increased isolation, and impaired judgment and reasoning (Sherman, 2004). In the past these manifestations that occur when one loses the ability to cope have been identified as either burnout or compassion fatigue. Two authors even go so far as to write "prolonged exposure to compassion ***stress*** can lead to compassion ***fatigue***" (Frank & Karioth, 2006). In reality it is the vicious circle that is created when stressor(s) from sources perceived as a threat initiate(s) the stress response without intervening periods of restoration and balance, thus fatigue occurs and manifests in many forms. Stress is stress, whatever the source, the physical/neuro-chemical response occurs which cascades into the many facets of human reaction. One's coping skills are critically important in dealing with the perceived threat. The range of possible human responses based on one's worldview is influenced by one's adult development dimension.

Models form the view

Two well known and accepted models; Abraham Maslow's Hierarchy of Needs and Elisabeth Kubler-Ross's Five Stages of Grief, offer a framework from which to view the complexity of perceptions that may trigger stress and the resulting coping responses. Along with these models Cook-Greuter (2004), offers a model from which one could conceivably explain the range of human responses to stress based on a developmental perspective of the adult. Following is a brief overview of each model.

Maslow developed his model in the 1940's and 50's. It continues to be a reliable theory for understanding motivation/personal development. Maslow's original five stage model included the following levels of needs: biological/physiological, safety, belongingness/love, esteem, and self-actualization (Seaward, 2006). Maslow maintained needs must be met in the given order, motivation and drive shift one to the next higher order, conversely if the basic needs were not met, one could not progress. This premise has been challenged but for the sake of simplicity, this author will accept the original hypothesis as true. Consider Sara, her basic needs are being threatened, yet she is expected to arrive at work and perform as usual. Upon arrival, she is further threatened (bullied and abandoned) by her co-workers. As a nurse she is expected to "care" as this is a foundational value that the professional nurse is expected to uphold. When she is distracted with her personal issues the mismatch of the expectations of the work world (expected to perform in spite of being threatened) initiates another stressor.

Elisabeth Kubler-Ross's model describes the five stages of grief: denial, anger, bargaining, depression, and acceptance as a perspective from which to make sense of the process/work of coping (Seaward, 2006). Kubler-Ross acknowledged her grief model was also amendable to illustrate the stages of personal change and emotional upset or "death of unmet expectations" (Seaward, 2006, p. 90). As an example the perceived threat to an ideal/value triggers stress, the stages of grief help explain the range of responses. As an example, could accumulated anger manifest as bullying? Is compassion fatigue or burnout associated with Kubler-Ross's stage of depression? Is choosing alcohol, drugs, or food really the manifestation of denial or bargaining in an attempt to deal with the stress? Does acceptance of the fact that stress is affecting one's health provide the incentive to engage in healing activities? Is this the person who starts to eat in a healthier manner? Is this the person who takes up swimming to relax and increase their physical fitness? Is this the person who takes an anger management class to learn more appropriate coping skills? Acceptance is recognition that adjustment and coping with change/loss is a healthy way to deal with stress. With the perception of a loss, individuals move within what Kubler-Ross called stages. Even when the loss is no longer acute, activation of the stress response (grieving) may occur with activities such as gossiping. Whatever the label or category we invent to describe this phenomenon; in the end we still have nurses/individuals whose coping style influences many others around them. Consider what you now know based on the stated definition of stress, the description of Maslow's and Kubler-Ross's models, then layer on the theory of adult development. The scope and magnitude for one's reaction to stress increases dramatically once these dimensions are considered. Why is it that one person may shrug off an incident, while another falls apart? In the past this ability to shrug it off was attributed to hardiness or resilience. Could it be these hardy folk are further along the adult development path? Do they possess the ability to see incidents/life from a more comprehensive perspective?

Cook-Greuter (2004) outlined a major shift in the field of adult development theory from one of viewing people as mostly different types (personality) to identifying the levels of what she calls "meaning making capacity" people achieve in their lifetime. This adult developmental theory not only depicts vertical and lateral growth, but explains growth and expansion that occurs through many "channels." These channels or methods for enhancing the self at various stages are listed as education, continued training, self directed and life-long learning as well as life experience. This theory makes the following assumptions: Stage of development influences what can be noticed or what one can become aware of, therefore what can be described, articulated, influenced, and changed. Those at a later stage can understand earlier world-views, but one at an earlier stage cannot understand the later ones. Each stage/world view/meaning making system becomes more comprehensive, differentiated, and effective in dealing with the complexities that life hands us. Lateral development is geared towards enriching a person's *current way of meaning making*. Vertical development supports one to transform current way of making meaning toward a broader perspective. People tend to respond with the most complex system, perspective, or mental model they have mastered. Only long term practices, self-reflection, and dialogue as well as living in the company of others further along on the development path has been shown in research to assist in vertical growth (Cook-Greuther, 2004). The implications this model brings to the topic of stress and the resulting way one copes are enormous. The model provides a framework from which one can grasp a wider spectrum of human response to stress. Cook-Greuter provides a clear example by sharing different responses collected in her research based on one's vertical level. When subjects were asked how they felt about "feedback" the respondents within lower levels of development interpreted the meaning to be "critical, demeaning, or threatening." The higher level respondents interpreted feedback to mean positive growth, increase in self knowledge, they considered feedback as part of the natural part of living systems and feedback was "accepted, welcomed, or invited" (Cook-Greuter, 2004). Clearly, coping is dependent upon the adult development level. The spectrum of responses to the same stressor now has a theory from which coping skills can be taught/learned.

Back to Sara

Depending on Sara's adult development level, she may have different degrees of choices for her response to the stressors that have been presented to her over the course of this day. She could just sit down and cry, she could get angry, she could just "stuff it inside," or she may start to feel physically ill. She could find a sympathetic ear and unload to a co-worker about how awful her life is lately. She could be distracted, make mistakes, snap at others, avoid still others, and blame it all on some one else. She could start drinking alcohol after work, she could start taking sleeping pills to help her relax, or she could drink caffeinated beverages, coffee or

(Continued to page 12)

The Many Dimensions of Stress in Nursing

(continued from page 11)

eat sugary snacks to help her feel energized so she can stay awake. On the other hand she may know her husband will step up to the plate (he always does), she can forgive Bernice as she knows Bernice is an awesome nurse, has been a wonderful mentor, and is caring for her mother with Alzheimer's and is herself pretty stressed out. Sara may find her voice and ask her co-workers to fill out the missed info on the report sheet, she may need to sit down with Mary and reinforce the expectations of her job, she will need to face the family in 410, but she knows she possesses the skills and compassion to deal with their concerns and knows they are suffering. She is confident today's turmoil will pass. She sustains herself by staying present, not ruminating about how awful people are, by taking breaks, eating nutritionally sound food, by recognizing she has many more moments of peace versus drama in each day.

Coping Skills

How do we move from non-stop adrenaline pumping lives to a life with moments of calm dispersed between all the busy activities? The first step is to recognize the frenzy. The next step to make a commitment to actively engage in stress management options every day. We need to remember our perception lens through which we view our world is made up of our values, beliefs, our culture, our family traditions, our education, and our social group. It is a life long process to examine this lens and make a conscious decision to retain or change how we view the world. This is part of the process described by Cook-Greuther, our ability to clearly see our self shapes our growth and development as adults. It then makes sense to engage in coping activities that assist in adult growth and development.

Nursing literature lists the following activities as possible stress management solutions: breathwork (it activates the parasympathetic/ relaxation response), stretch breaks, nutrition breaks, massage, progressive muscle relaxation, guided imagery, friendly physical environment (lights, noise, distance for supplies, safe work place), limits on staffing ratios, limits on hours worked, emotional and social support (especially in situations related to trauma, death, high risk outcomes), education related to enhanced communication skills among co-workers and other healthcare team members, development and implementation of policies that eliminate workplace violence, bullying, and incivility, job enrichment, autonomy of nursing practice, quiet spaces/break areas to rest, leadership training, reflective practice, and formal intervention by a trained mental health practitioner (Manojlovich, 2007; Mimura & Griffiths, 2003; Milliken, Clements, & Tillman, 2007; Sabo, 2006; Shirey, 2006a; Timmerman, 1999; Tuck, Alleyne, & Thinganjana, 2006; Wicks, 2006). There are many options; all that is needed is the personal commitment to take action. Mahatma Gandhi said "Be the change you want to see in the world." If you would like your world to be a kinder place, be kinder. If you would like your work world to be less stressed, be less stressed. Here is a formula with which to start: Feed the foundation: sound nutrition and regular physical activity every day. Nourish and detoxify the mind: foster clear thinking, learn the practice of "no thinking," (meditation). Evaluate relationships, heal or remove yourself from those that poison. Feed your spirit: seek meaning and purpose, be fully present in each moment. Your life occurs now. If the present moment is cared for, every moment will be full of care. Reach out at every opportunity to help others along, as nurses those we care for extends to our patients, families, co-workers, support staff, strangers, and ourselves. Experience the joy of giving to others without expecting anything in return. Everyone needs cycles of activity interspersed with periods of rest and restoration. If we get off center, we are sure to find ourselves manifesting any number of those symptoms labeled as compassion fatigued, burn out or stressed out. Practice and refinement of coping/ relaxation techniques provide the energy to more easily and quickly find our way back to center and balance. The table below list strategies that others have found beneficial.

Table 1.
Stress Management Options

Coping Skills	***Relaxation Techniques***
Humor	Meditation
Journal writing	Visualization/guided imagery
Art therapy	Massage
Prayer	Music
Positive affirmations	Physical exercise
Cognitive restructuring	Yoga
Behavior modification	Tai Chi
Creative problem solving	Bio-feedback
Communication skills	Breathwork
Resource management/ money/time	Progressive muscle relaxation
Social support groups	Nutritional health
Hobbies	Mindfulness
Forgiveness	

(Compiled from Olpin & Hesson, 2007; Seaward, 2006)

(Continued to page 13)

The Many Dimensions of Stress in Nursing

(continued from page 12)

Enlist the support of a friend or colleague, pick one skill and one technique. Learn and practice it together. Teach your co-workers. Be a role model. In many of the references listed at the end of this article you will find a treasure list of resources.

Recommended Reading

- ***Coming to Our Senses: Healing Ourselves and The World Through Mindfulness***, by Jon Kabat-Zinn (2005, Hyperion)
- ***The Exquisite Risk: Daring to Live an Authentic Life***, by Mark Nepo (2005, Harmony Books)
- ***Stand Like Mountain, Flow Like Water: Reflections on Stress and Spirituality***, by Brian Luke Seaward (2007, Health Communications, Inc.)
- ***Everyday Greatness: Inspiration for a Meaningful Life***, compiled by David Hatch, insights and comments by Steven Covey (2006, Rutledge Hill Press)

Final look at Sara

The end of Sara's story is up to you.

1. *If you were Sara, what would you do?*
2. *What goal(s) would you set?*
3. *What interventions would you choose?*
4. *How would you know you are moving toward established goal(s)?*
5. *How would you apply the principles outlined in this article to your nursing practice?*

New Posttest Format

Please note that this continuing nursing education activity does not contain multiple-choice questions. We have introduced a new type of posttest that substitutes the multiple-choice/True or False questions with open ended questions. Simply answer the five (5) open-ended question(s) listed under Final look at Sara at the end of the article and return the enrollment/evaluation form, with payment, to NDNA as usual. (Form is on the last page of this article).

You may email your answers with the Enrollment/ Evaluation Form. Please clearly identify your name and address/email address on all correspondence. Email to becky@ndna.org Please write: Prairie Rose Sara in the address line.

References

American Nurses Association/ANA (2006). Position Statements: *Assuring Patient Safety.* Retrieved March 15, 2008 from http://nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/workplac.aspx

Benson, H. (1975). *The relaxation response.* New York: Harper Collins.

Cook-Greuter, S. R. (2004). *Industrial and Commercial Training: Making the case for a developmental perspective. 36*(7). Retrieved March 2, 2008 from www.cook-greuther.com

Cox, M. (2008). Compassion Fatigue. *Advance for Nurses.* Retrieved Feb. 12, 2008 from https://nursingadvanceweb.com/Editorial/Content/PrintFriendly.aspx?CC=59289

Davis, M., Robbins-Eshelman, E. & Mckay, M. (2000). *The relaxation and stress reduction workbook.* New York: MJF Books.

Erickson, R. J. & Grove, W. J. C. (2007). Why emotions matter: Age, agitation, and burnout among Registered Nurses. *Online Journal of Issues in Nursing. 13*(1). Retrieved Nov. 1, 2007 from www.nursingworld.org

Expert Interview, Medscape Psychiatry & Mental Health (2005). *Compassion Fatigue: An Expert Interview with Charles R. Figley.* Retrieved Feb. 13, 2008 from http://www.medscape.com/viewarticle/513615

Felblinger, D. (2008). Incivility and bullying in the workplace and nurses' shame responses. *Journal of Obstetric, Gynecological & Neonatal Nursing, 37*(2), 234-242.

Figley, C. R. (2004). *Compassion Fatigue Therapist Course Workbook: A weekend training course.* Florida State University and Green Cross Foundation. Retrieved Feb.14, 2009 from http://www.greencross.org/

Frank, D. I., & Karioth, S.P. (2006). Measuring compassion fatigue in public health nurses providing assistance to hurricane victims. *Southern Online Journal of Nursing Research, 4*(7). Retrieved Feb. 13, 2008 from www.snrs.org

Gaba, D. M. & Howard, S. K. (2002). Fatigue among clinicians and the safety of patients. *New England Journal of Medicine, 347*(16), 1249-1255.

Gates, D.M. & Gillespie, G. L. (2008). Secondary traumatic stress in nurses who care for traumatized women. *Journal of Obstetric, Gynecological & Neonatal Nursing, 37*(2), 243-249.

Hauri, P. & Linde, S. (1996). *No More Sleepless Nights.* New York: John Wiley & Sons, Inc.

Jacobs, G. D. (1998). *Say Goodnight to Insomnia*, New York: Owl Books.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*, 116-120.

Longo, J. (2007). *Bullying in the Workplace reversing a culture.* Center for American Nurses monograph. Silver Springs, MD

Manojlovich, M. (2007). Power and empowerment in nursing: looking backward to inform the future. *Online Journal Issues in Nursing, 12*(1). Retrieved Feb.13, 2008 from http://www.medscape.com/viewarticle/553403

Matheson, L.K. & Bobay, K. (2007). Validation of oppressed group behaviors in nursing. *Journal of Professional Nursing, 23*(4), 226-234.

Meyer, G. & Lavin, M. (2005). Vigilance: The essence of nursing. *Online Journal of Issue in Nursing.* Retrieved Feb. 14, 2008 from http://nursingworld.org/ojin.

Milliken, T., Clements, P.T., & Tillman, H.J. (2007). The impact of stress management on nurse productivity and retention. *Nursing Economics, 25*(4), 203-210.

Mimura, C. & Griffiths, P. (2003). The effectiveness of current approaches to workplace stress management in the nursing profession: an evidence based literature review. *Occupational Environmental Medicine, 60*, 10-15.

NSO, Risk Advisor (2001). *Fighting Fatigue at work, 10*(1), 1-2.

Olpin, M. & Hesson, M. (2007). *Stress management for life.* Belmont, CA: Thompson Wadsworth.

Sabo, B.M. (2006). Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *International Journal of Nursing Practice, 12*, 136-142.

Seaward, B. L. (2006). *Managing stress: principles and strategies for health and well-being.* Sudbury, MA: Jones and Bartlett Publishers.

Sherman, D.W. (2004). Nurses' stress and burnout: how to care for yourself when caring for patients and their families experiencing life-threatening illness. *American Journal of Nursing, 104*(5), 48-56.

Shirey, M. R. (2006a). Authentic Leaders Creating Healthy Work Environments for Nursing Practice. *American Journal of Critical Care, 15*(3), 256-268.

Shirey, M. R. (2006b). Stress and coping in nurse managers: two decades of research. *Nursing Economics, 24*(4), 203-211.

Stevens, S. (2002). Nursing Workforce Retention: A bullying culture. *Health Affairs, 21*(5), 189-193.

Taylor, S.E., Klein, L.C., Lewis, B.P. Gruenewald, T.L., Gurung, R.A.R. & Updegraff, J.A. (2000). Female response to stress: tend and befriend, not fight or flight. *Psychological Review, 107*(3), 41-429.

Timmerman, G. M. (1999). Using self-care strategies to make lifestyle changes. *Journal of Holistic Nursing, 17*(2), 169-183.

Tuck, I., Alleyne, R. & Thinganjana, W. (2006). Spirituality and stress management in healthy adults. *Journal of Holistic Nursing, 24*(4), 245-253.

Vahey, D. Aiken, L. Sloane, D., Clarke, S. & Vargas, D. (2004). Nurse Burnout and Patient Satisfaction. *Medical Care, 42*(2), 57-66.

Wicks, R. J. (2006). *Overcoming Secondary Stress in Medical and Nursing Practice.* New York: Oxford University Press.

ENROLLMENT FORM
EVALUATION FORM
Program Title: *The Many Dimensions of Stress in Nursing*
Program Number: P2.43
Date: Please return by **May 2010** to NDNA 531 Airport Rd, Suite D, Bismarck, ND 58504

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. EVALUATION (Check **Y**es or **N**o)

HAVE YOU ACHIEVED EACH OBJECTIVE?	Yes	No
1. Objectives: • Examine the various terminologies related to stress used in nursing. • Explore the relationship of well known models (Grief/ Hierarchy of Needs) to the concept of stress. • Discover an adult developmental model that illustrates the wide range of human responses when coping with stressors.		
2. Did the objectives ***relate to the overall purpose/goal of the activity?*** Purpose: ***Examine commonly used terminology related to stress, while viewing the sources and consequences of stress through the lens of adult development theory.***		
3. Were the teaching/learning resources appropriate?		
4. How would you rate your knowledge of this content *before* reading this article? (0- no knowledge to 10-expert knowledge)	**Write number**	
5. How would you rate your knowledge of this content *after* reading this article? (0-no knowledge to 10-expert knowledge)	**Write number**	
6. HOW LONG DID IT TAKE YOU TO COMPLETE THIS ACTIVITY?	**Write 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:

_____

_____

_____

_____

_____

_____

_____

_____

CNE-Net™, the education division of the North Dakota Nurses Association Earns National Nursing CE Accreditation

CNE-Net™, the education division of the North Dakota Nurses Association has again received national ***accreditation*** as a **Provider** of continuing nursing education by the American Nurses Credentialing Center (ANCC) and as an **Approver** of continuing nursing education by the American Nurses Credentialing Center (ANCC).

The American Nurses Credentialing Center's system for accreditation of continuing nursing education is a voluntary peer-reviewed accreditation process. An institution, organization, agency, or entity submits to an in-depth analysis of their continuing nursing education program to determine the capacity of the organization to provide quality continuing education activities for nurses. CNE-Net™'s ANCC accreditation status, which includes annual reviews, is valid for four years.

ANCC is the largest and most prominent nurse credentialing organization in the United States.

Members In The News

The American Nurses Credentialing Center National Magnet Conference was held October 15-17, 2008 at Salt Lake City, Utah. Nurses from Medcenter One Health Systems, Bismarck were present to be recognized for achieving Magnet status in 2008. Karen Macdonald, RN, FNP-BC, also successfully wrote the Cardiac Vascular Nursing examination. Macdonald works at Medcenter One in Cardiovascular Surgery as a nurse practitioner. In addition to this specialty certification, she also holds specialty certification from ANCC in Gerontological Nursing. She has just completed her eight year appointment to the ANCC Certification Commission, and did serve the last four years as chair of the commission.

How To Join NDNA

Membership is now completed through the ANA website at http://nursingworld.org/memapp/

You may also stop over at the office Monday through Thursday and have one of the staff assist you in joining online.

Dues are $20/ month.

Member registration is now completed at the ANA website. See the link below. https://nursingworld.org/memapp/index.cfm?fuseaction=renew&onelogin=y or call 1-800-284-2378 (direct to member services).

ANA now manages membership services. Paper registration does not occur through NDNA any longer due to the switch over to ANA. Members will receive notices for renewal from ANA.