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THE OKLAHOMA NURSE

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PRESIDENT'S MESSAGE

100 Years of Oklahoma Nurses: Making a Difference Every Day!!

In early May, we will be celebrating National Nurses Week. The theme this year is "Nurse Making a Difference Every Day!" How fitting this is, considering that the Oklahoma Nurses Association is in the cusp of our 100th anniversary! This is going to be an exciting year for us as we celebrate our past, look to the future of our profession and also work to preserve our destiny.

Karen Tomajan

Imagine, 100 years of nurses making a difference every day. How many people have we touched? Virtually every Oklahoman is touched by a nurse in some capacity over the course of a year, and certainly over the course of their lives. For no matter the health care setting, the presence of a nurse is the one constant. Nurses are the fabric of the health care system (and I use the term "system" loosely!) While nurses are the one universal constant, I do believe we are at times transparent, and must work together to make our presence known.

Nurses are known for compassion and caring, and hold a very special place in the hearts and minds of the public, as the most trusted profession. The 2007 Gallup Poll results for the Most Trusted Profession are in, and nurse ranked #1 again for eight of the last 9 years. This level of trust is important, in that it acknowledges in a very real way the contribution nurses make to their patients every day, and to society as a collective.

Nurses serve a unique role in society...the work we do is a privilege.

"Nurses touch lives in the most intimate way. W are privileged to be with patients at the most sacred times in a life, from birth to death. It's all about caring and touching the lives of other human beings, whenever we encounter them...nurses are positioned to touch the lives of patients during times of their greatest and most profound need. We have the opportunity to impact their lives in ways we may never totally know or appreciate."—Stephen Krau, Vanderbilt Medical Center

As I said, at times the contribution of the nurse may seem to be unnoticed. My greatest lessons on the contribution of the nurse at the bedside have always come during my hours sitting with family in the hospital. One night several years ago, when my father was very ill, I witnessed one of those incredibly humbling moments when the presence of a nurse became a defining moment in his care. He was very restless and refused have his blood drawn unless he could have a drink of water, which was not possible due to his condition. Dad's assigned nurse and I talked with him for hours, trying to convince him to let them complete this task, and he continued to adamantly refuse. By 3 am, we were all exasperated. Suddenly a new face appeared in Dad's room. "Hi Mr. Bergman, I'm Janet, I was your nurse last night, do you remember me?" He said he did. She said "Your nurse told me you were having a rough night and are very thirsty. You must be very uncomfortable." He nodded his head. His eyes immediately softened. He told her he was frustrated, and she agreed it would be frustrating to not be in his situation. She went through the same options we had discussed over and over earlier, but this time, he agreed to suck on a wet wash cloth, if he could have unlimited "dips" in water. She told him that would be agreeable, and he told her she better get his blood before he changed his mind!

Nurses Making a Difference Every Day

I have been a nurse for many years, and was immediately in awe of this kind and compassionate nurse. I thought I knew all the tricks to being therapeutic, but in this instance, a nurse taught me what it meant to turn a difficult situation around in an instant. She was busy, and he was not her patient. She did not have to take the time to check on my dad, but she did, and it made a difference for my dad in that moment, and has made a difference in how I view my profession even today! I doubt she remembers that moment, and I will never forget it!

As we plan for our 100th anniversary, it is

Continued on page 5

In This Issue

WISERWoman

Managing the Risks of Retirement

A Quarterly Newsletter From The Women's Institute For A Secure Retirement

When creating a retirement financial plan, most financial advisors recommend a goal of saving enough money to have 80 to 85% of pre-retirement income in retirement, but WISER urges women to plan for 100% of their pre-retirement income. Why the difference?

There are bumps and pitfalls during the average 20-year retirement period that put people, particularly women, at risk of falling short of the funds needed to maintain a comfortable lifestyle. Inflation and the risk of outliving income, living alone—divorce and widowhood—and increased health care expenses, including increased costs for medical insurance premiums and prescription drugs.

Being aware of the risks and planning for these possibilities will place you in a more secure position financially.

The Impact of Inflation

Inflation can seriously erode retirement assets, even a relatively low rate of inflation. If the rate is low when you retire, it may rise significantly during your retirement years and cut your ability to pay for things in half. Social Security has cost-of-living adjustments to help retirees keep up with inflation, but most private pensions do not—and if you are managing a lump sum from a 401(k) plan it will take strong returns from your investments to make up for the inflation loss. One strategy is to aim to have 100% of your pre-retirement income after you retire, through a combination of savings and Social Security—if you earn $40,000 before retirement, save enough to have the same amount. Then, even if your expenses are lower in retirement, you will have the flexibility to weather inflation.

Living Alone—Divorce and Widowhood

Many of us approach our retirement years with plans we've made for travel, leisure or moving to a

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ONA Core Values

ONA believes that organizations are value driven and therefore adopts the following core values.

The Code of Ethics for Nurses
Cultural Diversity
Health Parity
Professional competence
Human dignity and ethical care
Professional integrity
Quality and safe patient care
Commitment to the public health of the citizens of Oklahoma

ONA Mission Statement

The ONA is a professional organization representing a community of nurses across all specialities and practice settings.

Oklahoma Nurse Editorial Guidelines and Due Dates Submittal Information

Materials Due Date to Editor:	***Oklahoma Nurse Issue Date:***
April 15, 2008	June 2008 Issue

1. Manuscripts should be word processed and double-spaced on one side of 8 1/2 x 11 inch white paper. Manuscripts should be emailed to Editor at toneditor@hotmail.com.
   - Manuscripts should include a cover page with the author's name, credentials, present position, address and telephone number. In case of multiple authors, list the names in order in which they should appear.
   - Style must conform to the *Publication Manual of the APA*, 4th edition, 1995.
   - *The Oklahoma Nurse* reserves one-time publication rights. Articles for reprint will be accepted if accompanied with written permission.
   - *The Oklahoma Nurse* reserves the right to edit manuscripts to meet style and space limitations.
   - Manuscripts may be reviewed by the Editorial Staff.
2. Photographs should be of clear quality. Black & white photographs are preferred but not required. Write the correct name(s) on the back of each photo. Photographs will be returned if accompanied by a self-addressed, stamped envelope. Mail photographs to:
   Addie Ogunbekun
   Editor, *The Oklahoma Nurse*
   6414 N. Santa Fe, Ste. A
   Oklahoma City, Oklahoma 73116
3. E-mail all narrative to ona@oknurses.com

Contact the ONA

Phone: 405.840.3476
Toll Free: 1.800.580.3476
E-mail: ona@oklahomanurses.org
Web site: www.oklahomanurses.org
Mail 6414 N. Santa Fe, Ste. A
Oklahoma City, OK 73116

Questions about your nursing license?
Contact the Oklahoma Board of Nursing at 405.962.1800.

Want to advertise in **The Oklahoma Nurse?**
Contact Mark Miller at 800.626.4081 or email at mark@aldpub.com.

Arthur L. Davis Publishing: Excellence in Publication Award

The Arthur L. Davis Publishing Agency proudly announces a $1000 award to be awarded to the ONA Member who submits the 'most excellent' manuscript for publication in *The Oklahoma Nurse*. This Award is offered in celebration of the agency's 24 successful years in publishing and to affirm nursing. The award will be presented at the Awards Banquet and the manuscript printed in a future issue of *The Oklahoma Nurse*.

Manuscript Submission Guidelines:

1. The manuscript must be an original, scholarly work addressing topics of interest to readers of *The Oklahoma Nurse*. Examples of topics: Integrative literature reviews, clinical topics, evolving/emerging professional issues, and analysis of trends influencing nurses and nursing in Oklahoma.
2. Manuscripts must not exceed 15 double spaced pages and must conform to APA guidelines.
3. Manuscripts must be received in an email or diskette as Word Documents by September 1, 2006 to be considered. A cover sheet listing author (s) name, credentials, address, and work and residence telephone numbers and email address must be included. The author (s) name must not appear anywhere else on the submission.
4. The topic must be relevant to nurses/nursing in Oklahoma and provide new insights and/or a contrarian view to promote debate and discussion.
5. Ideas must be supported with sound rationale and adequate documentation.
6. If the manuscript describes a research project, quality initiative, or organizational change process, methods must be appropriate and participant confidentiality protected (as indicated).
7. The manuscript must be grammatically correct, organized, and submitted according to guidelines to be considered.

Manuscripts must be accompanied by a statement signed by each author indicating 1) the manuscript is NOT being considered for publication in any other journal; 2) the manuscript WILL NOT be submitted to another journal until notification of acceptance or rejection is received from the Oklahoma Nurses Association; and 3) willingness to sign a copyright release form upon publication of the manuscript in *The Oklahoma Nurse*.

Submit Manuscripts to the Oklahoma Nurses Association, 6414 N Santa Fe, Ste. A, Oklahoma City, OK 73119 or via email at ona@oknurses.com.

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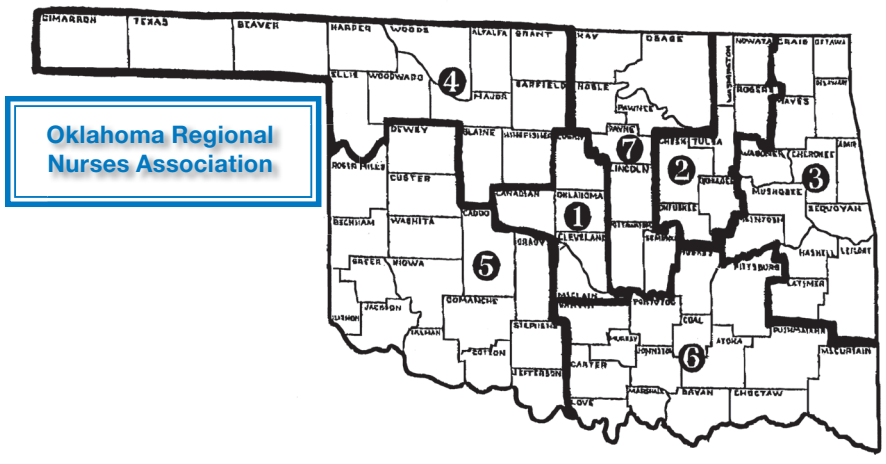
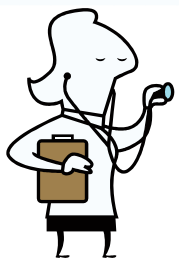


ONA News



Don't miss out on a great opportunity to have a voice with your State Representatives and Senators.

Sign up for

NURSE OF THE DAY!!!!

February 4 through May 30, 2008, Registered Nurses from all over the state sign up to represent Oklahoma Nurses at the Capitol during the Legislative session. This provides you with the opportunity to meet and discuss important Nursing issues with your Representatives and Senators. As an ONA member or member of an ONA Organizational Affiliate, when you sign up, you are able to bring along a student or a non-member nurse or one may be assigned to attend with you. Limited space in the clinic only allows room for 2 individuals to attend at one time. Below is information we need from you to sign you up for Nurse of the Day.

You can either email (ona@oklahomanurses.org) the information below or print off the form and fax 405.840-3013 or mail it to our office: ONA 6414 N. Santa Fe, Suite A, OKC, OK 73116. Any questions, please call 405-840-3476.

Name:_____

Address:_____

Day Phone:_____

Credentials:_____

Representative:_____

Senator:_____

Identify 3 dates (1st choice, 2nd choice, etc)

1st Choice: _____

2nd Choice:_____

3rd Choice:_____

(We will contact you to verify the date and will try to place you on the date you selected as first choice if possible)

Oklahoma Nurses Association 6414 N. Santa Fe, Suite A Oklahoma City Oklahoma 73116
450.840.3476 FAX 405.840.3013 www.oklahomanurses.org

The Importance of Nurse of the Day

Oklahoma Nurses Association's *Nurse of the Day* program serves as an effective advocacy tool for nurses across the state to talk one on one with Legislators. Everyday of the legislative session a registered nurse has the opportunity to actively participate in the legislative process. The *Nurse of the Day* has the opportunity to visit with legislators, attend various committee meetings and assist in the First Aid station at the Capitol. So that those participating in the *Nurse of the Day* or *Doctor of the Day* program are not tied to the First Aid station, there is a paid ER Nurse that oversees the care provided. The program allows nurses to voice their thoughts and opinions on currently legislation that affects nurses and healthcare.

This program serves as an ideal time way to let nursing's voice be heard! The *Nurse of the Day* will get a sense as to the respect and appreciation nurses have among legislators as they will hear related comments often while they are at the Capitol. Also it will provide an opportunity for nurses to learn more about the legislative process.

Now that the session has begun, many professional associations are trying to get legislators to take notice of their views. It is imperative that we have nurses to serve as *Nurse of the Day.* During the day the *Nurse of the Day* is introduced on the chamber floor at the beginning of the session and presented with a personalized certificate of appreciation. During the legislative session access to the chamber floor is reserved to a few privileged people, which includes the *Nurse of the Day.* This honor allows the *Nurse of the Day* beneficial one on one time with the legislators to discuss their views on current bills.

Please consider serving as *Nurse of the Day* sometime from February 5 to May 30. Nurses are the largest group of health care providers in the state. There are many issues that come before the Legislature that may affect the delivery of care, the nursing profession and nurses in general during the next session. It is imperative that Nurses are there to weigh in on these issues. The Oklahoma Nurses Association's *Nurse of the Day* has proven thought the years that it provides visibility and an opportunity for nurses' voices to be heard throughout the Capitol. Sign-up as *Nurse of the Day* using the form provided in this issue of the Oklahoma Nurse or on the ONA website www.oklahomanurses.org.

ONA News

MRC Volunteers Respond During the December Ice Storm

On Monday December 4th, 2007 the ice was thick, schools were closed and for many Oklahoma residents the electricity went out. Across the state shelters, many of them Red Cross shelters, opened to allow those without power to have a warm place to stay.

In Oklahoma City, American Red Cross opened shelters at Trinity International Baptist Church and the Reed Center. When the need for a larger shelter became evident the Cox Convention shelter opened jointly by the United Way, City of Oklahoma City, and the American Red Cross. Support was given by the Medical Reserve Corps volunteers who provided medical support and the Southern Baptist Convention as their volunteers provided meals. Initially MRC volunteer nurses were requested to assess individual's needs at the Trinity Baptist Church and the Reed Center. The request for volunteers grew at the Cox Convention Center to include medical and community volunteers. Over a 10 day period over 60 MRC volunteers donated their time.

In Tulsa the Medical Reserve Corps volunteers responded in support of Tulsa Area Red Cross. The Tulsa Metropolitan area experienced record-breaking power outages and catastrophic damage. Many MRC volunteers worked multiple six and twelve hour shifts to ensure the health and well-being of shelter occupants, despite being storm victim's themselves. In the end of a six day period, 30 MRC volunteers provided medical support to the three large ARC shelters and to 3 of the 5 ARC supported shelters in Tulsa County.

In Sapulpa, Bristow and Drumright shelters opened and 3 MRC volunteers worked over an eight day period.

ONA applauds all of the volunteers who helped during the December Ice Storm! We appreciate your commitment to caring for the people of Oklahoma especially during this busy season.

President's Message

(Continued from page 1)

important to recall the important accomplishments of our association and our profession. In 100 short years, we have established the licensure process for nurses, worked to define our scope of practice, lobbied the state legislature to pass the Nurse Practice Act and established a Board of Nursing to regulate our profession. A Code of Ethics for Nurses was developed, defining ethical practice of the registered nurse and is used in our state to guide our practice. In recent years, our association has worked with Nurse Midwives, Nurse Anesthetists, Nurse Practitioners and Clinical Nurse Specialists to formulate a new level of practice, designed to provide advanced level care and for some, an independent practice. The promise of this new role was, and still is, to create the potential for increased access to health care for all Oklahomans. It is extremely important that we all work together to demonstrate our commitment and resolve to protect this hard earned asset of our health care system. It is critical that we promote both the contributions made by advanced practice nurses today as well as clearly define the potential for the future as our industry works through some challenging times. Please watch for notices from the Oklahoma Nurses Association to contact your legislators. When you see those notices, please act swiftly. It will be a chance for you to make a difference for our patients every day, for the next 100 years and beyond.

I wish each and every one of you a wonderful nurse's week, and thank you for making a difference EVERY day! Making a difference for your patients, involves making a conscious choice to be present and engaged. It means going out of your way to assist patients and colleagues, just as Janet did for my father. As you know, we celebrate Nurses Week during Florence Nightingale's birthday, May 12. I leave you with some words from the Lady with the Lamp:

"Live your life while you have it. Life is a splendid gift. There is nothing small in it. For the greatest things grow by God's Law out of the smallest. But to live your life you must discipline it. You must not fritter it away in 'fair purpose, erring act, inconstant will' but make your thoughts, your acts all work to the same end and that end, not self but God. That is what we call character."—Florence Nightingale

Executive Director's Report

The Future of Oklahoma Nurses!

Jane Nelson

Now that our great state has celebrated its Centennial, it is time for ONA to celebrate 100 years of Caring!! Preparations are underway for ONA's Centennial. Numerous ideas have surfaced and projects are being researched for our celebration in the fall of 2008. Many of you have collected items over the years that commemorate nursing's and ONA's history. We would love to hear from you about what you have. Please contact us via email or mail ona.ed@oklahomanurses.org about your items and don't forget to include your contact information. We will be setting up a way to do this on our website www.oklahomanurses.org.

During the past 100 years, there have been many challenges facing the profession. Today is no different. Legislators need to hear our voice at the Capitol. We must work to ensure that all levels of nursing are regulated by nursing not medicine. That nursing's scope of practice in Oklahoma meets the national scope of practice. Our patients require access to health care, affordable insurance, coverage for chronic health issues, mental health and preventive health provided by all health care providers!

So you ask what are the specific issues facing nursing in 2008? To start, the Board of Nursing has approved changing prescriptive authority for APRNs from 7 to 30-days for Schedule III – V. This is much in keeping with the standard of care and DEA. In addition, Physician Assistants changed their prescriptive authority for these controlled substances last year from 10 to 30-days. This is now on its way to the Governor for signature. A bill dubbed the Non-Physicians Practitioner's Supervision Act has been introduced at the Capitol. This bill would move licensure and oversight of Advanced Practice Nurses away from the Board of Nursing to the Board of Medical Licensure. Legislators have heard and listened to the nurses in their district; Nurses want to be regulated by their peers and that this is not a CHANGE IN PRACTICE but only a CHANGE IN CONTROL. We must remain vigilant to protect nursing practice now and in the future.

The other issues before the Legislature affect our patients more than our practice. There are some in the Legislature that would like to allow insurance companies to have complete control over coverage, rolling back all the mandates for preventive health measures and then limiting the Legislature's ability for oversight of this industry. I am not sure I understand the rationale behind this bill. Why would an entity such as the Legislature give away its authority over any industry?

Oklahoma Nurses have worked hard to advocate for patients and coverage for preventive health issues at the Legislature. Now we must advocate not only for coverage of preventive and chronic care but also for all health care providers. Some insurance companies in this state don't cover care billed by Advance Practice Nurses. We must work to ensure that the citizens in Oklahoma have affordable health insurance coverage from all health providers.

Lets keep our Voices Raised! Policy makers in Oklahoma—Legislators, the Governor and other elected officials must hear the voice of nurses on these issues. I hope that you will continue to press the Legislature about the issues that affect nursing practice, access to health care, affordable insurance, coverage for chronic health issues, mental health and preventive health provided by all health care providers.

Local News

Oklahoma Fights Back Against Stroke!

Become a Stroke Hero! Get involved with this statewide initiative from the Oklahoma State Stroke Systems Advisory Committee to educate Oklahomans about Stroke.

A stroke is a sudden 'brain attack" that cuts off the blood flow and oxygen to the brain. Stroke is the 3rd leading cause of death in the nation. Oklahoma ranks 2nd for the number of deaths from [stroke or cardiovascular diseases]. Every year over 700,000 people in the U.S. die from a stroke. Become a STROKE HERO and **Act FAST!** to educate yourself and your community about a simple and accurate way to identify a Stroke.

FAST! is a mnemonic for **Face** droop, **Arm** drift, **Speech** slurred, and **Time** to call 911. **Act FAST!** is a statewide initiative from the Oklahoma State Stroke Systems Advisory Committee and the Oklahoma State Health Department. The Oklahoma State Health Department has a free toolkit for **Act FAST!** equipped with a 3 minute animated DVD, short instructions, posters, bookmarks, a list of frequently asked questions about stroke and a pre and post test evaluation with a postage paid return envelope. All that is needed is a toolkit, a HERO, a TV and DVD player, and approximately 15 minutes.

To become a Stroke Hero, present the ACT FAST! materials to a group of people in your community, at work, at your civic organizations, at your children's school, your church, or to your family. In 15 minutes you can become a HERO by educating and possibly saving your family and friends from death or permanent disability from a STROKE.

Stroke Heroes—**Act FAST!** and call the Oklahoma State Health Department for your toolkit today! Why? Because OKLAHOMANS don't like being #2 in anything! Educate yourself and others about STROKE and help save the life of a fellow Oklahoman.

For your free Act FAST! Toolkit, call 1-888-669-5934

Local News

Oklahoma Fights Back Against Stroke!

Information sheet to accompany the *Stroke Heroes Act Fast* video

Stroke FAQ

1. **What is a Stroke?** A stroke is a sudden "brain attack" that cuts off the blood flow and oxygen to the brain.
2. **Types of Strokes:**
   A. An ISCHEMIC stroke (85%) occurs when an artery is blocked by a build up of plaque, fatty deposits, or a blood clot.
   B. The HEMMORHAGIC stroke (15%) happens when a blood vessel breaks leaking blood into the brain.
3. **How does a stroke affect me?** Stroke is the third leading cause of death in the world and the leading cause of adult disability. There is one stroke every 45 seconds in the United States with a death from stroke every 3.3 minutes.
4. **What do you mean disabled?** Stroke causes brain cells to die at the rate of 2 million cells per minute unless quickly reversed, the abilities in that area of the brain are lost. This can include loss of speech, paralysis of one or more limb, difficulty in thought, and even difficulty in eating. 2/3 of all persons will have some type of disability, even if only a general weakness in an arm or leg.
5. **So why does Oklahoma need to fight back?** Oklahoma has the honor of being #2 in the nation—this means there is only one state that has more strokes and deaths from strokes per year than Oklahoma. This is not football —it is *NOT a good thing to be in the top TEN*! Currently, there is one stroke every 18 minutes in Oklahoma with a death from a new stroke every 3 hours.
6. **Who is at risk for a stroke? EVERYONE!** Stroke doesn't care who you are—it levels the playing field. ALL of us have some stroke risks, some we cannot change but some we can.
7. **The film said to Act FAST—what does that mean?** FAST is a quick test to help detect stroke symptoms and get the person help.
   F = FACE *Ask the person to smile. Does one sign of the face droop?*
   A = Arms *Ask the person to close their eyes and raise both arms. Does one arm drift downward?*
   S = Speech *Ask the person to repeat a simple sentence. Does the speech sound slurred or strange?*
   T = Time *If you observe any of these signs, call 9-1-1.*
8. **OKAY—Stroke is bad, I get it. But the film said with emergency medical care a stroke victim can recover. What did you mean?** There is a three hour window that begins from the time the stroke victim FIRST shows signs of a stroke during when the stroke victim can receive T-PA. T-PA can reduce the chances of dying or decrease the disability. The onset of stroke symptoms is when the patient experienced the first sign of a stroke or when the patient was last seen as normal.Confusing, right? If there is a witness to the change, mark down the time. If a person takes a nap beginning at 1 pm and wakes up with signs of a stroke at 2:30 pm, then the last time the person was normal was at 1 pm and that is the time to write down. DO NOT guess! Call 9-1-1 and tell them the person has had a stroke, the symptoms and when they began. DO NOT WAIT TO SEE IF THE SYMPTOMS GET BETTER. **Denial = Disability**. Call 9-1-1- immediately.
9. **Why can't I just put them in the car and take them?** The paramedics know what to do and which hospital to take the stroke victim to for emergency treatment. They can provide medical care that you can't.
10. **What do I do while I wait for the ambulance?** Gather all the information the hospital will need for the patient….identification, insurance cards, list of medications, etc. Stay with the patient for reassurance. Tell them what is happening. DON'T GIVE THE PATIENT ANYTHING BY MOUTH… no food, water, medication, nothing… NOT EVEN AN ASPIRIN!
11. **OKAY—back to the question—what can emergency medical care do?** If a stroke victim arrives in an emergency room within two hours of the first sign of symptoms, one of the first tests they are given is a CT scan of the brain to determine if they have had a stroke and what kind. Blood tests are also done along with an EKG. The doctors determine the course of treatment. If it is an ischemic stroke, and all factors make the stroke victim a candidate for T-PA, it can be given in the emergency room within the three hour window. T-PA is a 'clot buster' that can dissolve the clot and allow blood flow and oxygen back to the brain. With T-PA, disability can be decreased up to 50%.
12. **So I don't need to call 9-1-1 if it has been over 3 hours because there is nothing to be done?** Wrong! No matter what time the patient had first signs of a stroke, even if it was 3 days ago, get them to the hospital. Call 9-1-1. Without the CT scan and other tests, no one can tell if the patient had a stroke or there is another cause of the disability. There is still much that can be done for a stroke victim.
13. **Are there any other symptoms of stroke?** Yes—learn them and act FAST when they occur.
    A. Sudden numbness or weakness of the face, arm, or leg—especially on one side of the body.
    B. Sudden confusion, trouble speaking or understanding.
    C. Sudden severe headache with no known cause.
    D. Sudden trouble seeing in one or both eyes.
    E. Sudden trouble walking, dizziness, loss of balance or coordination.
14. **If everyone is at risk, there is nothing I can do, right?** Wrong.
    - Know your blood pressure and work with your doctor to control it if it is elevated. High blood pressure is the leading cause of stroke.
    - Control your diabetes. Follow your doctor's recommendations carefully. Diabetes puts you at risk for stroke.
    - If you drink alcohol, do it in moderation.
    - Add exercise daily. 30 minutes a day can improve your health in many ways and reduce risk.
    - If you smoke, stop. It doubles the risk.
    - Watching what and how much you eat. Cut down on salt and fat in your diet.

If you would like more information about stroke and the resources available, please call:

- Oklahoma State Department of Health at 1-888-669-5934
- American Heart Association at 1-888-4STROKES (787-6537)

Humor: One Byte at a Time

Diane Sears, RN, MS, ONC

When I first started nursing in the 70s, high tech was copy machine availability, a telephone at the desk, PDR on the shelf, paper worksheet, drip calculator card and my quad color ink pen. I was thrilled when we received simple e-mail and word processing capability. Though, it took me six months to get over the change revulsion of looking at a medication administration sheet online. Nowadays, I feel naked without a PDA in my pocket, pager clipped to the hip and computer at my fingertips.

Smart beds turn, weigh, monitor, chart, play music, exude aromatherapy and auto-page the nurse with a "Hey," if the patient should stray. Smart IV pumps refuse to infuse, unless all data checks are "go." Smart patient gowns record heart rate, temperature, moisture and come in wellness promotion colors. Smart radio frequency identification chips may be routinely implanted under patient's skin in the future and used in tandem with voice over Internet protocols to further shorten safe length of stays and prevent Code Grays. Smart nurses know that amidst all the high tech, high touch is still of paramount importance with healthy doses of humor to help the medicine go down, one byte at a time.

Use Voice Recognition Software Cautiously

"What the doctor said: He has a very good cholesterol.

What is typed: He is a vertical toy.

What the doctor said: Mom admits that when he was younger she spoiled him.

What is typed: Mom admits when he was younger she boiled him.

What the doctor said: She is here with her husband.

What is typed: She is here with her has-been." (Nurses Calendar, 2007)

"I want a computer that will do what I WANT it to do, not what I TELL it to do." ("Bizarro." cartoon, Dan Piraro, 12/24/05)

In "The Robotics Dept" with two robots talking to each other: "Here's the contract from our new Robot HMO Frank. Do they offer preventive care? Yes. There's no charge for anti-virus software. And dermatology? They'll do rust removal and repainting. For psychiatric care they'll make sure your head is screwed on straight, test for short circuits and provide for memory upgrades. How about this Y2K bug that's going around? Bad news…The HMO says Y2K is a pre-existing illness!" ("Frank & Earnest." cartoon, Thaves, 06/20/99)

"You know it's time to consider losing weight when your talking scale begs for mercy." ("B.C." cartoon, Creators Syndicate, Inc., 04/12/06)

Talking scale: "260 pounds!" Shoe: "Sigh!" –CLICK-. Scale: "117.9 kilograms!" Shoe: "Ah…much better!" ("Shoe", cartoon, Chris Cassatt & Gary Brookins, 12/20/07)

Writing on a bathroom wall: "For a good time, call: Home:…, Cell:…, text:… aim:, Myspace:…, Facebook:…, Blog:… Vlog:… Twitter:… E-fax:…. E-mail:… ichat:… website:… ("Speedbump," cartoon, Dave Coverly, 10/11/07)

Bytes At Work

THEN-ON THE DESK: "39 disorganized files, 22 pieces of mail, 6 unfinished projects. Coworker: "Oh you poor thing." NOW-ON THE HARD DRIVE: "640 disorganized files, 328 pieces of mail, 95 undiminished projects," Co-worker "Looks like you're done! Now you can help me!" Cathy: From the makers of the "paperless society," the "pitiless society." ("Cathy," cartoon, Cathy Guisewite, 07/05/03)

"Tina, our records show that you forwarded an average of nineteen e-mail jokes per week. Each joke goes to 30,000 employees, costing us ten million per year in lost productivity. We plan to blame you when we file for bankruptcy next week." ("Dilbert," cartoon, Scott Adams, 07/15/02)

Dogbert's Tech Support "Before I can help you, I need your tech support product identification code. You can find it by going to your local landfill and digging until you see your product's original packaging. But don't disturb the seagulls or they'll peck off your face." ("Dilbert," cartoon, Scott Adams. 01/02/06)

Brutus: "How dare you accuse me of being behind times!" I am on top of all the latest trends!" Boss: "Is that so? Your idea of text messaging… is when your wife leaves sticky notes for you on the refrigerator!" ("The Born Loser," cartoon. Art & Chip Sansom, 05/18/05)

Brutus Thornapple: "They call this the information age…If that's true…why does it seem like our parent knew more about life than we do?" ("The Born Loser," cartoon. Art & Chip Sansom, 07/24/03)

Innovations in Surgery. A family was on its way to the hospital, where the sixteen-year-old daughter was scheduled to undergo a tonsillectomy. She had never been in a hospital before, and was pretty nervous. During the ride, the teenager and her parents discussed the procedure. "Dad," the girl asked, "how are they going to keep my mouth open during the surgery? Without hesitation her dad said, "They're going to give you a phone." (Nurses Calendar, 2007)

Only Maxine

"I'm out of bed and I made it to the keyboard. What more do you want?

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Humor: One Byte at a Time

(Continued from page 8)

On Technology Revolution, my idea of rebooting is kicking somebody in the butt twice.

The worst thing about people at the office being replaced by computers is that computers don't respond to threats.

Why can't they make a garage door opener that would shut people's mouths?

My definition of "computer chip" is what's left over after I sledgehammer the computer."

I keep hitting the escape key, but I'm still here."

("Maxine," cartoons, J. Wagner)

Bits at home

Zoe: "Dad, can I use the computer for a second? Dad: "what for?" Zoe: I need to log on to my schools' web site, download my homework and print it out. Type, type type type type type. Dad: "Do you know how to do all that?" Zoe: "It's already done, thanks, dad. Zzzt!" Dad: "When I was your age, I had to walk ten miles through the snow to get the internet!" ("Baby Blues," cartoon, Baby Blues Partnership, 10/17/07)

Mom: "What do I do?" while handing over the new cell phone to her son.

Son: "Hit 'menu', scroll down to /messaging, then just select 'read message' and hit 'okay'. Mom: "Let me do it! Let me do it!" and she reads "Can I go see a movie with Pierce?" Mom to son: "How do I hit reply?" Son "Mom, it's sort of pointless of us to text each other if I have to go though this every time." ("ZITS," cartoon, Scott and Borgman, 07/05/07)

Son: "I tell yau mom…I'm really sick of this disconnected era we live in today. Whatever happened to the art of conversation…the simple communal act of a personal exchange of ideas? Mom: "Oh, I know deah. I was going on a rant about that just yestahday… on my podcast." ("Non Sequitir," cartoon, Wiley Miller, 07/19/06)

"And do you, funnygirl@bizone.net take harley99@comco.com.wedding? One wedding guest then turns to the other and says, "They met online." ("Speedbump," cartoon, Dave Coverly, 09/24/07)

Megabytes

Wife 1.0 Dear Tech Support:

This summer I upgraded from Girlfriend 7.0 to Wife 1.0 I soon noticed that the new program began unexpected child processing that took up a lot of space and valuable resources. In addition, Wife 1.0 installed itself into all other programs and now monitors all other system activity. Applications such as Poker Night 103, Football 5.0, Hunting and Fishing 7.5, and Racing 36 I can't seem to keep Wife 1.0 in the background while attempting to run my favorite applications. I'm thinking about going back to Girlfriend 7.0, but the uninstall doesn't work on Wife 1.0 . Please help! Thanks, Troubled User.

Dear Troubled User:

This is a very common problem that men complain about. Many people upgrade from Girlfriend 7.0 to Wife 1.0, thinking that it is just a Utilities and Entertainment program. Wife 1.0 is an OPERATING SYSTEM and is designed by its Creator to run EVERYTHING!!! It is also impossible to delete Wife 1.0 and to return to Girlfriend 7.0. It is impossible to uninstall, or purge the program files from the system once installed. You cannot go back to Girlfriend 7.0 because Wife 1.0 is designed to not allow this. Look in your Wife 1.0 manual under Warnings-Alimony-Child Support. I recommend that you keep Wife 1.0 and work on improving the situation. I suggest installing the background application "Yes Dear" to alleviate software augmentation. The best course of action is to enter the command C:\ APOLOGIZE because ultimately you will have to give the APOLOGIZE command before the system will return to normal anyway. Wife 1.0 is a great program, but it tends to be very high maintenance. Wife 1.0 comes with several support programs, such as Clean and Sweep 30, Cook It 1.5 and Do Bills 4.2. However, be very careful how you use these programs. Improper use will cause the system to launch the program Nag Nag 9.5. Once this happens, the only way to improve the performance of Wife 1.0 is to purchase additional software. I recommend Flowers 2.1 and Diamonds 5.0! WARNING!!! DO NOT, under any circumstances, install Secretary With Short Skirt 3.3. This application is not supported by Wife 1.0 and will cause irreversible damage to the operating system. Best of luck, Tech Support." e-mail 2005)

Wife talking to husband at dinner: "I don't want to read your blog, just tell me how your day was." ("Wit & Wisdom," cartoon, Casey Shaw)

Wife: "You found out what you had done wrong and fixed it?" Husband: "No-I discovered a program on the computer that enables me to take it back in time! So I just set the computer back to a date before I made the mistake, then it was like it had never happened!" Wife: "What a wonderful feature!" Husband: "Yeah...if only life had on option like that!" ("The Born Loser," cartoon. Art & Chip Sansom, 09/26/04)

Shoe: "Oh no…what are you doing to my computer now?" Wizard: "Not a thing… I was just playing around with this new search engine…it's amazing Tell me something you'd like to find and I type it in." Shoe: "Okay… my car keys." ("Shoe," cartoon, Chris Cassatt & Gary Brookins, 03/14/04)

Car salesman to customer: "And the global positioning system in this baby is so advanced…if you get lost, it will nag you until you stop and ask someone for directions." ("Shoe," cartoon, Chris Cassatt & Gary Brookins, 02/19/06)

Husband 1.0

Dear Tech Support,

Last year I upgraded from Boyfriend 5.0 to Husband 1.0 and noticed distinct slow down in the overall performance,

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Humor: One Byte at a Time

(Continued from page 9)

particularly in the flower and jewelry applications, which operated flawlessly under Boyfriend 5.0. In addition, Husband 1.0 uninstalled many other valuable programs, such as Romance 9.5 and Personal Attention 6.5 and then installed undesirable programs such as NFL 5.0, NHL 4.3, MLB 3.0, PSU 6.8 and NBA 3.6. Conversation 8.0 no longer runs, and Housecleaning 2.6 simply crashes the system. I've tried running Nagging 5.3 to fix these problems, to no avail. What can I do? Signed, Desperate

Dear Desperate,

First keep in mind, Boyfriend 5.0 is an Entertainment Package, while Husband 1.0 is an Operating System. Try to enter the command: G:/ITHOUGHTYOULOVEDME" to download Tears 6.2, which should automatically install Guilt 3.0. If that application works as designed, Husband 1.0 should then automatically run the applications Jewelry 2.0 and Flowers 3.5. But remember, overuse of the above application can cause Husband 1.0 to default to Grumpy Silence 2.5, Happy Hour 7.0, or Beer 6.1. WARNING: Beer 6.1 is a very nasty program that will create Snoring Loudly. CAUTION: Whatever you do, DO NOT install Mother-in-law 1.0 or reinstall another Boyfriend program. These are not supported applications and will crash Husband 1.0. In summary, Husband 1.0 is a great program, but it does have limited memory and cannot learn new applications quickly. You might consider buying additional software to improve memory and performance. I personally recommend Hot Food 3.0 and Lingerie 7.7. Good Luck, Tech Support" (e-mail, 2004)

Wife: "Has the computer crashed permanently?" Husband: "No-after trying everything I could think of, I finally found a way to get it running again!"

Wife: "You found what you had done wrong and fixed it?" Husband: "No-I discovered a program on the computer that enabled me to take it back in time! So, I just set the computer back to a date before I made the mistake, then it was like it had never happened!" Wife: "What a wonderful feature!" Husband: "Yeah…if only life had on option like that!" ("The Born Loser," cartoon. Art & Chip Sansom, 09/26/04)

"So, you're a systems analyst? So do you ask systems about their feelings? About how their parents screwed them up when they were kids?" (Paula Poundstone)

Computer Giggles

"This ought to make you feel better about your computer skills! Unbelievable, but supposedly all true!!!!

Tech support: What kind of computer do you have?
Female customer: A white one...
Customer: Hi, this is Celine. I can't get my diskette out.
Tech support: Have you tried pushing the Button?
Customer: Yes, sure, it's really stuck.
Tech support: That doesn't sound good; I'll make a note.
Customer: No, wait a minute... I hadn't inserted it yet... it's still on my desk... sorry....
Tech support: Click on the 'my computer' icon on to the left of the screen.
Customer: Your left or my left?

Tech support: Good day. How may I help you?
Male customer: Hello... I can't print.
Tech support: Would you click on "start" for me and...
Customer: Listen pal; don't start getting technical on me! I'm not Bill Gates.

Customer: Hi, good afternoon, this is Martha, I can't print. Every time I try, it says 'Can't find printer'. I've even lifted the printer and placed it in

Tech support: Your password is the small letter a as in apple, a capital letter V as fn Victor, the number 7.
Customer: Is that 7 in capital letters?

Customer: Can't get on the Internet.
Tech support: Are you sure you used the right password?
Customer: Yes, I'm sure. I saw my colleague do it.
Tech support: Can you tell me what the password was?
Customer: Five stars. (*****)

Customer: I have a huge problem. A friend has placed a screen saver on my computer, but every time I move the mouse, it disappears.

Tech support: How may I help you?
Customer: I'm writing my first e-mail.
Tech support: OK, and what seems to be the problem?
Customer: Well, I have the letter 'a' in the address, but how do I get the circle around it?

A woman customer called the Canon help desk with a problem with her printer.
Tech support: Are you running it under windows?
Customer: "No, my desk is next to the door, but that is a good point. The man sitting in the cubicle next to me is under a window, and his printer is working fine.

Customer: I have problems printing in red...
Tech support: Do you have a color printer?
Customer: Aaaah.....thank you.
Tech support: What's on your monitor now, ma'am?
Customer: A teddy bear my boyfriend bought for me at the 7-11.

Customer: My keyboard is not working anymore.
Tech support: Are you sure it's plugged into the computer?
Customer: No. I can't get behind the computer.
Tech support: Pick up your keyboard and walk 10 paces back.
Customer: OK
Tech support: Did the keyboard come with you?
Customer: Yes
Tech support: That means the keyboard is not plugged in. Is there another keyboard?
Customer: Yes, there's another one here. Ah...that one does work...

And last but not least...
Tech support: "Okay Bob, let's press the control and escape keys at the same time. That brings up a task list in the middle of the screen. Now type the letter "P" to bring up the Program Manager."
Customer: I don't have a P.
Tech support: On your keyboard, Bob.
Customer: What do you mean?
Tech support: "P".....on your keyboard, Bob.
Customer: I'M NOT GOING TO DO THAT!" (e-mail 06/06)

Nursing Interfaces & IT Vendors

"On occasion nurses need to explain to software vendors how terminology differs between the IT and the clinical world. Check out the following examples.

Pop-up message on the computer screen reading "Killed the Client" somehow doesn't seem appropriate, when there is a background job error—especially if the patient is alive and kicking.

Designing a desktop where the patient view is referred to as the "object level." Hmmmm—somehow seems worse than referring to the patient by room number.

"Deadly embrace" may sound romantic or perhaps even be the name of a great movie someday, but nurses wouldn't classify a system traffic jam (where jobs can't get through) as "deadly." They know what deadly really means." (Peggy Budnik, RN)

Nightbytes

A veteran nurse was experiencing stress as she adapted her long standing work schedule and documentation routines to the new computerization at work. She arrived at work in the morning telling the following nightmare.

"I was sitting on a plane, patiently waiting for friends to board. Suddenly the plane takes off with no pilot, due to "computer malfunction" but we end up safely landing in Muskogee." (Marilyn Vogel, RN)

You never want to byte off, more than you can chew. Smart, proactive Oklahoma nurses will keep some pen and paper in their pockets because you never know what the next wind sweeping down the plains will bring, could be rain, dust or ice.

Continuing Education

Loren Stein Selected Education Coordinator

Loren Stein, RNC, MSN has been selected as the new Education Coordinator for the Medical Reserve Corps effective September 2007. These responsibilities partner well with Loren's part-time work as the Project Director for the Oklahoma Nurses Association (ONA). ONA and Loren have been supporting the education of nurses within the Medical Reserve Corps since the 2004. As one of the original MRC grantees and as an approved provider of continuing education for Registered Nurses ONA has been developing disaster related educational programs for several years.

Loren Stein's Masters Degree is in Nursing Education and she is an Assistant Professor at the University Of Oklahoma College Of Allied Health. "Education is my forte." Loren stated. While the Medical Reserve Corps has had regular trainings offered they have not had a formal curriculum. In her new position, Loren oversees the development of a comprehensive curriculum based on national MRC core competencies; the implementation of the curriculum in seven counties with a goal to expand to new counties; facilitates community partnerships to establish local training resources and evaluates the effectiveness of the program. In addition, the MRC is exploring the means for volunteers to easily access on-line training and methods to track the volunteers' course work.

"We will develop the structure for local communities to organize and implement their customized educational programs to meet the unique needs of their community." said Loren. She noted that Oklahoma has a wonderful group of county volunteer coordinators, health department liaisons, American Red Cross educators, Emergency Management personnel who are excited about strengthening the local MRC training and education programs. Their support strengthens the response of volunteers with the knowledge and skills needed in their community.

NEWS FROM ANA
AMERICAN NURSES ASSOCIATION

Chemical Exposures on the Job May be Linked to Diseases in Nurses

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

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

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

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

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

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

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

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

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

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

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

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

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

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Diabetes & Lifestyle

Diabetes is often called a lifestyle disease, and now a new study from the University of Missouri-Columbia (MU) verifies that a lifestyle change brings strong improvements. And people with diabetes who attended classes to help them increase their exercise had more significant improvements than people who focused on trying to change exercise, diet modification and medication at the same time.

"In studies that focused on exercise only, blood glucose improved twice as much as in studies that focused on exercise, diet and medication adherence," said Vicki Conn, professor and associate dean of research in the MU Sinclair School of Nursing.

The meta-analysis considered data from 10,455 subjects in 103 research reports. No previous meta-analysis has compared exercise-only interventions with interventions including multiple diabetes self-management behaviors.

"One thing we found was that it doesn't matter how overweight you are or how poor your current blood glucose is at the start of the studies, the improvements from exercise were equal across the board," said Conn, a Missouri Nurses Association member.

The study also found that women did not improve as much as men. However, both young and older adults had similar benefits from the physical activity intervention.

"The censuses among these studies could mean that it is easier for people to focus on one thing at a time. It is easy for people to get overwhelmed when asked to make too many changes," Conn said.

The study was recently published in *Diabetologia*. The study was co-authored by David Mehr, professor in the MU School of Medicine, and Joseph LeMaster, assistant professor in the MU School of Medicine.

"Reprinted with permission from The American Nurse, September/October 2007, published by the American Nurses Association."

ANA Launches New Safe Staffing Website *Education, Resources for Nurses*

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

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

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

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

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

Financial Management and the Professional Nurse: Oxymoron or Professional Mandate?

Betty R. Kupperschmidt, EdD, RN, CNAA
University of Oklahoma
College of Nursing Faculty

I'm a _____, why do I need to learn financial management?

Regardless how you fill in the above blank, such as staff nurse, OR nurse, or even nursing faculty, in today's cost—conscious, competitive health care environment, a basic knowledge of financial management is integral to professional practice.

You may be asking, "Why must every practicing RN have a basic understanding of economics and financial management?" The answer is to practice according to the ANA Standards of Practice (2004). In this document, the following expectations are spelled out.

Standard of Professional Performance:

Standard 7. Quality of Practice, reads as follows:

- Participating in efforts to minimize **costs** and unnecessary duplication.
- Analyzing factors related to safety, satisfaction, **effectiveness and cost/benefit** options. (p. 33)

Standard 14. Resource Utilization, reads as follows:

- Evaluates factors such as safety, **effectiveness,** availability, **cost/benefit**...when choosing practice options that would result in the same expected outcome. (p.42)

How can professional RNs minimize costs if they do not know how to determine the cost of an item or procedure? How can they participate in initiatives to study cost effectiveness if they cannot differentiate direct and indirect costs or fixed and variable costs?

I was prompted to write this commentary when Shelly Wells, the faculty who teaches the OUCN financial management course, shared the following.

"I have had many graduate students tell me that they are glad they are "not in management" or "never want to be in management" to which I counter: EVERY advanced practice nurse is indeed a manager. Without some understanding of financial management in healthcare, an advanced practice nurse (APN) will not be successful. Patients will depend upon the APN to understand the financial consequences of prescriptions, diagnostics and the like. Organizations will depend upon their Managers and CNSs to understand the financial consequences of their work and the APNs themselves had better have some understanding of the financial consequences of their own actions as they relate to compensation."

I must admit I am really bothered by that attitude. Almost two decades ago, when I began teaching at OU, I taught a 2-hour required course about the basics of management. At that time, I had to 'convince' students that each nurse is a manager of resources (financial, physical, and human). I heard similar disclaimers from students that they did not want to be Managers because they did not want to have to be concerned about finances. As Timothy Porter O'Grady would say, "Colleagues, this is stinking thinking!"

I echo Shelly's words and broaden to Nurse Educators. Nurse Educators are infamous for long, 'processive' faculty meetings. If they took the time to really understand the cost of those meetings (something as simple as # faculty salary dollars X # hours in meetings), would they endeavor to become more outcome focused? What if some of the dollars saved could be applied to attendance at Faculty Development Conferences off campus, would that be an incentive to be more outcome focused?

If today's practicing nurses feel that they do not have to be concerned about, let alone informed about, the cost of the services we provide, leaders are dropping the ball somewhere. I suggest that every RN student, regardless of the type of program (ADN or BSN), must graduate with a basic understanding of financial management that prepares them to meet the above professional standards. There seems to be evidence that this may not be happening, thus the responsibility falls upon clinical leaders to provide the education for their staff RNs.

In summary, as an educator I realize that nursing curricula are already full. However, a basic understanding of financial management concepts, which includes economics, must be part of undergraduate and graduate nursing curricula. As Shelly reminds us, our patients expect it of us and we need some understanding of the financial consequences of our personal actions and how these actions relate to our compensation.

OONE
Oklahoma Organization of Nurse Executives

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Why Not More Federal Dollars for Nursing Education in Oklahoma?

Geraldine Ellison, PhD, RN Interim Executive Director, IONE

Each year the nursing profession lobbies for its "fair share" of federal funding to support nursing research (National Institute for Nursing Research), nursing education and retention (Health Resources Services Administration [HRSA], Division of Nursing) and scholarships. Many of you likely participate in organizations that send out hurried requests for contacts to be made to your legislators to support proposed funding levels or block proposed cuts to funding levels for nursing. Our collective responses do make a difference, and each year seems to add some additional funding for nursing (albeit growth is slow).

Along with 11 other states, Oklahoma is in the third tier for $ received through HRSA (2006 data). Of the $44,053,000 awarded to Oklahoma, approximately $590,741 (.013%) was for nursing education, diversity, and graduate nurse traineeships. Interestingly, Missouri (second tier) received $95,788,230 from HRSA and$1,235,203 (.013%) was awarded for nursing education related initiatives. Texas is in the first tier and received $330,482,818 from HRSA with $7,064,596 (2%) awarded to nursing. To be fair, of the 5.45 billion HRSA awarded, only $277,192,135 went to Health Professions—the category nursing education is in. This low "portion of the pie" for health professions education is the reason we need to continue to push for increases in funding for health professions and nursing, specifically. And so, there is an important lobbying role for all of us.

Why isn't Oklahoma in the top two tiers? The reasons are complex. While credence must be given to the "politics" of securing federal funding, the reasons we control are likely related to the writing skill and amount of time and energy involved in writing a competitive grant. The 120 pages of instructions are intimidating, and the recent requirement of an online submission has only increased the intimidation factor. Meanwhile, in this time of shortage, most nursing programs are doing everything possible to increase admissions. While a noble cause, these activities have resulted in an increased workload for the very faculty that would be the ones writing the grants.

Clearly, we need additional funding for nursing education in Oklahoma. Our success in resolving the nursing shortage will depend, in large part, on our educational programs adding new options and increasing admissions to existing programs. We also need to test innovative and creative approaches and partnerships, and federal funding is ideal for these types of initiatives. What can be done to increase our success in obtaining federal training grants for Oklahoma nursing education?

First, we must support additional funding for nursing. Join professional nursing organizations that have lobbying arms, and when you get those calls from your organizations to act on behalf of nursing, respond immediately. Second, in terms of securing more grants, one thing is clear, if we don't submit grants we won't receive funding! Therefore, more nursing programs must submit grants each year. It isn't unreasonable to establish a goal of doubling the total amount of awards each year. To that end, let's help each other. There are several successful grant writers in Oklahoma. Let's get this group together to share their knowledge and expertise about the elements of a good grant. Each year prior to the submission date, technical workshops are held around the country for nurses who are planning to submit a nursing grant. These fill up fast and so watch the HRSA, Division of Nursing website for dates and locations. A technical workshop is well worth attending, and staff is available to answer any questions you have about your grant idea or approaches you might use.

A thorough needs assessment with good data is critical to the success of a grant, and so we need good data about target areas. But where are these data? Some we must gather ourselves, and some are already available. The Oklahoma Board of Nursing annual reports are a good source of data. The Oklahoma HealthCare Workforce Center has data from the survey reported in the *Oklahoma's Health Care Industry Workforce: 2006 Report**. IONE has formed a Data and Research Committee for the purpose of collecting data with relevance to nursing education, and so it will be another important resource in the near future. The Oklahoma Department of Commerce is another source of data, and HRSA provides information on health professional shortages areas and healthcare workforce profiles by state. The Oklahoma State Regents for Higher Education (OSRHE) also offer technical assistance for grants and their services are described on their website http://okhighered.org/grant-opps/. Finally, if you are a nurse faculty with thoughts of writing a grant and you have a question about the grant process, email me at gellison@institute-ONE.org and I will do my best to answer. Federal funding won't solve all our problems but it will help. We should take better advantage of this source of funding than we have in the past. Likewise, we simply must become experts in working the political process to benefit quality health care and, most especially, our profession. There are in excess of 30,000 nurses in Oklahoma. Just think 30,000 voters! Just think, 30,000 articulate, knowledgeable, politically-savvy nurses who believe in and support their profession, and oh yes, who vote. I wonder what all we could do?

HRSA Grantees by Program or State, HRSA Grants Awards by Major Program or State (2006 data). Retrieved from http://www.hrsa.gov/grants/default.htm on December 26. 2008.

The full report is available on the Oklahoma Department of Commerce website: http://Okcommerce.gov/

WISERWoman Managing the Risks of Retirement

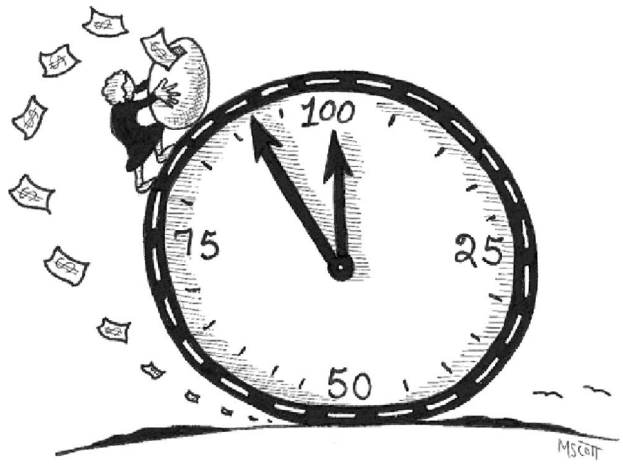
(Continued from page 1)

new location—plans made with a spouse in mind. But few of us plan for the eventuality of losing a spouse and the financial consequences of living alone. This is one of the largest planning pitfalls for women. By the time women reach age 80, only 16% will be married. Compare that to men who live to age 80—about 80% of them will be married. Because women live longer than men, widowhood is a very real possibility and the financial consequences of widowhood are serious.

Once widowed or divorced, women experience a significant decline in income, usually the result of losing one of the couple's two Social Security benefits, and if there is a pension a reduction of 50% of the benefit and in some cases, the loss of the entire pension check. But, many of the expenses of daily living, such as housing and utility costs, will remain about the same. The result is a large drop in income to pay for food, medical care and other expenses. Consider also that the average older woman spends 20% of her income on medical expenses, and you can see how as she ages, a woman's financial position becomes riskier.

How to manage this risk?

- √ Couples with a traditional pension at retirement should consider choosing the survivor benefit option. Former *Washington Post* reporter, Stan Hinden, a financial writer for 20 years, claimed his biggest mistake when retiring was not choosing the survivor benefit for his wife. One reason many people do not choose the survivor benefit is that the monthly amount of the benefit will be less because it works like an insurance policy by paying on the life of the survivor.
- √ Women in couples who have planned to have a combined Social Security, pension and savings income equal to 100% of their pre-retirement income will have a better cushion to fall back on when a spouse dies.
- √ Women who purchase immediate annuities with part of their savings can have a guaranteed stream of income over their lifetime, and are less at risk of running out of money. Annuities are purchased from insurance companies, and in exchange for a lump sum of money, the insurance company promises a steady stream of income that will not stop until she dies. For example, a $125,000 investment in a fixed-rate annuity would pay an average of $800 a month for life. Money invested in certain types of annuities can be passed on to heirs when the purchaser dies. For many women, it may make sense to explore this option in order to insure a stable source of income to supplement Social Security.
- √ Women with substantial equity in their home, who plan to live in their home long-term, may consider taking a "reverse mortgage" on their home and borrowing against the equity for living expenses. Funds from a reverse mortgage can be paid in a lump sum or monthly payments. The loan does not have to be repaid until the borrower dies or sells the house. A reverse mortgage can help many retirees live more comfortably, and remain in their own homes. You should consult a financial advisor before taking a reverse mortgage. Home equity spent on daily living expenses will not be available if the homeowner decides to move to an assisted living or other senior housing arrangement, and also will not be available to pass on to heirs.
- √ About half of all marriages in this country end in divorce, and there has been an increase in divorce among mid-life and older adults over the last two decades. Under the divorce laws of every state, a pension earned during a marriage is considered to be a joint asset or the marital property of both husband and wife. However, it is not automatic—your attorney must specifically ask for a share of the pension at the time of your divorce, not later when your husband retires. The attorney must also ask for a special court order, a Qualified Domestic Relations Order or QDRO that spells out how the share of the pension should be paid by the pension plan.



Health Care Expenses

The average retired woman spends close to 20% of her income on health care costs. For low-income retirees, the burden is much greater. Lower income retirees, primarily women and minorities, may spend 35% or more of their resources on health care. Paying for prescription drugs is a major concern for many seniors.

A recent study found that only those workers with a traditional pension, Social Security and retiree medical coverage will reach the level of income needed in retirement.

- √ Planning in advance for retiree health care coverage, or having sufficient funds to purchase Medigap insurance is the surest way to manage this risk. Most retirees who are successfully managing health care expenditures have additional coverage beyond Medicare.
- √ Work longer and be retired fewer years. See article Delaying Retirement Reaps Big Rewards on page 5.
- √ Seniors can obtain free consumer counseling at Medicare-sponsored insurance counseling services offered around the country, called SHIP programs. These counselors will help seniors find state and private prescription drug plans, managed care plans or other services or government benefit programs to help pay health care costs.

Continued on page 18

Managing the Risks of Retirement

(Continued from page 17)

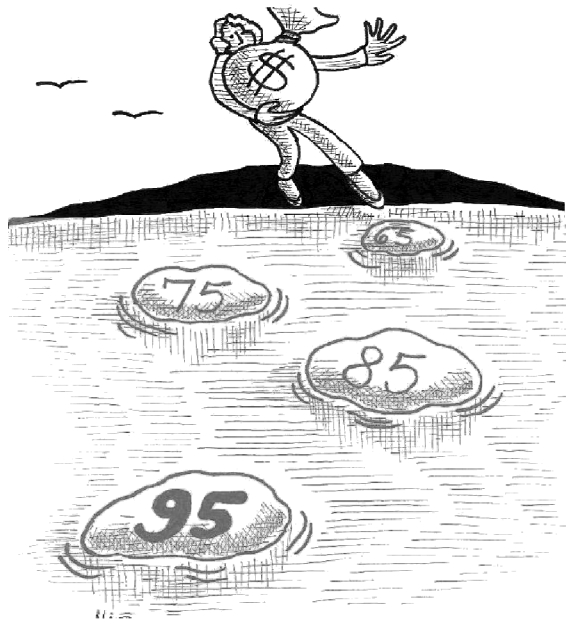
Housing Needs/Living Independently

Many seniors at some point in their lives will experience a loss of ability to live independently, often as a result of illness, disease or age. The risk increases sharply with advancing age. Yet, many near retirees have no plan for what they will do when they are no longer able to live independently. Often, a change in housing is also precipitated and seniors may find they need an assisted-living arrangement, nursing home or even just a new apartment or home that is wheelchair accessible or without stairs.

√ Give serious consideration to buying long-term care insurance once you are age 50 or older. Shop around for a policy before you commit to one. WISER's Spring/Summer 2005 newsletter contains "A Woman's Guide to Long-Term Care Insurance" (on our website at www.wiserwomen.org). The guide explains long-term care policies, how to buy them, and what to look for in a policy. Long-term care insurance will give you more choices in the type of care and setting, and policies with a good home care benefit can help you remain in your own home.

√ If you think you may need to move to a senior or assisted living community, look around at what's available before you are in a crisis situation. Some assisted living communities require a large lump-sum payment for entrance. Take the time to investigate what's available in your community and understand what the costs are. Moves can often be financed through savings, home equity and retirement income.

√ Medicaid will pay for nursing home care for the disabled, but only after the individual "spends down" their personal resources. There may be more limited options for choosing the setting for the care under Medicaid—individuals with long-term care insurance, savings and home equity will have better quality choices.



Living Too Long/Running Out of Money

Many times, people arrive at retirement with a lump sum amount of cash, and no idea how much they can withdraw each year, or when they will run out of money. As a rule of thumb, you can withdraw about 4 to 6% of your assets in your 60s, 5 to 7% in your 70s, 6 to 8% in your 80s and 8 to 10% in your 90s.

As an example, if you have $50,000 saved for retirement, you will be able to withdraw about $2,500 each year or about $200 each month in your 60s. In your 70s, the amount you will be able to withdraw will increase to about $250 each month and about $300 each month in your 80s.

Make a list of all your expected sources of retirement income, including pensions, Social Security, savings, employment and any other income. WISER's website has a link to a calculator that will help you calculate how much you need to save for retirement.

Every woman should have a retirement plan during her working years, and review the plan periodically. Take an active role in making your plan work as you may need to rely on it for the 20 or more years that you will live in retirement.

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Taking Care of Ourselves During a Crisis

Kate C. Walker, MSN, APRN, BC

Kate Walker

Kate is a Master's prepared Advanced Practice Nurse specializing in Psychiatric/ Mental Health issues. With 22 years of Psychiatric Nursing experience in Pennsylvania and at both the Delaware Psychiatric Center (DPC) & the Division of Substance Abuse & Mental Health (DSAMH), she has practiced extensively using the Recovery Model of treatment.

She has worked as an Assistant Director of Nursing and a Unit Director of both the Recovery Mall and several Treatment Units at DPC. Currently she is practicing as a DSAMH Nurse Educator providing education to DSAMH employees throughout the state. She is actively involved in the Recovery-based process for both professional staff & consumers. She also practices as a "Disaster Mental Health" responder for the state of Delaware.

On September 11, 2001, our world as we knew it changed. The nursing profession, as the front line of health care, is still adjusting to these changes. Although all nurses might not directly respond to a terrorist attack or other natural disaster, we provide care and support (physical, emotional or both) to those who have been affected directly by these horrifying events.

We, as nurses should prepare ourselves now to recognize our own stressors and be aware of our family members' reactions as well. For who knows better than a nurse when help is needed. If we can become familiar with universal stress responses, including signs and symptoms of depression &/or anxiety, in ourselves, our families, and our patients, we will be better able to assist them through future troubling times.[1]

Below is a list of "Common Stress Reactions" as manifested by the following behaviors and symptoms (Adapted from US Department of Health & Human Services, 2005).[2]

BEHAVIORAL CHANGES:

- ❑ Increase or decrease in activity level
- ❑ Substance use or abuse (alcohol or drugs)
- ❑ Difficulty communicating or listening
- ❑ Irritability, outbursts of anger, frequent arguments
- ❑ Inability to rest or relax
- ❑ Decline in job performance, absenteeism
- ❑ Frequent crying
- ❑ Hyper-vigilance or excessive worry
- ❑ Avoidance of activities or places that trigger memories
- ❑ Becoming accident-prone

PHYSICAL CHANGES:

- ❑ Gastrointestinal problems (nausea or diarrhea)
- ❑ Headaches, other aches & pains
- ❑ Visual disturbances
- ❑ Weight loss or gain
- ❑ Sweating or chills
- ❑ Tremors or muscle twitching
- ❑ Being easily startled
- ❑ Chronic fatigue or sleep disturbances
- ❑ Immune system disorders.

PSYCHOLOGICAL/EMOTIONAL CHANGES:

- ❑ Feeling heroic, euphoric, or invulnerable
- ❑ Denial
- ❑ Anxiety or fear
- ❑ Depression
- ❑ Guilt
- ❑ Apathy
- ❑ Grief

THINKING CHANGES:

- ❑ Memory problems
- ❑ Disorientation and confusion
- ❑ Slow thought processes; lack of concentration
- ❑ Difficulty setting priorities or making decisions
- ❑ Loss of objectivity

SOCIAL CHANGES:

- ❑ Isolation
- ❑ Blaming
- ❑ Difficulty in giving or accepting support of help
- ❑ Inability to experience pleasure or have fun

Possessing a heightened awareness of signs and symptoms of stress, which may appear within 24 hours up to 24-36 months after a traumatic event, we are better able to provide appropriate care. The key to management of any of the above symptoms is knowledge and planning.

Using knowledge of possible stress reactions discussed above, we can assess ourselves and others around us who may be affected. If we are aware of what we have experienced personally, we are better able to not only care for ourselves but to be available to help others.

Planning comprises a list of coping skills developed in advance, which have worked best in the past. We are then armed with personal "STRESS BUSTERS" to be used as needed.

For example, if we are feeling anxious or worried and find ourselves overwhelmed, relaxation breathing techniques can be used to move forward. For each of us, the answer will be different dependent on knowing "What works best for me when I am stressed?" For one person, the answer might be meditation; for another it might be exercise, listening to music or journaling. Each of us needs to spend the time now when we are not stressed to develop our action plan. Then we are better prepared to cope with unfolding emergent events.

Most, if not all Delaware nurses wear many hats and have many people to take care of besides ourselves. We have varying family responsibilities, many of us with children, and some of us in the "sandwich" generation with older parents about whom we are concerned.[3] All of us have had our personal sense of safety threatened at some time.

And last, but never least, our clients who depend on us to provide a safe environment, have had that safe place compromised. The type of care provided, in a post-911 world, could further damage the client's current physical or mental illnesses (from diabetes to drug abuse) making them more vulnerable to stress responses. In order to handle all of our responsibilities and maintain a sense of personal well-being, we must first reduce our own stress if we are to be able to help anyone else.

Lastly, "resilience,"[4] defined as "the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress" is another tool to develop and use. It will be invaluable as we prepare to meet our future challenges and life changes. It is important to remember that change is always possible but not usually liked by any of us. If we can utilize a mindset that considers change as a challenge and not just a problem, we can face the situation better. For we as human beings, are "resilient" even when faced by life's stresses and traumas.

FACTORS IN THE FORMATION OF A RESILIENT SPIRIT:

- ❑ Supportive relationships and a balanced lifestyle (work & recreation)
- ❑ Ability to make & implement an appropriate plan of action
- ❑ Confidence in your own abilities
- ❑ Problem-solving/communication skills
- ❑ Awareness & appropriate management of inner feelings

STRATEGIES IN RESILIENCE-BUILDING

- ❑ Cultivate positive personal supports
- ❑ See a challenge, not an overwhelming problem or crisis
- ❑ Realize that change in our lives is inevitable
- ❑ Alter your goals in the face of the emergency but continue to work toward them
- ❑ Make realistic actions part of your daily life
- ❑ Use the situation to learn new facts about yourself, i.e., strengths you didn't realize you had
- ❑ Take care of yourself, physically and mentally
- ❑ Believe in yourself and nurture your positive attributes
- ❑ Keep a healthy and realistic perspective
- ❑ And most of all, keep hope alive

(Courtesy of the American Psychological Association; www.APAHelpCenter.com)

If we are able to utilize even a few of these strategies, we have the tools to care for ourselves and our lives in spite of traumatic life events.[5] If we find we are having trouble doing this, look for additional support. When nurses are the ones needing support through a difficult time, we should avail ourselves of the help available, always taking care of ourselves as best as we are able.

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Emergency Preparedness for Adults with Disabilities

Marianne Smith, RN

Marianne Smith

The author began her 40 years of public service to people with developmental disabilities following her graduation from Peninsula General School of Nursing. Over the past four decades, she has served the Division of Developmental Disabilities Services in several capacities, including staff nurse, nurse supervisor, early intervention nurse, training coordinator, regional and, then, statewide director for Community Services. In her current role as Director of the Division of Developmental Disabilities Services, she directs the activities of over 600 employees who serve nearly 3,000 children and adults throughout Delaware. Marianne is also a member of the Governor's Commission on Community-Based Alternatives for Individuals with Disabilities.

Emergency preparedness (EP) has become an important part of everyday life in America! For individuals with disabilities, this has particular resonance. It is commonly known that individuals with disabilities had increased difficulty evacuating the Gulf Coast during Hurricane Katrina in the summer of 2005. This recent historical example has increased awareness of the need to improve EP for people living with disabilities. The Centers for Disease Control and Prevention estimates approximately 50 million adults in the U.S. have disabilities.[1] This figure represents almost 17% of the U.S. population. These people are as heterogeneous as the general population. They live in all types of residences. Many of them live independently without any caregiver or family. They come from all racial, ethnic, and socioeconomic groups. Their uniqueness, as a distinct demographic group, is that individually they have one or more cognitive, mental, sensory (hearing or vision loss), or physical disability. While some of these disabilities appear more obvious than others; each of them creates specific challenges in providing adequate and timely EP. These challenges have been described, by some, as 'special needs'. Delaware refers to them as 'non-typical needs'. Regardless, these 'needs' represent challenges that must be addressed in inclusively when developing EP strategies.

In June 2005, I attended at statewide conference on 'EP and Response for Individuals with Disabilities and Special Needs.' At that conference, the Disability Preparedness Center, an organization that provides EP resources to organizations, presented an 'Inclusive Emergency Planning Cycle'[2] that serves as a guide to programmers as they strive to develop effective EP strategies for adults with disabilities. The 'Cycle' includes eight steps:

1. Locating and Recruiting Individuals with 'Special Needs'
2. Developing Communication Links
3. Sheltering In Place
4. Evacuating
5. Transportation
6. Rescue
7. Recovery
8. Practice/Exercise

While each of these steps is critical, I think that the first two steps should be highlighted. Most individuals living with disabilities are not part of any particular 'service system'. They have independent lives as disperse and varied as the rest of us. At the same time, we realize that there are those individuals with disabilities that do live in nursing homes, group residential settings, and have significant, complex medical needs. Identifying all of these locations and integrating reliable communication systems amongst them and with EP organizations is quite challenging. Additionally, it is important for EP organizations to hear, first hand, from individuals with disabilities as to what it is they need if, in fact, they have to evacuate (or stay-in-place) during a time of emergency. For EP personnel, on the other hand, we have learned that information geared towards aiding individuals with disabilities needs to be concise and straight-to-the-point so that tasks can be effectuated quickly during a time of emergency.

The Center for Development and Disability has developed a pocket-sized, color-coded, flip-chart entitled 'Tips for First Responders'.[3] This field guide is filled with useful and succinct information for first responders as to how they can best help the following groups of people during an emergency situation: those with service animals, mobility impairments, autism, sensory impairment; multiple chemical sensitivities as well as those who are seniors. The tips are divided into various categories which are customized to that group's particular 'non-typical needs'. The section which is dedicated towards assisting those individuals with autism is categorized into three parts: communication, social, and sensory and behavior. It includes the following bulleted points:

1. Avoid using phrases that have more than one meaning such as 'spread eagle,' 'knock it off,' or 'cut it out.'
2. Because of the lack of social understanding, persons with autism spectrum disorders may display behaviors that are misinterpreted as evidence of drug abuse or psychosis, defiance or belligerence. Don't assume!
3. If the person is showing obsessive or repetitive behaviors, or is fixated on a topic or object, try to avoid stopping these behaviors or taking the object away from them, unless there is risk to self or others.

Another section focuses on assisting people who are deaf or hard of hearing. It includes:

1. If possible, flick the lights when entering an area or room to get their attention.
2. Establish eye contact with the individual, not with the interpreter, if one is present.

Such information can make the difference between effective and ineffective communication during a time when it is crucially important. In Delaware, the Division of Developmental Disabilities Services participates in a statewide, multi-agency group called the "EP for Individuals with Non-Typical Needs Workgroup." Members represent various Delaware Health and Social Services' Divisions, the Delaware Developmental Disabilities Council, the Delaware State Police, the Department of Transportation, Delaware's Emergency Management Agency and the Federal Emergency Management Agency (FEMA). The group is working on supporting communication efforts between people with special needs and emergency responders. The workgroup focuses on assuring the accurate, timely, and effective flow of emergency related information to and from people with 'non-typical needs'. Additionally, there is a subgroup working on identifying emergency evacuation needs for all citizens of Delaware and assuring that people with non-typical transportation needs are accounted for and accommodated.[4]

Nationally, there are federal efforts such as the reference guide recently produced by the Federal Emergency Management Agency (FEMA). It outlines access requirements and standards for people with disabilities during periods of disaster. It is entitled 'The Reference Guide for Accommodating Individuals with Disabilities in the Provision of Disaster Mass Care, Housing and Human Services.' The FEMA website states that this guide was developed as a requirement of recent federal law.[5] The National Association of State Director of Developmental Disabilities Services says that this is the first of a series of disability-related guidelines to be produced by FEMA for disaster preparedness and response planners and service providers at all levels.[6] I urge emergency preparedness professionals and policy makers to review this guideline as well as future guidelines that will be forthcoming. Hopefully, these guidelines coupled with integrated, state-supported, and inclusive EP efforts will result in effective emergency responses for individuals living with disabilities during times of natural and man-made disasters.

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